

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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 Facility ID Number: <u>0042648</u></p> <p>Facility Name: <u>Manorcare of Northbrook</u></p> <p>Address: <u>3300 Milwaukee Avenue</u> <u>Northbrook</u> <u>60062</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 795-9700</u> Fax # <u>(847) 795-9600</u></p> <p>IDPA ID Number: <u>520886946022</u></p> <p>Date of Initial License for Current Owners: <u>03/22/99</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input 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 _____</td> <td><input checked="" 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>Craig Dekany</u> Telephone Number: <u>(419) 252-5740</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<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>06/01/00</u> to <u>5/31/01</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: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Barry Lazarus</u></td> </tr> <tr> <td></td> <td>(Title) <u>Vice President - Reimbursement</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 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>Barry Lazarus</u>		(Title) <u>Vice President - Reimbursement</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																	
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Paid Preparer	(Signed) _____ (Date) _____																																		
	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) <u>()</u> Fax # ()																																		

Facility Name & ID Number Manorcare of Northbrook

0042648 Report Period Beginning: 06/01/00 Ending: 5/31/01

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	148	Skilled (SNF)	148	54,020	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	148	TOTALS	148	54,020	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 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	6,767	3,768	8,049	18,584	8
9	SNF/PED					9
10	ICF	3,464	19,849	282	23,595	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,231	23,617	8,331	42,179	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.08%

D. How many bed-hold days during this year were paid by Public Aid? 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)
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 03/22/99

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 65 and days of care provided 6,203

Medicare Intermediary B/C Maryland

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 5/31/01

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

STATE OF ILLINOIS

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/00 Ending: 5/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	230,482	36,693	11,701	278,876	1,785	280,661		280,661		1
2	Food Purchase		191,157		191,157		191,157	(1,152)	190,005		2
3	Housekeeping	163,605	24,812	398	188,815		188,815		188,815		3
4	Laundry	51,493	11,039	1,720	64,252		64,252	(18,550)	45,702		4
5	Heat and Other Utilities			103,932	103,932	8,182	112,114		112,114		5
6	Maintenance	48,078	10,126	53,771	111,975		111,975		111,975		6
7	Other (specify):*			1,515	1,515		1,515		1,515		7
8	TOTAL General Services	493,658	273,827	173,037	940,522	9,967	950,489	(19,702)	930,787		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	2,098,581	173,965	48,765	2,321,311	32,341	2,353,652		2,353,652		10
10a	Therapy	203,535	12,397	21,646	237,578		237,578		237,578		10a
11	Activities	94,062	5,782	(2,360)	97,484		97,484		97,484		11
12	Social Services	94,356	139	(23,436)	71,059		71,059		71,059		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,490,534	192,283	59,615	2,742,432	32,341	2,774,773		2,774,773		16
	C. General Administration										
17	Administrative	173,601		357,621	531,222	(69,475)	461,747		461,747		17
18	Directors Fees										18
19	Professional Services			2,703	2,703		2,703	(2,703)			19
20	Dues, Fees, Subscriptions & Promotions			105,531	105,531		105,531	(21,974)	83,557		20
21	Clerical & General Office Expenses	303,057	49,802	114,607	467,466		467,466	(111,110)	356,356		21
22	Employee Benefits & Payroll Taxes			526,371	526,371	(17,115)	509,256		509,256		22
23	Inservice Training & Education			1,867	1,867		1,867		1,867		23
24	Travel and Seminar			22,592	22,592		22,592		22,592		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,413	39,413		39,413		39,413		26
27	Other (specify):*										27
28	TOTAL General Administration	476,658	49,802	1,170,705	1,697,165	(86,590)	1,610,575	(135,787)	1,474,788		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,460,850	515,912	1,403,357	5,380,119	(44,282)	5,335,837	(155,489)	5,180,348		29

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

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

Facility Name & ID Number

Manorcare of Northbrook

#0042648

Report Period Beginning:

06/01/00

Ending:

5/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			319,876	319,876	44,282	364,158		364,158		30
31	Amortization of Pre-Op. & Org.			27,694	27,694		27,694		27,694		31
32	Interest							(5,448)	(5,448)		32
33	Real Estate Taxes			318,349	318,349		318,349		318,349		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			24,015	24,015		24,015		24,015		35
36	Other (specify):*										36
37	TOTAL Ownership			689,934	689,934	44,282	734,216	(5,448)	728,768		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		168,583	29,475	198,058		198,058		198,058		39
40	Barber and Beauty Shops			29,216	29,216		29,216		29,216		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			81,030	81,030		81,030		81,030		42
43	Other (specify):*		91,069		91,069		91,069		91,069		43
44	TOTAL Special Cost Centers		259,652	139,721	399,373		399,373		399,373		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,460,850	775,564	2,233,012	6,469,426		6,469,426	(160,937)	6,308,489		45

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

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning: 06/01/00

Ending: 5/31/01

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,152)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,288)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(18,550)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,448)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9,141)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,669)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,703)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(89,012)	21		24
25	Fund Raising, Advertising and Promotional	(21,974)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (160,937)		\$	30

OHF 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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (160,937)		37

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

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

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

Manorcare of Northbrook

ID# 0042648

Report Period Beginning: 06/01/00

Ending: 5/31/01

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
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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 Manorcare of Northbrook# 0042648

Report Period Beginning:

06/01/00

Ending:

5/31/01

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,152)	0	0	0	0	0	0	0	0	0	0	(1,152)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(18,550)	0	0	0	0	0	0	0	0	0	0	(18,550)	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	(19,702)	0	0	0	0	0	0	0	0	0	0	(19,702)	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	Nurse Aide 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	(2,703)	0	0	0	0	0	0	0	0	0	0	(2,703)	19
20	Fees, Subscriptions & Promotions	(21,974)	0	0	0	0	0	0	0	0	0	0	(21,974)	20
21	Clerical & General Office Expenses	(111,110)	0	0	0	0	0	0	0	0	0	0	(111,110)	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	(135,787)	0	0	0	0	0	0	0	0	0	0	(135,787)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(155,489)	0	0	0	0	0	0	0	0	0	0	(155,489)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Northbrook# 0042648

Report Period Beginning:

06/01/00

Ending:

5/31/01

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
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	(5,448)	0	0	0	0	0	0	0	0	0	0	(5,448) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(5,448)	0	0	0	0	0	0	0	0	0	0	(5,448) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(160,937)	0	0	0	0	0	0	0	0	0	0	(160,937) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc	100	Health Care & Retirement Corporation of America (SEE H.O. COST REPORT)	Toledo, OH			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See						1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a						6
		Home Office Allocation	\$ 357,621	HCR Manor Care, Inc.	100.00%	\$ 357,621	\$	
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 372,121			\$ 372,121	\$ *	14

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

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/00 Ending: 5/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/00 Ending: 5/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization HCR ManorCare, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

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

1 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	1	Dietary - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	\$	\$	0	1
2	1	Dietary - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	671,002	407,536	5,497,277	1,785
3	5	Utilities - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	262,823	5,497,277	795	3
4	5	Utilities - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	2,777,349	5,497,277	7,387	4
5	10	Nursing - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	6,096,791	4,282,378	5,497,277	18,453
6	10	Nursing - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	5,221,432	3,383,186	5,497,277	13,888
7	17	General & Admin - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	23,025,730	19,694,773	5,497,277	69,691
8	17	General & Admin - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	82,128,599	31,955,235	5,497,277	218,454
9	22	Employee Benefits - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	2,724,065	5,497,277	8,245	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	(9,534,453)	5,497,277	(25,360)	10
11	30	Depreciation - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	74,480	5,497,277	225	11
12	30	Depreciation - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	16,563,680	5,497,277	44,058	12
13									13
14	32	Interest		0		14,161,817		0	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 144,173,315	\$ 59,723,108	\$ 357,621	25

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/00

Ending:

5/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	N/A						\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$	\$			\$	(5,448)	9							
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$		14							
15	TOTALS (line 9+line14)						\$	\$			\$	(5,448)	15							

* 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.)

Facility Name & ID Number **Manorcare of Northbrook**# **0042648** Report Period Beginning: **06/01/00** Ending: **5/31/01****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 2000 report.		\$	42,000	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.)		\$	42,000	2
3.	Under or (over) accrual (line 2 minus line 1).		\$		3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	318,349	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 19 _____ 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.		\$	318,349	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	_____	8	
		1997	_____	9	
		1998	0	10	
		1999	42,000	11	
		2000	318,349	12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2000	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042648

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-30-200-013-0000</u>	<u>See Attached</u>	\$ <u>4,637.24</u>	\$ <u>4,637.24</u>
2. <u>04-30-200-020-0000</u>	<u>See Attached</u>	\$ <u>85,171.82</u>	\$ <u>85,171.82</u>
3. <u>04-30-200-024-0000</u>	<u>See Attached</u>	\$ <u>26,640.99</u>	\$ <u>26,640.99</u>
4. <u>14-30-200-025-0000</u>	<u>See Attached</u>	\$ <u>198,899.38</u>	\$ <u>198,899.38</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>315,349.43</u>	\$ <u>315,349.43</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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1999</u>	\$ <u>1,885,717</u>	1
2					2
3	TOTALS			\$ <u>1,885,717</u>	3

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/00

Ending:

5/31/01

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	148		1999	\$ 8,207,461	\$ 153,890		\$ 153,890	\$	\$ 153,890
5									
6									
7									
8									
Improvement Type**									
9	BUILDING IMPROVEMENTS (Current Year Depreciation)				80,569		80,569		80,986
10			1999	531					
11			1999	1,470					
12			1999	73					
13			1999	449					
14	SECURE CARE SYSTEM		2000	14,841					
15	MAGNETIC DOORHOLDER		2000	1,134					
16	ACCESS DOORS - FIRE DAMPERS		2000	2,473					
17	ENGINEER COST V#3413 RESIDENTS ROOMS		2000	14,790					
18	WALLCOVERING-2ND FL RESIDENT R		2000	1,398					
19	ADD'L T CONSTRUCTION COST-RESIDENTS ROOMS		2000	205					
20	CIRCUITRY SECURE CARE SYSTEM		2001	1,374					
21	SITWORK		2000	1,036,860					
22	FENCE		2000	965					
23	BLOCKING AND PULLY SYSTEM		2001	977					
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

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/00

Ending:

5/31/01

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)	\$ 9,285,002	\$ 234,459		\$ 234,459	\$	\$ 234,876	70

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

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/00

Ending:

5/31/01

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,285,002	\$ 234,459		\$ 234,459	\$	\$ 234,876	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	TOTAL (lines 1 thru 33)		\$ 9,285,002	\$ 234,459		\$ 234,459	\$	\$ 234,876	34

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

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/00 Ending: 5/31/01

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	\$ 27,140	\$ 85,416	\$ 85,416	\$		\$ 89,976	71
72	Current Year Purchases	1,108,856						72
73	Fully Depreciated Assets							73
74	H/O Office			44,283	44,283			74
75	TOTALS	\$ 1,135,996	\$ 85,416	\$ 129,699	\$ 44,283		\$ 89,976	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 12,306,715	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 319,875	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 364,158	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 44,283	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 324,852	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2002 \$ _____
13. _____/2003 \$ _____
14. _____/2004 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 24,015 Description: 02 Concentrator, Wheelchairs Gerichairs, Elect Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES 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. 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 AIDE _____</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 AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	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	10a	3259	hrs	\$ 68,676	424	\$ 8,929	\$ 2,464	3,683	\$ 80,069	1	
2	Licensed Speech and Language Development Therapist	10a	1077	hrs	22,682	254	5,342	84	1,331	28,108	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	5324	hrs	112,177	350	7,375	5,577	5,674	125,129	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	39,2		# of prescripts				168,583		168,583	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify):	39,3					29,475	4,272		33,747	13	
14	TOTAL				\$ 203,535	1,028	\$ 51,121	\$ 180,980	10,688	\$ 435,636	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning: 06/01/00

Ending:

5/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 5/31/01

(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	\$ 108,056	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (245,554))	1,054,146		3
4	Supply Inventory (priced at)	28,123		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,190,325	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,923,542		13
14	Buildings, at Historical Cost	8,247,177		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,135,995		16
17	Accumulated Depreciation (book methods)	(324,852)		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)	\$ 11,981,862	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,172,187	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,104	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	311,456		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	318,349		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	48,007		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 700,916	\$	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)	\$ 700,916	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,471,271	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,172,187	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,698,635	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,698,635	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,087,235	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,087,235	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(2,314,599)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,314,599)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 12,471,271	24 *

* This must agree with page 17, line 47.

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	\$ 7,679,366	1
2	Discounts and Allowances for all Levels	(1,213,274)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,466,092	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	818,432	6
7	Oxygen	(82)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 818,350	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,669	12
13	Barber and Beauty Care	35,680	13
14	Non-Patient Meals	1,152	14
15	Telephone, Television and Radio	11,273	15
16	Rental of Facility Space	15	16
17	Sale of Drugs	175,959	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,483	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	18,550	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 266,781	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,438	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,438	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,556,661	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	940,522	31
32	Health Care	2,742,432	32
33	General Administration	1,697,165	33
B. Capital Expense			
34	Ownership	689,934	34
C. Ancillary Expense			
35	Special Cost Centers	399,373	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,469,426	40
41	Income before Income Taxes (line 30 minus line 40)**	1,087,235	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,087,235	43

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

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

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

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

Facility Name & ID Number **Manorcare of Northbrook**# **0042648**Report Period Beginning: **06/01/00**Ending: **5/31/01**

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	600	21,257	31.54	1
2	Assistant Director of Nursing	2,207	68,379	27.62	2
3	Registered Nurses	27,149	672,253	22.07	3
4	Licensed Practical Nurses	13,542	207,655	13.67	4
5	Nurse Aides & Orderlies	88,554	1,102,415	11.10	5
6	Nurse Aide Trainees				6
7	Licensed Therapist	8,554	203,535	21.07	7
8	Rehab/Therapy Aides				8
9	Activity Director	9,233	94,062	9.10	9
10	Activity Assistants				10
11	Social Service Workers	5,018	94,356	16.78	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	23,486	230,482	8.74	15
16	Dishwashers				16
17	Maintenance Workers	2,548	48,078	16.80	17
18	Housekeepers	16,745	163,605	8.72	18
19	Laundry	6,385	51,493	7.20	19
20	Administrator	2,080	173,601	45.71	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	18,336	303,057	16.53	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	2,196	26,622	10.81	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	226,633	3,460,850 *	13.65	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	Monthly 10,805	5,1,3	35
36	Medical Director	Monthly 15,000	5,9,3	36
37	Medical Records Consultant	Monthly 2,625	5,10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly 1,695	5,11,3	44
45	Social Service Consultant	Monthly 75	5,12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 30,200		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	181	4,003	5,10,3	50
51	Licensed Practical Nurses	187	2,557	5,10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	368	\$ 6,560		53

Facility Name & ID Number Manorcare of Northbrook# 0042648Report Period Beginning: 06/01/00Ending: 5/31/01**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$ 1059
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 75,409 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 81,030
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (1,152)
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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.