

		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

<p>I. IDPH License ID Number: <u>0047134</u></p> <p>Facility Name: <u>Manor Court of Clinton</u></p> <p>Address: <u>1 Park Lane West</u> <u>Clinton</u> <u>61727</u> Number City Zip Code</p> <p>County: <u>Dewitt</u></p> <p>Telephone Number: <u>(217) 935-8500</u> Fax # <u>(217) 935-8520</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>04/15/2005</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (C) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (C) 3</u>	<input 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	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>04/01/2009</u> to <u>03/31/2010</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Darcee Fanning</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Regional Director</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>See Attached Independent Accountant's Report</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E Main Street, Suite 210</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> <td></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Darcee Fanning</u>			(Title) <u>Regional Director</u>		Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u>	(Date) _____	(Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E Main Street, Suite 210</u>		(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u>		(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>	
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Facility Name & ID Number Manor Court of Clinton

0047134 Report Period Beginning: 04/01/2009 Ending: 03/31/2010

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 N/A

	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>134</u>	Skilled (SNF)	<u>134</u>	<u>48,910</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6		ICF/DD 16 or Less			6
7	<u>134</u>	TOTALS	<u>134</u>	<u>48,910</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>18,117</u>	<u>9,902</u>	<u>7,053</u>	<u>35,072</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>0</u>			12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,117</u>	<u>9,902</u>	<u>7,053</u>	<u>35,072</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.71%

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

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

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

None

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 04/15/2005

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

YES Date 04/15/2005 NO

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

YES NO If YES, enter number of beds certified 134 and days of care provided 6,739

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 3/31/10 Fiscal Year: 3/31/10

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

Facility Name & ID Number Manor Court of Clinton # 0047134 Report Period Beginning: 04/01/2009 Ending: 03/31/2010

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	276,118	40,251	8,514	324,883		324,883	(63,408)	261,475		1
2	Food Purchase		343,767		343,767		343,767	(67,094)	276,673		2
3	Housekeeping	138,625	50,210	2,627	191,462		191,462	(23,017)	168,445		3
4	Laundry	46,208	19,548		65,756		65,756	(7,905)	57,851		4
5	Heat and Other Utilities			190,693	190,693		190,693	(32,095)	158,598		5
6	Maintenance	59,570	29,572	39,934	129,076		129,076	(15,387)	113,689		6
7	Other (specify):*										7
8	TOTAL General Services	520,521	483,348	241,768	1,245,637		1,245,637	(208,906)	1,036,731		8
	B. Health Care and Programs										
9	Medical Director			15,400	15,400		15,400		15,400		9
10	Nursing and Medical Records	1,937,172	405,050	3,718	2,345,940		2,345,940		2,345,940		10
10a	Therapy			557,549	557,549		557,549	(136,456)	421,093		10a
11	Activities	72,630	5,419		78,049		78,049	(651)	77,398		11
12	Social Services	21,919			21,919		21,919		21,919		12
13	CNA Training										13
14	Program Transportation			952	952	4,178	5,130		5,130		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,031,721	410,469	577,619	3,019,809	4,178	3,023,987	(137,107)	2,886,880		16
	C. General Administration										
17	Administrative	101,747			101,747		101,747	(12,232)	89,515		17
18	Directors Fees							3,424	3,424		18
19	Professional Services			363,030	363,030		363,030	(41,956)	321,074		19
20	Dues, Fees, Subscriptions & Promotions			83,917	83,917		83,917	(63,926)	19,991		20
21	Clerical & General Office Expenses	78,339	26,393	34,495	139,227		139,227	(18,595)	120,632		21
22	Employee Benefits & Payroll Taxes			591,289	591,289		591,289	(52,874)	538,415		22
23	Inservice Training & Education			4,255	4,255		4,255		4,255		23
24	Travel and Seminar			1,711	1,711		1,711	(29)	1,682		24
25	Other Admin. Staff Transportation			8,355	8,355	(4,178)	4,177	(27)	4,150		25
26	Insurance-Prop.Liab.Malpractice			106,035	106,035		106,035	23	106,058		26
27	Other (specify):* See Att Sch V	37,589		186,201	223,790		223,790	(223,790)			27
28	TOTAL General Administration	217,675	26,393	1,379,288	1,623,356	(4,178)	1,619,178	(409,982)	1,209,196		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,769,917	920,210	2,198,675	5,888,802		5,888,802	(755,995)	5,132,807		29

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

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

Facility Name & ID Number

Manor Court of Clinton

#0047134

Report Period Beginning:

04/01/2009

Ending:

03/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			37,684	37,684		37,684	(5,265)	32,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							566	566			32
33	Real Estate Taxes			220,540	220,540		220,540	(37,492)	183,048			33
34	Rent-Facility & Grounds			1,135,536	1,135,536		1,135,536	(193,041)	942,495			34
35	Rent-Equipment & Vehicles			6,562	6,562		6,562		6,562			35
36	Other (specify):*											36
37	TOTAL Ownership			1,400,322	1,400,322		1,400,322	(235,232)	1,165,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			295	295		295		295			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,608	5,608		5,608		5,608			41
42	Provider Participation Fee			73,365	73,365		73,365		73,365			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			79,268	79,268		79,268		79,268			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,769,917	920,210	3,678,265	7,368,392		7,368,392	(991,227)	6,377,165			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(1,058)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,380)	V-21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(184,004)	V-27		24
25	Fund Raising, Advertising and Promotional	(57,065)	V-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 See Att Sch VI	(756,978)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,002,485)		\$	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 See Att Sch III	11,258		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 11,258		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (991,227)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Manor Court of Clinton

ID# 0047134

Report Period Beginning: 04/01/2009

Ending: 03/31/2010

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

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
Residential Alternatives of Illinois, Inc. (Non-profit Organization)	100	See Attached Schedule I		See Attached Schedule I		

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		\$	LTC Support Services, LLC		\$	\$	1
2	V			See Attached Independent Accountant's Report				2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Manor Court of Clinton

0047134

Report Period Beginning:

04/01/2009

Ending:

03/31/2010

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	See Attached Schedule III								\$ 3,424	18-7	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	\$ 3,424		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 Manor Court of Clinton

0047134 Report Period Beginning: 04/01/2009

Ending: 3/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Residential Alternatives of Illinois, Inc.
 Street Address 285 S. Farnham
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-1550
 Fax Number (309) 343-2857

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

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	See Attached Schedule II & III				\$	\$		\$ 11,258	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 11,258	25

Facility Name & ID Number

Manor Court of Clinton

0047134

Report Period Beginning:

04/01/2009

Ending:

03/31/2010

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									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Home office allocation adj	X								1,624	6							
7	Less Interest Income		X	from page 5, line 10						(1,058)	7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 566	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 566	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report.		\$	257,782		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.)		\$	204,686		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(53,096)		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	273,636		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.		\$	220,540		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	146,216	8	FOR BHF USE ONLY	
	2006	144,592	9	13	FROM R. E. TAX STATEMENT FOR 2009 \$
	2007	200,561	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2008	204,686	11	15	LESS REFUND FROM LINE 6 \$
	2009	218,716	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
This facility is leased from an unrelated for-profit entity. The lease agreement requires the lessee to pay the real estate taxes. Amount accrued includes 12 months of 2009 and 3 months of 2010. The real estate tax estimate is based on 2009 tax bill. Taxes paid are for 2008 tax bill. See Att Sch VI and X for the portion of real estate taxes allocated to supportive living and the SNF allocation.					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Court of Clinton COUNTY Dewitt

FACILITY IDPH LICENSE NUMBER 0047134

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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>07-34-304-001</u>	<u>Lot 1 & Out Lot A & B</u>	\$ _____	\$ _____
2.	_____	<u>Liberty Village Subdivision</u>	\$ <u>218,716.00</u>	\$ <u>181,534.00</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>218,716.00</u></u>	\$ <u><u>181,534.00</u></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? X YES _____ NO

If YES, attach an explanation and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Manor Court of Clinton

0047134

Report Period Beginning:

04/01/2009 Ending:

03/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,256 B. General Construction Type: Exterior Brick Frame Wood 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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A Facility Leased</u>			\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	134			\$	\$		\$	\$	\$
5									
6									
7									
8									
	Improvement Type**								
9	Electric Sign		2005	4,433	442	10	442		2,214
10	Canopy, Fiberglass Insulation		2006	16,622	1,108	15	1,108		4,549
11	Sign		2007	2,600	260	10	260		672
12	Tub Installation		2007	6,036	604	10	604		1,962
13	Install smoke seams/seals		2008	5,561	556	10	556		927
14	Relocate dry pendent sprinkler heads		2008	5,833	233	25	233		389
15	Hot Water Supply Boiler		2010	9,445	79	20	79		79
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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)	\$ 50,530	\$ 3,282		\$ 3,282	\$	\$ 10,792	70

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

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	\$ 254,510	\$ 27,878	\$ 27,878		3-20 yrs	\$ 139,347	71
72	Current Year Purchases	15,285	1,259	1,259		10 yrs	1,259	72
73	Fully Depreciated Assets							73
74	Indirect Costs							74
75	TOTALS	\$ 269,795	\$ 29,137	\$ 29,137			\$ 140,606	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2005 Ford E350	2005	\$ 46,919	\$	\$	\$	4 yrs	\$ 46,919	76
77										77
78										78
79										79
80	TOTALS			\$ 46,919	\$	\$	\$		\$ 46,919	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)	\$ 367,244	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,419	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,419	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)	\$ 198,317	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	2003 GMC Van - 2005	\$ 29,800	\$	\$ 29,800	86
87	2006 Toyota Corolla - 2006	14,900	3,725	14,279	87
88	1991 Ford F250 - 2007	6,159	1,540	3,593	88
89					89
90					90
91	TOTALS	\$ 50,859	\$ 5,265	\$ 47,672	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Mid-Illini Healthcare, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		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>2004</u>	<u>98</u>	<u>4/15/2006</u>	\$ <u>1,135,536</u>	<u>10</u>	<u>5</u>	3
4	Additions	<u>2006</u>	<u>63</u>					4
5								5
6								6
7	TOTAL		<u>161</u>		\$ <u>1,135,536</u>			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

9. Option to Buy: YES NO Terms: Fair Market Value *

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: \$ Amt not determined Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 4/15/2005

Ending 4/14/2014

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

Fiscal Year Ending Annual Rent

12. 03/31/2011 \$ 1,215,036

13. 03/31/2012 \$ 1,215,036

14. 03/31/2013 \$ 1,215,036

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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			\$		\$	\$		\$	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 Manor Court of Clinton# 0047134Report Period Beginning: 04/01/2009Ending: 03/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2010

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 10,412	\$	1
2	Cash-Patient Deposits	11,055		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>82,538</u>)	1,008,536		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,891		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interdivision Recbl</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,074,894	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	50,530		15
16	Equipment, at Historical Cost	367,573		16
17	Accumulated Depreciation (book methods)	(245,989)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 172,114	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,247,008	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 71,769	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,055		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	70,093		31
32	Accrued Real Estate Taxes(Sch.IX-B)	273,636		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision payable</u>	1,740,523		36
37	<u>Accrued Claims</u>	41,033		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,208,109	\$	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	<u>Security Deposits</u>	48,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 48,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,256,109	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,009,101)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,247,008	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,028,818)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,028,818)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	19,717	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)	\$ 19,717	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)	\$ (1,009,101)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manor Court of Clinton

0047134

Report Period Beginning: 04/01/2009

Ending: 03/31/2010

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	\$ 7,348,817	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,348,817	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,384	6
7	Oxygen	1,160	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,544	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	8,389	12
13	Barber and Beauty Care	2,828	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,284	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)	\$ 12,501	23
D. Non-Operating Revenue			
24	Contributions	1,886	24
25	Interest and Other Investment Income***	1,058	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,944	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Sch VII	16,303	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,303	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,388,109	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,245,637	31
32	Health Care	3,019,809	32
33	General Administration	1,623,356	33
B. Capital Expense			
34	Ownership	1,400,322	34
C. Ancillary Expense			
35	Special Cost Centers	5,903	35
36	Provider Participation Fee	73,365	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,368,392	40
41	Income before Income Taxes (line 30 minus line 40)**	19,717	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 19,717	43

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

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

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

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

Facility Name & ID Number **Manor Court of Clinton**

0047134

Report Period Beginning: **04/01/2009**

Ending:

03/31/2010

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	1,934	2,080	\$ 63,334	\$ 30.45	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	10,818	11,632	266,607	22.92	3
4	Licensed Practical Nurses	22,546	24,242	474,183	19.56	4
5	CNAs & Orderlies	86,753	93,282	999,986	10.72	5
6	CNA Trainees					6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director		0			9
10	Activity Assistants	7,103	7,637	72,630	9.51	10
11	Social Service Workers	1,359	1,461	21,919	15.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,827	33,147	276,118	8.33	15
16	Dishwashers					16
17	Maintenance Workers	4,390	4,720	59,570	12.62	17
18	Housekeepers	14,819	15,934	138,625	8.70	18
19	Laundry	5,209	5,601	46,208	8.25	19
20	Administrator	1,934	2,080	77,765	37.39	20
21	Assistant Administrator	1,325	1,425	23,982	16.83	21
22	Other Administrative	2,077	2,233	37,589	16.83	22
23	Office Manager					23
24	Clerical	6,391	6,872	78,339	11.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,100	2,258	38,001	16.83	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,588	1,707	18,777	11.00	31
32	Other Health Care(specify)	3,547	3,814	76,284	20.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,720	220,125	\$ 2,769,917 *	\$ 12.58	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	***	\$ 8,514	1-3	35
36	Medical Director	***	15,400	9-3	36
37	Medical Records Consultant	***	1,760	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,958	10-3	39
40	Physical Therapy Consultant	***	222,197	10a-3	40
41	Occupational Therapy Consultant	***	207,959	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	127,393	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	0	10-3	46
47					47
48	<u>*** Monthly fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 585,181		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Gary Coulter	Administrator	None	\$ 77,765	Workers' Compensation Insurance	\$ 179,181	IDPH License Fee	\$		
Melissa White	Asst. Admin	None	20,045	Unemployment Compensation Insurance	80,286	Advertising: Employee Recruitment		15,848	
Elisa Houston	Asst. Admin	None	3,264	FICA Taxes	208,028	Health Care Worker Background Check			
Sarah Case	Asst. Admin	None	673	Employee Health Insurance	113,044	(Indicate # of checks performed <u>120</u>)		1,200	
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promo & Yellow pages		57,065	
				401(k)	6,897	Subscriptions		3,395	
				Other Employee Benefits	3,853	IHCA Dues		5,199	
TOTAL (agree to Schedule V, line 17, col. 1)						Other Licenses and Fees		1,210	
(List each licensed administrator separately.)			\$ 101,747			Indirect Costs - See Att Sch III & Sch VI		(6,861)	
B. Administrative - Other						Less: Public Relations Expense	(
Description			Amount	Less allocation for ALC portion	(52,874)	Non-allowable advertising		(57,065)	
			\$			Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 538,415			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,991
(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	
RFMS, Inc.	Administrative Services		\$ 171,600			\$	Out-of-State Travel	\$	
LTC Support Services, LLC	Support Services		165,840						
McGladrey & Pullen, LLP	Accounting Services		17,542						
My Innerview	Management Services		687				In-State Travel		
Polsinelli Shughart PC	Legal Services		5,345				Staff use of personal vehicle on facility		
Davis & Campbell L.L.C.	Legal Services		2,016				business and meals (under \$250 per travel voucher)	0	
							Seminar Expense	1,711	
							Less: non-allowable out-of-state travel	0	
							Less Allocation for ALC portion	(29)	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 363,030				TOTAL	\$ 1,682	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manor Court of Clinton# 0047134Report Period Beginning: 04/01/2009Ending: 03/31/2010**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. See Page 21 Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? N/A
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,132 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 73,365
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP
- (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.