

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,462			5,462	13
14	TOTALS	5,462			5,462	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.27%

D. How many bed-hold days during this year were paid by the Department?
300 (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 09/15/90

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 07/13/91 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
 ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/08 Fiscal Year: 09/30/08
 * All facilities other than governmental must report on the accrual basis

STATE OF ILLINOIS

Facility Name & ID Number **Richland Manor** # **0036285** Report Period Beginning: **10/01/07** Ending: **09/30/08**

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	53,638	4,453	1,946	60,037		60,037	60,037			1
2	Food Purchase		51,279		51,279	(1,778)	49,501	49,501			2
3	Housekeeping	32,223	10,658		42,881		42,881	42,881			3
4	Laundry		2,598		2,598		2,598	2,598			4
5	Heat and Other Utilities			14,307	14,307		14,307	14,307			5
6	Maintenance	3,840	5,393	5,104	14,337		14,337	14,337			6
7	Other (specify):* Garbage pick-up			1,149	1,149		1,149	1,149			7
8	TOTAL General Services	89,701	74,381	22,506	186,588	(1,778)	184,810	184,810			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	133,990	6,402	10,180	150,572	(194)	150,378	150,378			10
10a	Therapy										10a
11	Activities	26,356	85	521	26,962		26,962	26,962			11
12	Social Services	5,705			5,705		5,705	5,705			12
13	CNA Training			48	48		48	48			13
14	Program Transportation			2,575	2,575	(1,056)	1,519	1,519			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	166,051	6,487	13,324	185,862	(1,250)	184,612	184,612			16
	C. General Administration										
17	Administrative	44,288			44,288	(26)	44,262	44,262			17
18	Directors Fees							1,217	1,217		18
19	Professional Services			91,214	91,214		91,214	2,215	93,429		19
20	Dues, Fees, Subscriptions & Promotions			639	639		639	639	639		20
21	Clerical & General Office Expense:	23,942	7,304		31,246		31,246	1,685	32,931		21
22	Employee Benefits & Payroll Tax			31,564	31,564	1,778	33,342	12,611	45,953		22
23	Inservice Training & Educator			26	26	220	246	246	246		23
24	Travel and Seminar			98	98		98	98	98		24
25	Other Admin. Staff Transportator			3,858	3,858		3,858	2,019	5,877		25
26	Insurance-Prop.Liab.Malpractice			7,475	7,475		7,475	7,475	7,475		26
27	Other (specify):*										27
28	TOTAL General Administration	68,230	7,304	134,874	210,408	1,972	212,380	19,747	232,127		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	323,982	88,172	170,704	582,858	(1,056)	581,802	19,747	601,549		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

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor #0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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			23,448	23,448	23,448	258	23,706			30
31	Amortization of Pre-Op. & Org										31
32	Interest										32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds						467	467			34
35	Rent-Equipment & Vehicles						1,600	1,600			35
36	Other (specify): ³										36
37	TOTAL Ownership			23,448	23,448	23,448	2,325	25,773			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportatior					1,056	1,056	1,056			38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fec			33,446	33,446	33,446		33,446			42
43	Other (specify): ³										43
44	TOTAL Special Cost Centers			33,446	33,446	1,056		34,502			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	323,982	88,172	227,598	639,752			661,824			45

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

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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 Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room:				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patient:				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund:				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 Retainer:				22
23	Malpractice Insurance for Individual:				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotions				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employee:				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ None		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	22,072	Pg 6a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,072		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 22,072		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport	x		\$ 1,056	L14	38
39						39
40	Gift and Coffee Shop:		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,056		47

STATE OF ILLINOIS

Richland Manor

ID# 0036285

Report Period Beginning: 10/01/07

Ending: 09/30/08

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Richland Manor

0036285

Report Period Beginning:

10/01/07

Ending:

09/30/08

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Richland Manor

0036285

Report Period Beginning:

10/01/07

Ending:

09/30/08

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	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): ³	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	37											
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportator	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 Fec	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify): ³	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	44											
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	45											

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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
		<u>Our Place</u>	<u>Murphysboro</u>	<u>(Marion County</u>	<u>Salem</u>	<u>Home Office</u>
		<u>Prairie Estates</u>	<u>Flora</u>	<u>Horizon Center)</u>		

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	<u>See Pg 6A</u>	\$			\$	\$	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

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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	Bernadine Rankin	Director	Board Member	0.00	634	1	3.00	Director Fee	\$ 317	L18,C7	1
2	Susan Wieldt	Director	Board Member	0.00	634	1	3.00	Director Fee	317	L18,C7	2
3	Angela Simmons	Director	Board Member	0.00	1,065	1.5	3.33	Director Fee	533	L18,C7	3
4	Terry Elwood	Director	Board Member	0.00	100	1	3.33	Director Fee	50	L18,C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,217		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

STATE OF ILLINOIS

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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 Marion County Horizon Center
 Street Address 122 N. Hotze Road
 City / State / Zip Code Salem, IL 62881
 Phone Number (618 548 0309
 Fax Number (618 548 3720

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	35	Vehicle Rent	Licensed Beds	48	3	\$ 4,800	\$ 0	16	\$ 1,600	1
2	22	Workmen's Comp. Insurance	Licensed Beds	48	3	11,198	0	16	3,733	2
3	22	Unemp. Tax (501 c 3)	Licensed Beds	48	3	9,500	0	16	3,167	3
4	30	Depreciation	Licensed Beds	48	3	775	0	16	258	4
5	18	Directors' Fees	Licensed Beds	48	3	2,850	0	16	950	5
6	21	Telephone	Licensed Beds	48	3	800	0	16	267	6
7	25	Gas & Oil	Licensed Beds	48	3	6,057	0	16	2,019	7
8	21	Office Supplies	Licensed Beds	48	3	4,253	0	16	1,418	8
9	19	Accounting	Licensed Beds	48	3	6,645	0	16	2,215	9
10	18	Directors' Fees	Licensed Beds	48	3	800	0	16	267	10
11	22	Employee Health Insurance	Licensed Beds	48	3	17,132	0	16	5,711	11
12	34	Other Rent	Licensed Beds	48	3	1,400	0	16	467	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					\$ 66,210	\$		\$ 22,072	25

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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		8	9	10	
					Original	Balance				
Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
A. Directly Facility Related										
Long-Term										
1						\$	\$			\$
2										
3										
4										
5										
Working Capital										
6										
7										
8										
9	TOTAL Facility Related					\$	\$		\$	
B. Non-Facility Related*										
10										
11										
12										
13										
14	TOTAL Non-Facility Related					\$	\$		\$	
15	TOTALS (line 9+line14)					\$ None	\$ None		\$ None	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # _____

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

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

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																											
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.		\$	None 7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>_____</td><td style="text-align: center;">8</td></tr> <tr><td>2004</td><td>_____</td><td style="text-align: center;">9</td></tr> <tr><td>2005</td><td>_____</td><td style="text-align: center;">10</td></tr> <tr><td>2006</td><td>_____</td><td style="text-align: center;">11</td></tr> <tr><td>2007</td><td>_____</td><td style="text-align: center;">12</td></tr> </table>	2003	_____	8	2004	_____	9	2005	_____	10	2006	_____	11	2007	_____	12	<table border="1"> <tr><td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td></tr> <tr><td style="text-align: center;">13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$ _____</td></tr> <tr><td style="text-align: center;">14</td><td>PLUS APPEAL COST FROM LINE 5 \$ _____</td></tr> <tr><td style="text-align: center;">15</td><td>LESS REFUND FROM LINE 6 \$ _____</td></tr> <tr><td style="text-align: center;">16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2007 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
2003	_____	8																									
2004	_____	9																									
2005	_____	10																									
2006	_____	11																									
2007	_____	12																									
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2007 \$ _____																										
14	PLUS APPEAL COST FROM LINE 5 \$ _____																										
15	LESS REFUND FROM LINE 6 \$ _____																										
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____																										
Non-profit received real estate tax exemption in 1992																											

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual o taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of ar 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 Richland Manor COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0036285

CONTACT PERSON REGARDING THIS REPORT Rita Armbrust

TELEPHONE 618 548-0309 FAX #: 618 548-3720

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		\$ <u>None</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.

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,572 B. General Construction Type: Exterior Vinyl Frame Wood & Brick Number of Stories One

C. Does the Operating Entity? [x] (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? [x] (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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc. List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [x] 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.

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Row 1: Facility, 25,425, 1991, \$ 9,000. Row 2: (blank), (blank), (blank), (blank). Row 3: TOTALS, 25,425, (blank), \$ 9,000.

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

0036285

Report Period Beginning:

10/01/07

Ending:

09/30/08

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			1991	1985	\$ 347,410	\$ 13,896	25	\$ 25		\$ 238,552	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Storage Shed		1987	869		15			869	9
10		Remodeling		1990	4,872	195	25	195		3,460	10
11		Storage Shed		1991	618	31	20	31		531	11
12		Wood Deck		1991	2,978		15			2,978	12
13		Paving/Concrete		1991	11,475	574	20	574		9,851	13
14		Lawn		1991	768		10			768	14
15		Landscaping		1991	740		10			740	15
16		Air Conditioning System		1994	1,500	100	15	100		1,433	16
17		Door, cabinet, countertop		1995	1,767		10			1,767	17
18		Driveway Work, Concrete		1997	5,280	264	20	264		3,014	18
19		Air Conditioning System (4 ton		1997	1,242		5			1,242	19
20		Carpet/Installation		1999	9,217	922	10	922		8,604	20
21		Cabinets/Installation		1999	8,195	820	10	820		7,925	21
22		Garage (Van/Storage)		2000	22,718	1,136	20	1,136		9,561	22
23		Fence		2000	5,246	350	15	350		2,858	23
24		Concrete Driveway		2000	4,439	222	20	222		1,850	24
25		Garage Shelving		2000	1,176	118	10	118		982	25
26		Landscaping		2001	600	60	10	60		470	26
27		Air Conditioning/heating system		2001	3,400		10			3,400	27
28		Bathroom floor replaced		2005	2,048	102	20	102		383	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2

See Page 12A, Line 70 for total

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

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

0036285

Report Period Beginning:

10/01/07

Ending:

09/30/08

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 436,558	\$ 18,790		\$ 4,919	\$	\$ 301,238	70

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

STATE OF ILLINOIS

Facility Name & ID Number **Richland Manor** # **0036285** Report Period Beginning: **10/01/07** Ending: **09/30/08**

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	\$ 68,224	\$ 831	\$ 831	\$	10	\$ 66,328	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 68,224	\$ 831	\$ 831	\$		\$ 66,328	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	Facility Transportation	Dodge Caravan 2005	3/22/2005	\$ 20,423	\$ 4,085	\$ 4,085	\$	5	\$ 14,297	76
77										77
78										78
79										79
80	TOTALS			\$ 20,423	\$ 4,085	\$ 4,085	\$		\$ 14,297	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)	\$ 534,205	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,706	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,706	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)	\$ 381,863	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	None	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	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.

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Jack Woods/Shivam Hotels, LLC

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	Office	1987		03/09/92	420	5	N/A	5
6								6
7	TOTAL				\$ 420			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

None

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	Facility Transportation	2004 GMC Envoy	\$ 133.33	\$ 1,600	17
18					18
19					19
20					20
21	TOTAL		\$ 133.33	\$ 1,600	21

10. Effective dates of current rental agreement:

Beginning 03/09/92

Ending 03/09/09

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

Fiscal Year Ending Annual Rent

12.	<u>09/30/09</u>	\$ <u>4,200</u>
13.	<u>09/30/10</u>	\$ <u>4,200</u>
14.	<u>09/30/11</u>	\$ <u>4,200</u>

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

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

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

0036285 Report Period Beginning:

10/01/07 Ending:

09/30/08

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL			\$ None	None	\$ None	\$ None	\$ None	None	\$ None	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.

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/08 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 91,510	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable Patients (less allowance)	226,339		3
4	Supply Inventory (priced at cost)	4,452		4
5	Short-Term Investments			5
6	Prepaid Insurance	711		6
7	Other Prepaid Expenses	758		7
8	Accounts Receivable (owners or related parties)	267,834		8
9	Other(specify) <u>Acc. Int. Receivable</u>	164		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 591,768	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,000		13
14	Buildings, at Historical Cos	371,615		14
15	Leasehold Improvements, at Historical Cos	64,942		15
16	Equipment, at Historical Cos	79,602		16
17	Accumulated Depreciation (book methods)	(372,918)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Cost:			19
	Accumulated Amortization			
20	Organization & Pre-Operating Cost:			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify)			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 152,241	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 744,009	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 10,162	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposit			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,891		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,316		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Tax			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 35,369	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 35,369	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 708,640	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 744,009	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 714,737	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 714,737	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(8,934)	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 Purpose:		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Deferred Maintenance Expense	2,837	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (6,097)	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)	\$ 708,640	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor # 0036285 Report Period Beginning: 10/01/07 Ending: 09/30/08

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	\$ 627,456	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 627,456	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		10
11	CNA Training Reimbursements		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)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,306	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,306	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Transportation Revenue	1,056	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,056	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 630,818	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	186,588	31
32	Health Care	185,862	32
33	General Administration	210,408	33
B. Capital Expense			
34	Ownership	23,448	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	33,446	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 639,752	40
41	Income before Income Taxes (line 30 minus line 40)**	(8,934)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (8,934)	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.

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

0036285

Report Period Beginning: 10/01/07

Ending: 09/30/08

09/30/08

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	209	209	\$ 4,601	\$ 22.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,334	1,406	12,751	9.07	9
10	Activity Assistants	1,583	1,592	13,605	8.55	10
11	Social Service Workers	205	212	5,705	26.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,766	1,872	21,030	11.23	14
15	Cook Helpers/Assistants	3,755	3,888	32,608	8.39	15
16	Dishwashers					16
17	Maintenance Workers	386	389	3,840	9.87	17
18	Housekeepers	3,142	3,200	32,223	10.07	18
19	Laundry					19
20	Administrator	552	572	12,268	21.45	20
21	Assistant Administrator	925	962	20,609	21.42	21
22	Other Administrative	410	424	11,411	26.91	22
23	Office Manager					23
24	Clerical	1,522	1,553	23,942	15.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	925	962	20,609	21.42	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	12,196	12,826	108,780	8.48	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	28,910	30,067	\$ 323,982 *	\$ 10.78	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	38	\$ 1,946	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	13	839	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	528	L10, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	40	3,000	L10, C3	47
48	Psychology Consultant	21	2,192	L10, C3	48
49	TOTAL (lines 35 - 48)	122	\$ 8,505		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	102	\$ 2,708	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	102	\$ 2,708		53

STATE OF ILLINOIS

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Report Period Beginning: 10/01/07

Ending: 09/30/08

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		
Trena Briscoe	Administrator	0	\$ 12,268	Workers' Compensation Insurance	\$ 10,791	IDPH License Fee	\$		
Elizabeth Riggs	Asst. Admn.	0	20,610	Unemployment Compensation Insurance	3,167	Advertising: Employee Recruitment	297		
Charlotte Watton	Admn. Asst.	0	11,410	FICA Taxes	23,481	Health Care Worker Background Check			
				Employee Health Insurance	5,711	(Indicate # of checks performed _____)			
				Employee Meals	1,778	Patient Background Checks	5 50		
				Illinois Municipal Retirement Fund (IMRF)*		Other advertising	22		
				Pneumovax for Staff	620	Dues & Subscriptions	192		
				Staff Hepatitis Shots	180	License Fee	78		
				Staff Flu Shots	225				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 44,288			Less: Public Relations Expense	()		
B. Administrative - Other						Non-allowable advertising	()		
Description			Amount			Yellow page advertising	()		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
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	
Krehbiel & Associates	*Accounting		\$ 2,215			\$	Out-of-State Travel	\$	
Health Care Management	Admn Consulting Fees		91,200						
Coles County Clerk	Client Birth Certificate		14				In-State Travel	98	
*Pass thru home office							Seminar Expense	0	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 93,429	TOTAL		\$ None	Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 98	

* Attach copy of IMRF notifications

**See instructions.

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

0036285

Report Period Beginning: 10/01/07

Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Interior Painting	06/06	\$ 890	36 mo.	\$	\$ 99	\$ 296	\$ 296	\$ 199	\$	\$	\$	\$
2	Interior Painting	09/07	1,410	36 mo.			39	470	470	431			
3	Interior Painting	02/07	6,214	36 mo.			1,381	2,071	2,071	691			
4													
5													
6													
7													
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16													
17													
18													
19													
20	TOTALS		\$ 8,514		\$	\$ 99	\$ 1,716	\$ 2,837	\$ 2,740	\$ 1,122	\$	\$	\$

STATE OF ILLINOIS

Facility Name & ID Number Richland Manor

0036285

Report Period Beginning: 10/01/07

Ending: 09/30/08

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? If YES, give association name and amount No
- (3) Did the nursing home make political contributions or payments to a political 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 purchase? What was the average life used for new equipment added during this period? Yes
N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. : 373 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? If YES, give effective date of lease No
- (9) Are you presently operating under a sublease agreement? YES _____ NO x
- (10) Was this home previously operated by a related party (as is defined in the instructions to 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. 33,446
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 for an individual employee? Yes 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 benefit on Schedule V. \$ 1,778 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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 program during this reporting period. : 1,056
 - c. What percent of all travel expense relates to transportation of nurses and patients? 40%
 - 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? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees _____

1	Employee Benefits and Payroll Taxes, Line 22 Food Purchase, Line 2	\$1,778	\$1,778
	To reclassify free employee meals from food costs to employee benefits.		
2	Medically Necessary Transportation, Line 38 Program Transportation, Line 14	\$1,056	\$1,056
	To reclassify medical transportation for clients per the separate contract with the Department of Public Aid.		
3	Inservice Training & Education, Line 23 Nursing and Medical Records, Line 10 Administrative, Line 17	\$220	\$194 \$26
	To reclassify inservice training fees paid to instructors as follows: 10/03/07 Libby Riggs--Safe Lifting 1/31/2008 Libby Riggs--BMP Review 03/05/08 Shannon Blank--Physical Therapy 03/18/08 Trena Briscoe--CPR 04/04/08 Sylvia Slichenmyer, R.N.--Annual Health Revues 04/30/08 Libby Riggs--Abuse & Neglect Policy/Procedures 05/19/08 Libby Riggs--Emergency Procedures for Nat. Disasters 06/03/08 Libby Riggs--Infection Control 08/14/08 Sylvia Slichenmyer, R.N.--Infection Control/MRSA 09/22/08 Libby Riggs--Review of Seizures 09/24/08 Libby Riggs--CPI		

4A

Deferred Maintenance

*** NOTE: Line 6 Column 3 includes the maintenance expense for this year's portion of deferred maintenance expense ~~42837~~.

3A

Schedule V Line <u>Reference</u>	<u>Item</u>	Total Marion County Horizon <u>Center Expenses</u>	% of <u>Ownership</u>	<u>Allocation</u>		
				<u>Prairie Estates</u>	<u>Our Place</u>	<u>Richland Manor</u>
18	Director Fees	\$3,650	0%	\$1,217	\$1,216	\$1,217
19	Accounting	\$6,645	0%	\$2,215	\$2,215	\$2,215
21	Telephone	\$800	0%	\$267	\$266	\$267
21	Office Supplies	\$4,253	0%	\$1,418	\$1,417	\$1,418
22	W/C Insurance	\$11,198	0%	\$3,733	\$3,732	\$3,733
22	Unemp Tax (501 c3)	\$9,500	0%	\$3,167	\$3,166	\$3,167
22	Emp. Health Insurance	\$17,132	0%	\$5,711	\$5,710	\$5,711
25	Gas & Oil	\$6,057	0%	\$2,019	\$2,019	\$2,019
30	Depreciation	\$775	0%	\$259	\$258	\$258
34	Other Rent	\$1,400	0%	\$467	\$466	\$467
35	Vehicle Rent	<u>\$4,800</u>	0%	<u>\$1,600</u>	<u>\$1,600</u>	<u>\$1,600</u>
		66210		\$22,073	\$22,065	\$22,072

	#0036277 Prairie Estates	#0036293 Our Place	#0036285 Richland Manor	<u>Total</u>
Bernadine Rankin	\$ 317.00	\$ 317.00	\$ 317.00	\$ 951.00
Susan Wieldt	\$ 317.00	\$ 317.00	\$ 317.00	\$ 951.00
Angela Simmons	\$ 533.00	\$ 532.00	\$ 533.00	\$ 1,598.00
Terry Elwood	<u>\$ 50.00</u>	<u>\$ 50.00</u>	<u>\$ 50.00</u>	<u>\$ 150.00</u>
	<u>\$ 1,217.00</u>	<u>\$ 1,216.00</u>	<u>\$ 1,217.00</u>	<u>\$ 3,650.00</u>

	<u>Cost</u>	<u>Current Book Depreciation</u>	<u>Straight Line Depreciation</u>	<u>Adjustment</u>	<u>Component Life</u>	<u>Accm. Depreciation</u>
<u>Equipment (Purchased in Prior Years)</u>						
Home office	\$ 27,134.00	\$ 775.00	\$ 775.00	\$ -	7	\$ 26,832.00
% Home office allocated	<u>x.333</u>	<u>x .333</u>	<u>x.333</u>	\$ -	7	<u>x.333</u>
	\$ 9,045.00	\$ 258.00	\$ 258.00			\$ 8,944.00
Richland Manor equipment	<u>\$ 59,179.00</u>	<u>\$ 573.00</u>	<u>\$ 573.00</u>			<u>\$ 57,384.00</u>
Total XI-C, Line 71	<u>\$ 68,224.00</u>	<u>\$ 831.00</u>	<u>\$ 831.00</u>	<u>\$ -</u>		<u>\$ 66,328.00</u>
 <u>Equipment (Current Year Purchases)</u>						
Home office	\$ -	\$ -	\$ -	\$ -	5	\$ -
% Home office allocated	<u>x.333</u>	<u>x.333</u>	<u>x.333</u>	<u>x.333</u>	5	<u>x.333</u>
	\$ -	\$ -	\$ -	\$ -		\$ -
Richland Manor equipment	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	10	<u>\$ -</u>
Total XI-C, Line 72	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>		<u>\$ -</u>

Other Administrative Transportation (Line 25, Column 8)

Reimbursement to employees for administrative miles were reimbursed at a rate of \$.45/mile for the period 10/01/07 to 09/30/08. Detailed logs of these miles are maintained at the facility.

Total Miles reimbursed - 8573 miles x \$.45/mile	\$3,858
Repair, maintenance, gas and oil for vans (from home office)	<u>\$2,019</u>
Line 25, Column 8	<u><u>\$5,877</u></u>

Elizabeth Riggs's hours have been allocated as follows:

QMRP - 18.5 hours per week

Assistant Administrator - 18.5 hours per week

Housekeeping - 5 hours per week

Clerical - 5 hours per week

Maintenance 3 hours per week

Charlotte Watton's hours have been allocated as follows:

1/6 Social Worker

1/3 Administrative Asst.

1/2 Clerical