

Facility Name & ID Number Bryan Manor

0033373 Report Period Beginning: 07/1/07 Ending: 06/30/08

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>93</u>	Intermediate/DD	<u>93</u>	<u>34,038</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>34,038</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>32,812</u>			<u>32,812</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>32,812</u>			<u>32,812</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.40%

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

621 (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)

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 02/12/88

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 _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 7/1/07-6/30/08 Fiscal Year: 7/1/07-6/30/08

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

Facility Name & ID Number

Bryan Manor

0033373

Report Period Beginning:

07/1/07

Ending:

06/30/08

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	278,954	19,750	12,053	310,757		310,757		310,757			1
2	Food Purchase		207,901		207,901		207,901		207,901			2
3	Housekeeping	212,673	59,413		272,086		272,086		272,086			3
4	Laundry	256,547	72,872		329,419		329,419		329,419			4
5	Heat and Other Utilities			217,528	217,528		217,528		217,528			5
6	Maintenance	54,596	74,491	35,994	165,081		165,081		165,081			6
7	Other (specify):*											7
8	TOTAL General Services	802,770	434,427	265,575	1,502,772		1,502,772		1,502,772			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	2,908,673	353,410	71,057	3,333,140		3,333,140		3,333,140			10
10a	Therapy			46,312	46,312		46,312		46,312			10a
11	Activities	45,098	5,418		50,516		50,516		50,516			11
12	Social Services	22,178			22,178		22,178		22,178			12
13	CNA Training	170,568	5,182		175,750		175,750		175,750			13
14	Program Transportation		7,095		7,095		7,095		7,095			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,146,517	371,105	120,369	3,637,991		3,637,991		3,637,991			16
	C. General Administration											
17	Administrative	113,049		61,610	174,659		174,659		174,659			17
18	Directors Fees											18
19	Professional Services			189,163	189,163		189,163		189,163			19
20	Dues, Fees, Subscriptions & Promotions			48,180	48,180		48,180		48,180			20
21	Clerical & General Office Expenses	87,296	28,297		115,593		115,593		115,593			21
22	Employee Benefits & Payroll Taxes			833,327	833,327		833,327		833,327			22
23	Inservice Training & Education			2,918	2,918		2,918		2,918			23
24	Travel and Seminar			1,507	1,507		1,507		1,507			24
25	Other Admin. Staff Transportation			1,536	1,536		1,536		1,536			25
26	Insurance-Prop.Liab.Malpractice			47,426	47,426		47,426		47,426			26
27	Other (specify):*											27
28	TOTAL General Administration	200,345	28,297	1,185,667	1,414,309		1,414,309		1,414,309			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,149,632	833,829	1,571,611	6,555,072		6,555,072		6,555,072			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 Bryan Manor #0033373 Report Period Beginning: 07/1/07 Ending: 06/30/08

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			152,292	152,292	152,292		152,292			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			144,772	144,772	144,772	(26,812)	117,960			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			297,064	297,064	297,064	(26,812)	270,252			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			267,268	267,268	267,268		267,268			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			267,268	267,268	267,268		267,268			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,149,632	833,829	2,135,943	7,119,404	7,119,404	(26,812)	7,092,592			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 Bryan Manor

0033373

Report Period Beginning: 07/1/07

Ending: 06/30/08

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	26,812	32-3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 26,812		\$	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))	\$ 26,812		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.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						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

Bryan Manor

ID# 0033373

Report Period Beginning: 07/1/07

Ending: 06/30/08

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

Facility Name & ID Number

Bryan Manor

0033373

Report Period Beginning:

07/1/07

Ending:

06/30/08

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

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

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

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

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

Facility Name & ID Number Bryan Manor # 0033373 Report Period Beginning: 07/1/07 Ending: 06/30/08

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									\$		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 Bryan Manor

0033373 Report Period Beginning: 07/1/07

Ending: 06/30/08

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	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	PEOPLES NATIONAL BANK		X	MORTGAGE	\$18,000.00	06/24/05	\$ 1,649,834	\$ 1,260,894	06/24/2014	5.0000	\$ 97,244	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$18,000.00		\$ 1,649,834	\$ 1,260,894			\$ 97,244	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,649,834	\$ 1,260,894			\$ 97,244	15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.		\$	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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	_____	12
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bryan Manor COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0033373

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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 Bryan Manor

0033373 Report Period Beginning:

07/1/07 Ending:

06/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,341 B. General Construction Type: Exterior BRICK/BLOCK Frame WOOD/BLOCK Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>BLDG</u>	<u>304,920</u>		<u>\$ 63,244</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	304,920		\$ 63,244	3

Facility Name & ID Number Bryan Manor

0033373

Report Period Beginning:

07/1/07

Ending:

06/30/08

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93		1988		\$ 990,822	\$ 38,669	27	\$ 38,669	\$	\$ 756,859	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		BOILER		1989	2,188	81	27	81		1,546	9
10		GARAGE		1990	3,965		15			3,965	10
11		15965 SQ FT ADDITION		1993	1,588,478	58,832	27	58,832		872,686	11
12		RENOVATION OF APPROX 3000 SQ FT									12
13		ACTIVITY AREA INCLUDING DROP CEILING									13
14		INSULATION & SPRINKLERS									14
15		AND WALL CONSTRUCTION		1988	50,590	1,874	27	1,874		37,287	15
16		CENTRAL AIR IN RESIDENT ROOMS		1989	45,000	1,667	27	1,667		33,168	16
17		INSULATE RESIDENT WINGS		1989	6,967	258	27	258		4,987	17
18		FENCE		1989	572		7			572	18
19		RENOVATION OF BATHS IN RESIDENT WINGS		1989	5,856	217	27	217		4,193	19
20		SMALL BLDG ADD TO HOUSE WATER HEATERS		1990	9,900		15			9,900	20
21		SERVICE FLUSH SINK		1991	4,050		15			4,050	21
22		WATER HEATER		1991	2,290		15			2,290	22
23		UNDERGROUND WATER PIPING		1995	10,710	714	15	714		9,580	23
24		PARKING LOT		1991	5,225		15			5,225	24
25		REMODEL EAST WING		1996	36,800	2,453	15	2,453		28,621	25
26		BOILER IMPROVEMENTS		1997	3,495	233	15	233		2,621	26
27		INSTALL DRAINS AND GARBAGE DISPOSALS		1997	6,350	423	15	423		4,655	27
28		AIR CONDITIONERS		1999	1,682	112	15	112		1,176	28
29		PARKING LOT IMPROVEMENTS		1999	1,410	94	15	94		987	29
30		12 X 24 STORAGE SHED		1999	2,969	197	15	197		1,684	30
31		COURTYARD & SIDEWALKS		1999	13,060	871	15	871		7,402	31
32		HS529-60 A/C UNIT		2000	4,656	310	15	310		2,637	32
33		DOORS		1999	1,659	111	15	111		942	33
34		WINDOWS		2000	7,340	489	15	489		4,158	34
35		CABINETS		2000	4,196	280	15	280		2,378	35
36		BOILER & HEATING IMPROVEMENTS		1999	12,700	847	15	847		7,198	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 Bryan Manor

0033373

Report Period Beginning:

07/1/07

Ending:

06/30/08

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	AIR CONDITIONERS	2000	\$ 1,625	\$ 108	15	\$ 108	\$	\$ 811	37
38	WINDOWS	2001	4,451	297	15	297		2,226	38
39	GENERATOR	2002	45,960	3,064	15	3,064		19,916	39
40	FURNACE	2001	9,023	602	15	602		3,962	40
41	FIRE ALARM SYSTEM	2002	44,647	2,976	15	2,976		18,105	41
42	STANDBY POWER SYSTEM	2002	34,346	2,290	15	2,290		13,930	42
43	ROOF REPLACEMENT	2002	31,527	1,167	27	1,167		7,592	43
44	BASEMENT WATER SYSTEM	2002	3,000	200	15	200		1,100	44
45	COMPRESSOR FIRE ALARM SYSTEM	2002	3,925	262	15	262		1,505	45
46	ROOF REPLACEMENT	2004	7,300	487	15	487		1,988	46
47	FURNACES	2004	4,950	330	15	330		1,182	47
48	Addition	2008	2,495		10				48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,016,179	\$ 120,515		\$ 120,515	\$	\$ 1,883,084	70

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

Facility Name & ID Number Bryan Manor # 0033373 Report Period Beginning: 07/1/07 Ending: 06/30/08

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	\$ 139,315	\$ 18,594	\$ 18,594	\$	AVG 7	\$ 86,125	71
72	Current Year Purchases	71,671				AVG 7		72
73	Fully Depreciated Assets	406,457				AVG 7	406,457	73
74								74
75	TOTALS	\$ 617,443	\$ 18,594	\$ 18,594	\$		\$ 492,582	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT/ADMIN	2005 GMC SAVANNA	2005	\$ 45,494	\$ 9,099	\$ 9,099	\$	5	\$ 30,329	76
77	PATIENT/ADMIN	1998 FORD E-150 VAN	2004	18,554	3,711	3,711		5	15,152	77
78	PATIENT/ADMIN	2006 Mazda Truck	2008	11,176	373	373		5	373	78
79	PATIENT/ADMIN	95 GMC/96 DODGE VAN	98/01	22,212				5	22,212	79
80	TOTALS			\$ 97,436	\$ 13,183	\$ 13,183	\$		\$ 68,066	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)		\$ 3,794,302	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 152,292	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 152,292	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,443,732	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 Bryan Manor

0033373

Report Period Beginning: 07/1/07

Ending: 06/30/08

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:				\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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	1,244	3,938		5,182
3	Classroom Wages (a)		42,160		42,160
4	Clinical Wages (b)		84,320		84,320
5	In-House Trainer Wages (c)	10,581	33,507		44,088
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 11,825	\$ 163,925	\$	\$ 175,750
10	SUM OF line 9, col. 1 and 2 (e)	\$ 175,750			

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	136
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	34
2. From other facilities (f)	
TOTAL TRAINED	170

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

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

Facility Name & ID Number Bryan Manor# 0033373

Report Period Beginning:

07/1/07

Ending:

06/30/08

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

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

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

Facility Name & ID Number Bryan Manor# 0033373Report Period Beginning: 07/1/07

Ending:

06/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(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	\$ 620,608	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,190,907		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,609		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,822,124	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	2,675,688		14
15	Leasehold Improvements, at Historical Cost	393,735		15
16	Equipment, at Historical Cost	714,879		16
17	Accumulated Depreciation (book methods)	(2,443,732)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	105,033		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,455,603	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,277,727	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 691,082	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	141,319		29
30	Accrued Salaries Payable	167,387		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,519		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		206,544		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,218,851	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,119,575		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)	\$ 1,119,575	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,338,426	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 939,301	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,277,727	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 852,008	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 852,008	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 87,293	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)	\$ 87,293	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 939,301	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bryan Manor# 0033373Report Period Beginning: 07/1/07Ending: 06/30/08**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	\$ 4,808,304	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,808,304	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	2,043,953	10
11	CNA Training Reimbursements	224,295	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,268,248	23
D. Non-Operating Revenue			
24	Contributions	79,562	24
25	Interest and Other Investment Income***	26,812	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 106,374	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income-Insur Reimbursement	23,772	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,772	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,206,698	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,502,772	31
32	Health Care	3,637,992	32
33	General Administration	1,414,309	33
B. Capital Expense			
34	Ownership	297,064	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	267,268	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,119,405	40
41	Income before Income Taxes (line 30 minus line 40)**	87,293	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 87,293	43

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

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

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

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

Facility Name & ID Number Bryan Manor

0033373

Report Period Beginning: 07/1/07

Ending:

06/30/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,872	2,080	\$ 65,369	\$ 31.43	1
2	Assistant Director of Nursing	1,925	2,115	40,924	19.35	2
3	Registered Nurses	12,893	14,003	262,626	18.75	3
4	Licensed Practical Nurses	24,872	26,148	475,551	18.19	4
5	CNAs & Orderlies					5
6	CNA Trainees	16,320	16,320	126,480	7.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,917	2,087	24,556	11.77	9
10	Activity Assistants	2,184	2,267	20,542	9.06	10
11	Social Service Workers	1,549	1,602	22,178	13.84	11
12	Dietician					12
13	Food Service Supervisor	1,997	2,190	31,444	14.36	13
14	Head Cook	9,402	9,958	122,611	12.31	14
15	Cook Helpers/Assistants	11,753	12,226	99,919	8.17	15
16	Dishwashers	2,938	3,056	24,980	8.17	16
17	Maintenance Workers	5,380	5,577	54,596	9.79	17
18	Housekeepers	20,277	21,983	212,673	9.67	18
19	Laundry	24,464	26,258	256,547	9.77	19
20	Administrator	2,080	2,080	15,500	7.45	20
21	Assistant Administrator					21
22	Other Administrative	1,879	2,080	42,191	20.28	22
23	Office Manager					23
24	Clerical	4,202	4,511	61,121	13.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,412	6,943	89,485	12.89	28
29	Resident Services Coordinator	1,975	2,080	55,358	26.61	29
30	Habilitation Aides (DD Homes)	180,036	197,728	2,018,807	10.21	30
31	Medical Records	1,980	2,194	26,175	11.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	338,307	365,486	\$ 4,149,633 *	\$ 11.35	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	211	\$ 12,053	1-4	35
36	Medical Director	30	3,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	2,100	10-3	39
40	Physical Therapy Consultant	56	4,343	10a-3	40
41	Occupational Therapy Consultant	836	64,385	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	77	5,538	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychologist	25	1,760	10a-3	47
48	Dental/Vision/Podiatry	51	4,573	10-3	48
49	TOTAL (lines 35 - 48)	1,307	\$ 97,752		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,610	\$ 64,385	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,610	\$ 64,385		53

Facility Name & ID Number Bryan Manor

0033373

Report Period Beginning: 07/1/07

Ending: 06/30/08

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	
G. Miller	ADMIN		\$ 15,500	Workers' Compensation Insurance	\$ 144,295	IDPH License Fee	\$ 15,320	
C. Hiestand	SERV COORD		55,358	Unemployment Compensation Insurance	0	Advertising: Employee Recruitment		
S. Hotz	HR COORD		42,191	FICA Taxes	314,577	Health Care Worker Background Check (Indicate # of checks performed)	4,257	
				Employee Health Insurance	250,186	Patient Background Checks		
				Employee Meals		Dues	20,841	
				Illinois Municipal Retirement Fund (IMRF)*		License & Fees	765	
				Physicals, Vaccines, Retirement, ETC	124,269	Subscriptions	4,957	
						Promotional	2,040	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 113,049			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Penta Nascent (G. Miller)			\$ 61,610					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 61,610	TOTAL (agree to Schedule V, line 22, col.8)	\$ 833,327	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 48,180	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
CSI	MGMT		\$ 134,844				Out-of-State Travel	\$
Crain, Miller, & Wernsman	Legal		21,951					
S. Milner	Clerical		450				In-State Travel	
S. Hamilton	Accounting		575					
Creative Systems	Computer		12,088					
Glass & Shuffet, LTD.	Auditing		6,500					
RSM McGladrey	Accounting		1,582				Seminar Expense	1,507
KWI	Clerical		11,173					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 189,163	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	()
							TOTAL	\$ 1,507

* 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. IARF \$20841
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 5YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,465 Line 10-F
- (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? _____
If YES, give effective date of lease. NO
- (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. \$ 267,268
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? N/A 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? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 2,742
- c. What percent of all travel expense relates to transportation of nurses and patients? 50
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: GLASS & SHUFFET, LTD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES 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.