

		FOR BHF USE				

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**2008**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2008)**

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:** 0027458

**Facility Name:** Manorcare at Decatur

**Address:** 444 West Harrison Street Decatur 62526  
 Number City Zip Code

**County:** Macon

**Telephone Number:** 217-877-7333 **Fax #** 217-872-6723

**HFS ID Number:** Old 520886946005; New 260615541001;

**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
<b>IRS Exemption Code</b> _____	<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 **Telephone Number:** 419-252-5740  
**Email Address:** cdekany@hcr-manorcare.com

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 6-01-07 to 5-31-08 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Barry Lazarus</u>	
<b>Paid Preparer</b>	(Title) <u>Vice President - Reimbursement</u>	
	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>( )</u>	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 Decatur

# 0027458 Report Period Beginning: 6-01-07 Ending: 5-31-08

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	<u>112</u>	Skilled (SNF)	<u>112</u>	<u>40,992</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>112</u>	TOTALS	<u>112</u>	<u>40,992</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>6,219</u>	<u>18,755</u>	<u>14,026</u>	<u>39,000</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,219</u>	<u>18,755</u>	<u>14,026</u>	<u>39,000</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.14%

D. How many bed-hold days during this year were paid by the Department? 25 (Do not include bed-hold days in Section B.)

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

N/A

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

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

YES  NO

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

YES  NO

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

Date started 11/01/81

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

YES  Date 11/01/81 NO

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

YES  NO  If YES, enter number of beds certified 112 and days of care provided 12,646

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12-31-08 Fiscal Year: 05-31-08

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

Facility Name & ID Number      Manorcare at Decatur      #      0027458      Report Period Beginning:      6-01-07      Ending:      5-31-08

**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
	<b>A. General Services</b>										
1	Dietary	262,592	18,303	17,512	298,407	2,435	300,842		300,842		1
2	Food Purchase		223,974		223,974		223,974	(2,006)	221,968		2
3	Housekeeping	143,583	24,079	3,121	170,783		170,783		170,783		3
4	Laundry	51,267	10,194	1,016	62,477		62,477		62,477		4
5	Heat and Other Utilities			144,837	144,837	5,585	150,422	(2,377)	148,045		5
6	Maintenance	53,566	35,932	88,444	177,942		177,942		177,942		6
7	Other (specify):*			3,483	3,483		3,483		3,483		7
8	<b>TOTAL General Services</b>	<b>511,008</b>	<b>312,482</b>	<b>258,413</b>	<b>1,081,903</b>	<b>8,020</b>	<b>1,089,923</b>	<b>(4,383)</b>	<b>1,085,540</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			37,000	37,000		37,000		37,000		9
10	Nursing and Medical Records	2,184,391	191,694	58,115	2,434,200	4,514	2,438,714	(4,857)	2,433,857		10
10a	Therapy	745,784	10,935	143,949	900,668		900,668		900,668		10a
11	Activities	84,669	4,986	5,506	95,161		95,161	(10)	95,151		11
12	Social Services	124,497		1,001	125,498		125,498		125,498		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,139,341</b>	<b>207,615</b>	<b>245,571</b>	<b>3,592,527</b>	<b>4,514</b>	<b>3,597,041</b>	<b>(4,867)</b>	<b>3,592,174</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	89,663		435,580	525,243	(109,594)	415,649		415,649		17
18	Directors Fees										18
19	Professional Services			5,705	5,705	(4,366)	1,339	(1,339)			19
20	Dues, Fees, Subscriptions & Promotions			99,439	99,439		99,439	(43,743)	55,696		20
21	Clerical & General Office Expenses	347,942	51,262	412,994	812,198	4,366	816,564	(252,666)	563,898		21
22	Employee Benefits & Payroll Taxes			756,159	756,159	57,088	813,247		813,247		22
23	Inservice Training & Education			7,225	7,225		7,225		7,225		23
24	Travel and Seminar			12,596	12,596		12,596		12,596		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			156,234	156,234		156,234		156,234		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>437,605</b>	<b>51,262</b>	<b>1,885,932</b>	<b>2,374,799</b>	<b>(52,506)</b>	<b>2,322,293</b>	<b>(297,748)</b>	<b>2,024,545</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,087,954</b>	<b>571,359</b>	<b>2,389,916</b>	<b>7,049,229</b>	<b>(39,972)</b>	<b>7,009,257</b>	<b>(306,998)</b>	<b>6,702,259</b>		<b>29</b>

\*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 Decatur #0027458 Report Period Beginning: 6-01-07 Ending: 5-31-08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			318,995	318,995	17,201	336,196	336,196			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(742)	(742)	22,771	22,029	22,029			32
33	Real Estate Taxes			82,264	82,264		82,264	82,264			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			61,015	61,015		61,015	61,015			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			461,532	461,532	39,972	501,504	501,504			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			236	236		236	236			38
39	Ancillary Service Centers		225,516	1,200	226,716		226,716	226,716			39
40	Barber and Beauty Shops		30	20,908	20,938		20,938	20,938			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			61,320	61,320		61,320	61,320			42
43	Other (specify):*		38,361	33,002	71,363		71,363	71,363			43
44	<b>TOTAL Special Cost Centers</b>		263,907	116,666	380,573		380,573	380,573			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,087,954	835,266	2,968,114	7,891,334		7,891,334	(306,998)	7,584,336		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 Decatur

# 0027458

Report Period Beginning: 6-01-07

Ending:

5-31-08

**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	(2,006)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,377)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,657)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(33)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,339)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(252,123)	21		24
25	Fund Raising, Advertising and Promotional	(35,126)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,337)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (306,998)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (306,998)		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.		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Decatur

ID# 0027458

Report Period Beginning: 6-01-07

Ending: 5-31-08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Activities Income	\$ (10)	11	1
2	Phys Svc	(1,200)	10	2
3	Donations Rev	(510)	21	3
4	AR Sub Fee	(8,617)	20	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	<b>Total</b>	(10,337)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,006)	0	0	0	0	0	0	0	0	0	0	(2,006)	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	(2,377)	0	0	0	0	0	0	0	0	0	0	(2,377)	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	<b>TOTAL General Services</b>	<b>(4,383)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,383)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,857)	0	0	0	0	0	0	0	0	0	0	(4,857)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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	<b>TOTAL Health Care and Programs</b>	<b>(4,867)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,867)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(1,339)	0	0	0	0	0	0	0	0	0	0	(1,339)	19
20	Fees, Subscriptions & Promotions	(43,743)	0	0	0	0	0	0	0	0	0	0	(43,743)	20
21	Clerical & General Office Expenses	(252,666)	0	0	0	0	0	0	0	0	0	0	(252,666)	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	<b>TOTAL General Administration</b>	<b>(297,748)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(297,748)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(306,998)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(306,998)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Decatur# 0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	0	0	0	0	0	0	0	0	0	0	0	0	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	(306,998)	0	0	0	0	0	0	0	0	0	0	(306,998)	45

**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
ManorCare, Inc	100	Health Care & Retirement Corp. 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	\$ 435,580	HCR Manorcare, Inc.	100.00%	\$ 435,580	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	42,881	Heartland Management Services	100.00%	42,881	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 478,461			\$ 478,461	\$ *

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

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 6-01-07 Ending: 5-31-08

## 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	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 Decatur

# 0027458

Report Period Beginning:

6-01-07

Ending: 5-31-08

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 HCR ManorCare, Inc.  
 Street Address 333 North Summit Street  
 City / State / Zip Code Toledo, OH 43604  
 Phone Number ( 419-252-5500  
 Fax Number ( 419-252-5495

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	2,813,673,080	369 Nurs Fac	\$ 59,848	\$ 7,243,785	\$ 154	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	369 Nurs Fac	1,061,370	577,717	7,243,785	2,281	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	369 Nurs Fac	497,772	7,243,785	1,282	3	
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	369 Nurs Fac	2,002,556	7,243,785	4,303	4	
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	369 Nurs Fac		7,243,785	0	5	
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	369 Nurs Fac	2,100,636	1,287,391	7,243,785	4,514	6
7	17	General & Admin - Direct	Accumulated Cost	2,813,673,080	369 Nurs Fac	41,222,846	32,327,667	7,243,785	106,128	7
8	17	General & Admin - Pooled	Accumulated Cost	3,371,307,314	369 Nurs Fac	102,324,370	42,519,840	7,243,785	219,860	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	369 Nurs Fac	7,830,100	7,243,785	20,159	9	
10	22	Employee Benefits - Pooled	Accumulated Cost	3,371,307,314	369 Nurs Fac	17,187,062	7,243,785	36,929	10	
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	369 Nurs Fac		7,243,785	0	11	
12	30	Depreciation - Pooled	Accumulated Cost	3,371,307,314	369 Nurs Fac	8,005,430	7,243,785	17,201	12	
13									13	
14	32	Interest						22,771	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 182,291,990	\$ 76,712,615	\$ 435,582	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Conv Sub. Debentures		X	Facility			\$ 738,560	\$ 738,560			\$ 22,771	1								
2												2								
3												3								
4												4								
5	Interest						Interest Income				(742)	5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 738,560	\$ 738,560			\$ 22,029	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 738,560	\$ 738,560			\$ 22,029	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.)



**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 Manorcare at Decatur COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0027458

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 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. <u>04-12-03-451-010</u>	<u>See Attached</u>	\$ <u>39,853.50</u>	\$ <u>39,853.50</u>
2. <u>04-12-03-451-012</u>	<u>See Attached</u>	\$ <u>455.96</u>	\$ <u>455.96</u>
3. <u>04-12-03-451-013</u>	<u>See Attached</u>	\$ <u>66.91</u>	\$ <u>66.91</u>
4. <u>04-12-03-451-016</u>	<u>See Attached</u>	\$ <u>755.74</u>	\$ <u>755.74</u>
5. <u>04-12-03-451-010</u>	<u>See Attached</u>	\$ <u>39,853.50</u>	\$ <u>39,853.50</u>
6. <u>04-12-03-451-012</u>	<u>See Attached</u>	\$ <u>455.96</u>	\$ <u>455.96</u>
7. <u>04-12-03-451-013</u>	<u>See Attached</u>	\$ <u>66.91</u>	\$ <u>66.91</u>
8. <u>04-12-03-451-016</u>	<u>See Attached</u>	\$ <u>755.74</u>	\$ <u>755.74</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>82,264.22</u>	\$ <u>82,264.22</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 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 Manorcare at Decatur

# 0027458 Report Period Beginning:

6-01-07 Ending:

5-31-08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 34,879 B. General Construction Type: Exterior Masonry Frame Steel 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).

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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	Facility		1981, 2005	\$ 245,843	1
2	Facility		2006	165,606	2
3	TOTALS			\$ 411,449	3

Facility Name &amp; ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	96			1963	\$ 659,655	\$ 87,509		\$ 87,509	\$	\$ 1,951,090	4
5	6			2002	682,385						5
6				2002	(201,827)						6
7				2005	1,072,957						7
8	7/1/06 Capital Rate Adj #1			2005	259,992						8
	<b>Improvement Type**</b>										
9	<b>BUILDING IMPROVEMENTS (Current Year Depreciation)</b>					113,734		113,734		1,503,670	9
10				1983	102,669						10
11				1984	5,247						11
12				1985	4,600						12
13				1986	9,308						13
14				1987	92,366						14
15		<b>RETIREMENTS</b>		1987	(86,079)						15
16				1988	38,377						16
17				1989	18,196						17
18				1990	6,261						18
19				1991	162,665						19
20		<b>RETIREMENTS</b>		1991	(3,037)						20
21				1992	121,887						21
22		<b>RETIREMENTS</b>		1992	(6,084)						22
23				1993	191,712						23
24				1994	75,641						24
25				1995	47,351						25
26		<b>A/C WALL SLEEVE UNIT</b>		1995	2,952						26
27		<b>INSTALL FIRE BOXES</b>		1995	513						27
28		<b>ELECTRICAL</b>		1995	7,058						28
29		<b>HANDRAILS</b>		1995	8,442						29
30		<b>CONCRETE FLOOR</b>		1995	884						30
31		<b>ARCHITECT-ARCADIA / LOBBY</b>		1995	1,439						31
32		<b>LIGHTING</b>		1995	4,074						32
33		<b>FLOORING</b>		1995	2,080						33
34		<b>NURSE CALL SYSTEM</b>		1995	38,400						34
35		<b>DOOR LOCKS</b>		1995	698						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	UPGRADE ARCADIA / LOBBY	1996	\$ 10,460	\$		\$	\$	\$	37
38	WALLVINYL	1996	2,759						38
39	HANDRAILS	1996	9,792						39
40	CAPITALIZED LABOR-ARCADIA / LOBBY	1996	7,272						40
41	5/31/99 AUDIT ADJUSTMENT	1996	(7,272)						41
42	REMODELING-ARCADIA / LOBBY	1996	2,466						42
43	INSTALL FIRE DOORS	1996	8,340						43
44	PHONE WIRING/JACKS	1996	1,486						44
45	SIGNS/BOARDS	1996	952						45
46	A/C WORK	1996	3,237						46
47	ELECTRICAL-ARCADIA / LOBBY	1996	3,479						47
48	INSTALL TILES	1996	1,825						48
49	INSTALL ASPHALT	1996	4,390						49
50	WALLCOVERINGS	1997	3,715						50
51	ROOFTOP TRANE UNITS	1997	12,448						51
52	INSTALL TILES/CEILING & WALLPANELS	1997	7,385						52
53	INSTALL WATER HEATER	1997	7,010						53
54	REPAIR ROOF LEAKS	1997	1,500						54
55	ELECTRICAL	1997	1,549						55
56	INSTALL DOORS	1997	12,737						56
57	WALLCOVERINGS	1997	1,623						57
58	INSTALL VINYL TILE	1997	11,728						58
59	A/C COMPRESSOR WORK	1997	2,257						59
60	FACILITY PLAN ALLOC	1997	2,759						60
61	5/31/99 AUDIT ADJUSTMENT	1997	(2,759)						61
62	REPAIR WATER LEAKS	1997	1,408						62
63	NURSES STATION GATE	1997	625						63
64	LANDSCAPING	1997	828						64
65	SIDEWALK	1997	4,023						65
66	INSTALL PATIO COVERS	1997	1,082						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,439,886	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	70

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

Facility Name &amp; ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,439,886	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	1
2	ROOFING	1998	1,992						2
3	HVAC	1998	3,794						3
4	TILE & CARPET	1998	6,771						4
5	FINISH/STUD	1998	3,333						5
6	MASONRY WORK	1998	1,333						6
7	PLUMBING	1998	3,172						7
8	PAINTING/WALLCOVERINGS	1998	2,182						8
9	ELECTRICAL WORK	1998	2,352						9
10	CORPORATE OVERHEAD	1998	1,702						10
11	5/31/99 AUDIT ADJUSTMENT	1998	(1,702)						11
12	SECURITY SYSTEM	1998	22,488						12
13	IDPU PLAN REVIEW	1998	1,362						13
14	DOORS/WINDOWS	1998	2,681						14
15	GENERAL CONTRACTOR FEES	1998	1,973						15
16	FINISH/STUD	1998	9,004						16
17	MASONRY WORK	1998	21,533						17
18	FLOORING	1998	5,943						18
19	PAINTING/WALLCOVER	1998	9,311						19
20	PLUMBING	1998	1,183						20
21	ROOFING	1998	41,500						21
22	GENERAL CONTRACTORS FEES	1998	4,278						22
23	DOORS/WINDOWS	1998	3,634						23
24	ELECTRICAL	1998	1,333						24
25	HVAC	1998	5,359						25
26	SIGNAGE	1998	11,862						26
27	WALLCOVERING	1999	18,122						27
28	FLOORING	1999	1,600						28
29	WATER HEATER	1999	1,089						29
30	CARPET	1999	2,769						30
31	LEONARD MIXING VALVE	1999	3,236						31
32	FLOOR COVERING	1999	1,552						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,636,627	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	34

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

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,636,627	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	1
2	FREIGHT CARPET TILES	1999	214						2
3	BUILDING DECORATIONS	1999	23						3
4	BATH STATION TRANSFORMER	1999	3,355						4
5	MJ ROST FREIGHT	1999	616						5
6	WALLCOVERING	1999	1,325						6
7	CORNERGUARD	1999	270						7
8	BOILER	2000	3,076						8
9	CONCRETE & CARPENTRY	2000	30,863						9
10	PAINTING	2000	49,231						10
11	PLUMBING	2000	14,039						11
12	PLUMBING-2003 AUDIT ADJUSTMENT	2000	(6,908)						12
13	DEVELOPERS COST-10 BED ADDTN	2000	116,845						13
14	DEVELOPERS COST-2003 AUDIT ADJUSTMENT	2000	(116,845)						14
15	ADDTL COST ON CONSTRUCTION-10 BED ADDTN	2000	1,938						15
16	CARPET INSTALLATION V#3504	2000	1,805						16
17	CEILING / FLOORING	2000	25,652						17
18	AWNING FRONT ENT / SERVICE ENT	2000	2,013						18
19	CLOSET DOOR	2000	350						19
20	B G ASSEMBLY	2001	487						20
21	B G ASSEMBLY	2001	321						21
22	B G ASSEMBLY	2001	776						22
23	WATER HEATER	2001	8,452						23
24	WATER HEATER	2001	7,755						24
25	WATER HEATER - 2003 AUDIT ADJUSTMENT	2001	(500)						25
26	VINLY WALL COVERING	2001	433						26
27	AWNING	2001	2,013						27
28	VINLY WALL COVERING	2001	62						28
29	Border	2001	244						29
30	VWC	2001	316						30
31	Wall Coverings	2001	277						31
32	VWC	2001	200						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,785,326	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	34

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

Facility Name &amp; ID Number Manorcare at Decatur

# 0027458

Report Period Beginning:

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**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,785,326	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	1
2	Painting	2001	7,218						2
3	Window Treatments	2001	648						3
4	CARPET	2001	1,629						4
5	Light Fixtures	2001	3,404						5
6	Carpet	2001	870						6
7	Handrails	2001	1,865						7
8	Add'l Cost Smoke Shelter	2001	3,960						8
9	Smoke Shelter	2001	2,015						9
10	Painting	2001	7,200						10
11	Painting	2001	2,602						11
12	Add'l Cost Smoke Shelter	2001	600						12
13	Double Glass Doors	2001	4,050						13
14	Vinyl Tile & Sheets	2001	7,759						14
15	Wallpaper & Painting Retainage	2001	500						15
16	Wallpaper & Painting	2001	4,500						16
17	Doors	2001	4,935						17
18	Smoking Shelter	2001	5,400						18
19	VWC	2001	823						19
20	Smoke Shelter	2001	3,492						20
21	Artwork	2001	2,068						21
22	ARTWORK - 2003 AUDIT ADJUSTMENT	2001	(2,068)						22
23	Smoke Shelter	2001	388						23
24	Carpet	2001	8,821						24
25	Smoke Shelter	2001	400						25
26	Smoke Shelter	2001	988						26
27	Window treatments	2001	593						27
28	Kitchen store room door	2001	1,380						28
29	Sidewalk & Parking Lot	2001	8,555						29
30	Entrance Double Door	2001	1,305						30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,871,226	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	34

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

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 3,871,226	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	1
2	Shower Room Renovation	2002	655						2
3	Window treatments	2002	3,459						3
4	Carpet and Installation	2002	1,190						4
5	Artwork	2002	2,199						5
6	ARTWORK - 2003 AUDIT ADJUSTMENT	2002	(2,199)						6
7	Renovation - OH & Int.	2002	1,905						7
8	RENOVATION-2003 AUDIT ADJUSTMENT	2002	(1,905)						8
9	Reno - Flooring, Painting	2002	29,775						9
10	Reno - Plumbing & Electrical	2002	37,536						10
11	Arch & Engineering Costs	2002	2,240						11
12	Arch & Engineering Costs	2002	619						12
13	Exterior Renovations - Soffitt & Gutters	2002	9,112						13
14	7/1/06 CAPITAL RATE ADJ #2	2002	(142)						14
15	Exterior Renovations - Soffitt & Gutters	2002	1,013						15
16	Vent Work	2002	331						16
17	Baseboard	2002	4,164						17
18	Adjust asset #1680 - (Reno-Plumbing & Electrical)	2002	(4,164)						18
19	Addn. - Carpet, VWC & Sig	2002	9,213						19
20	Addn - Concrete test & L	2002	3,599						20
21	Addn - Permits	2002	8,834						21
22	Renovation-Roofing & Sheet Metal	2003	67,148						22
23	Renovation-General Overhead	2003	1,031						23
24	7/1/06 CAPITAL RATE ADJ #3	2003	(1,031)						24
25	Renovation-Interest	2003	581						25
26	7/1/06 CAPITAL RATE ADJ #4	2003	(581)						26
27	AWNING	2003	2,470						27
28	Landscaping-Install Facade Materials	2003	23,983						28
29	GAZEBO	2003	6,215						29
30	ADD'L COST GAZEBO	2003	2,611						30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,081,088	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	34

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

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 4,081,088	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	1
2	Renovation-Engineering	2004	4,880						2
3	Renovation-General Overhead	2004	10,453						3
4	7/1/06 Capital Rate Adj #5	2004	(10,453)						4
5	Renovation-Interest	2004	138						5
6	7/1/06 Capital Rate Adj #6	2004	(138)						6
7	Doors and Downspouts	2004	7,110						7
8	Doors Retainage	2004	790						8
9	Vinyl Tile and Cove Base	2004	17,910						9
10	Vinyl Tile and Base	2005	2,974						10
11	7/1/06 Capital Rate Adj #7	2005	(2,974)						11
12	Vinyl Tile	2005	2,974						12
13	7/1/06 Capital Rate Adj #7	2005	(2,974)						13
14	Vinyl Tile and Cove Base	2005	10,985						14
15	Water/Sewer/Utilities	2005	76,296						15
16	7/1/06 Capital Rate Adj #8	2005	(76,296)						16
17	Paving/Parking	2005	45,064						17
18	7/1/06 Capital Rate Adj #9	2005	(45,064)						18
19	Site Concrete	2005	20,963						19
20	7/1/06 Capital Rate Adj #10	2005	(20,963)						20
21	Site Preparation	2005	50,580						21
22	7/1/06 Capital Rate Adj #11	2005	(50,580)						22
23	Fencing/Gazebo/Courtyard	2005	13,234						23
24	7/1/06 Capital Rate Adj #12	2005	(13,234)						24
25	Landscaping	2005	30,808						25
26	7/1/06 Capital Rate Adj #13	2005	(30,808)						26
27	Site Demolition	2005	25,400						27
28	7/1/06 Capital Rate Adj #17	2005	(25,400)						28
29	Water/Sewer Testing	2005	9,025						29
30	Landscaping	2005	10,269						30
31	7/1/06 Capital Rate Adj #14	2005	(10,269)						31
32	Landscaping	2005	1,838						32
33	7/1/06 Capital Rate Adj #15	2005	(1,838)						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,131,788	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	34

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

Facility Name &amp; ID Number    Manorcare at Decatur

#    0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 4,131,788	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	1
2	Nursing Station Carpentry	2005	3,360						2
3	Vinyl Wall Covering	2005	1,344						3
4	Architect & Engineering Fees	2005	150,302						4
5	7/1/06 Capital Rate Adj #18	2005	(13,833)						5
6	General Overhead & Interest	2005	221,331						6
7	7/1/06 Capital Rate Adj #19	2005	(221,331)						7
8	Permit Fees, Plan Reviews	2005	15,128						8
9	7/1/06 Capital Rate Adj #16	2005	(9,600)						9
10	Vinyl Wall Covering, Flooring	2005	34,343						10
11	Vinyl Wall Covering	2005	1,551						11
12	Carpet	2005	3,680						12
13	Canopy Sprinklers	2005	3,950						13
14	Blinds	2005	2,375						14
15	Vinyl Wall Covering	2005	(676)						15
16	Fabrics	2005	499						16
17	Flooring	2005	14,253						17
18	Overhead & Interest	2005	1,641						18
19	7/1/06 Capital Rate Adj #20	2005	(1,641)						19
20	Carpentry	2005	26,507						20
21	Wallcovering	2006	624						21
22	Doors	2006	5,715						22
23	HVAC	2006	16,890						23
24	Painting	2006	2,325						24
25	Rooftop Unit	2006	10,910						25
26	Demolish & Reinstall Floors	2006	30,700						26
27	Ductwork	2006	1,163						27
28	Electrical	2006	4,176						28
29	Wallcovering, Painting	2006	2,187						29
30	Fence	2006	9,983						30
31	ENGINEERING FOR ENTRANCE	2007	1,425						31
32	EXTERIOR SIGN	2008	4,345						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,455,411	\$ 201,243		\$ 201,243	\$	\$ 3,454,760	34

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

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 6-01-07 Ending: 5-31-08

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	\$ 1,523,780	\$ 117,752	\$ 117,752	\$		\$ 1,088,830	71
72	Current Year Purchases	50,168						72
73	Fully Depreciated Assets	(2,835)						73
74	Home Office			17,201	17,201			74
75	TOTALS	\$ 1,571,113	\$ 117,752	\$ 134,953	\$ 17,201		\$ 1,088,830	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)	\$ 6,437,973	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 318,995	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 336,196	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,201	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,543,590	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 Decatur

# 0027458

Report Period Beginning:

6-01-07

Ending: 5-31-08

**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:	<u>N/A</u>			\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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: \$ 61,015      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			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (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 Manorcare at Decatur# 0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$ 282,009	608	\$ 15,195	\$ 2,113	608	\$ 299,317	1
2	Licensed Speech and Language Development Therapist	10a	hrs	198,579	2,396	59,888	75	2,396	258,542	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	265,196	2,755	68,866	8,747	2,755	342,809	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	5,39,2	# of prescrpts				225,516		225,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>P/S X-Ray &amp; Lab</u>	5,39,3				33,002			33,002	13
14	<b>TOTAL</b>			\$ 745,784	5,759	\$ 176,951	\$ 236,451	5,759	\$ 1,159,186	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 Decatur# 0027458Report Period Beginning: 6-01-07

Ending:

5-31-08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 5-31-08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 29,582	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,349,712		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,424		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,382,718	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	411,449		13
14	Buildings, at Historical Cost	4,455,410		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,571,113		16
17	Accumulated Depreciation (book methods)	(4,543,590)		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):	205,510		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,099,892	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,482,610	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 70,189	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	427,204		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,396		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Exp	106,169		36
37	Acc Sales & Use Tax	1,202		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 728,160	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 728,160	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,754,450	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,482,610	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,197,101	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,197,101	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,245,095	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)	\$ 1,245,095	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	(1,687,746)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,687,746)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,754,450	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Decatur# 0027458Report Period Beginning: 6-01-07Ending: 5-31-08**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,214,317	1
2	Discounts and Allowances for all Levels	168,890	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,383,207	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,347,098	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,347,098	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,524	12
13	Barber and Beauty Care	21,690	13
14	Non-Patient Meals	468	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	333,751	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,078	19
20	Radiology and X-Ray	18,129	20
21	Other Medical Services	1,017	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 405,657	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	510	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 510	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Discounts</u>	(41)	28
28a	<u>Late Charges</u>	(2)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (43)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,136,429	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,081,903	31
32	Health Care	3,592,527	32
33	General Administration	2,374,799	33
<b>B. Capital Expense</b>			
34	Ownership	461,532	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	380,573	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,891,334	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,245,095	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,245,095	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 Decatur

# 0027458

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	1,968	2,116	\$ 67,016	\$ 31.67	1
2	Assistant Director of Nursing	4,317	4,642	116,443	25.08	2
3	Registered Nurses	9,218	9,913	234,020	23.61	3
4	Licensed Practical Nurses	35,824	38,524	741,601	19.25	4
5	CNAs & Orderlies	89,890	96,807	1,078,168	11.14	5
6	CNA Trainees					6
7	Licensed Therapist	10,303	11,185	406,294	36.32	7
8	Rehab/Therapy Aides	8,782	9,534	262,655	27.55	8
9	Activity Director					9
10	Activity Assistants	7,906	8,536	84,669	9.92	10
11	Social Service Workers	6,090	6,571	124,497	18.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,434	26,363	262,592	9.96	15
16	Dishwashers					16
17	Maintenance Workers	2,433	2,626	53,566	20.40	17
18	Housekeepers	13,024	14,058	143,583	10.21	18
19	Laundry	4,901	5,291	51,267	9.69	19
20	Administrator	2,080	2,080	89,663	43.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,177	23,856	347,942	14.59	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	1,996	2,154	23,978	11.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	245,343	264,256	\$ 4,087,954 *	\$ 15.47	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 37,000	5,9,3	36
37	Medical Records Consultant	Monthly 1,470	5,10,3	37
38	Nurse Consultant	Monthly 26,740	5,10,3	38
39	Pharmacist Consultant	Monthly 5,009	5,10,3	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	Medical Services Consultant	Monthly 7,315	5,10,3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 77,534		49

**C. CONTRACT NURSES**

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





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA 2498.74
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes 5731.7 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? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,081 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. \$ 61,320  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (468)
- (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? \_\_\_\_\_
- 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.