

		FOR OHF USE				

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

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><b>I. IDPH Facility ID Number:</b> <u>0027466</u></p> <p><b>Facility Name:</b> <u>MANORCARE AT ELGIN</u></p> <p><b>Address:</b> <u>180 South State</u> <u>Elgin</u> <u>60123</u>          Number City Zip Code</p> <p><b>County:</b> <u>Kane</u></p> <p><b>Telephone Number:</b> <u>(847) 742-3310</u> Fax # <u>(847) 742-0924</u></p> <p><b>IDPA ID Number:</b> <u>520886946012</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>11/01/81</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Craig Dekany</u> <b>Telephone Number:</b> <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	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/01</u> to <u>05/31/02</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 data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Barry Lazarus</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Title) <u>Vice President - Reimbursement</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>      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>	Paid Preparer	(Title) <u>Vice President - Reimbursement</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ 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																											
<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
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Facility Name & ID Number MANORCARE AT ELGIN

# 0027466 Report Period Beginning: 06/01/01 Ending: 05/31/02

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	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3	37	Intermediate (ICF)	37	13,505	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	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	Other		
8	SNF	2,133	536	3,243	5,912	8
9	SNF/PED					9
10	ICF	11,966	8,051	0	20,017	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,099	8,587	3,243	25,929	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.80%

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 11/01/81

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/81 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 21 and days of care provided 2,913

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/02 Fiscal Year: 05/31/02

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

STATE OF ILLINOIS

Facility Name & ID Number MANORCARE AT ELGIN # 0027466 Report Period Beginning: 06/01/01 Ending: 05/31/02

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	175,176	16,321	3,035	194,532	937	195,469		195,469		1
2	Food Purchase		122,286		122,286		122,286	(700)	121,586		2
3	Housekeeping	84,066	12,030	999	97,095		97,095		97,095		3
4	Laundry	11,163	6,592	2,365	20,120		20,120		20,120		4
5	Heat and Other Utilities			89,031	89,031	4,456	93,487		93,487		5
6	Maintenance	31,270	6,258	49,759	87,287		87,287		87,287		6
7	Other (specify):* <b>Med Waste</b>			1,095	1,095		1,095		1,095		7
8	<b>TOTAL General Services</b>	301,675	163,487	146,284	611,446	5,393	616,839	(700)	616,139		8
<b>B. Health Care and Programs</b>											
9	Medical Director			12,600	12,600		12,600		12,600		9
10	Nursing and Medical Records	1,132,764	87,745	304,400	1,524,909	20,732	1,545,641		1,545,641		10
10a	Therapy	113,084	2,232	9,505	124,821		124,821		124,821		10a
11	Activities	49,573	1,625	1,715	52,913		52,913		52,913		11
12	Social Services	29,921	54		29,975		29,975		29,975		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,325,342	91,656	328,220	1,745,218	20,732	1,765,950		1,765,950		16
<b>C. General Administration</b>											
17	Administrative	62,844		243,818	306,662	(122,070)	184,592		184,592		17
18	Directors Fees										18
19	Professional Services			3,623	3,623	(210)	3,413	(3,413)			19
20	Dues, Fees, Subscriptions & Promotions			37,239	37,239		37,239	(22,085)	15,154		20
21	Clerical & General Office Expenses	179,744	34,209	10,623	224,576	210	224,786	(8,242)	216,544		21
22	Employee Benefits & Payroll Taxes			360,239	360,239	6,896	367,135		367,135		22
23	Inservice Training & Education			3,421	3,421		3,421		3,421		23
24	Travel and Seminar			12,275	12,275		12,275		12,275		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,547	54,547		54,547		54,547		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	242,588	34,209	725,785	1,002,582	(115,174)	887,408	(33,740)	853,668		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,869,605	289,352	1,200,289	3,359,246	(89,049)	3,270,197	(34,440)	3,235,757		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 AT ELGIN #0027466 Report Period Beginning: 06/01/01 Ending: 05/31/02

## 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	
	<b>D. Ownership</b>											
30	Depreciation			206,210	206,210	23,907	230,117		230,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					65,142	65,142		65,142			32
33	Real Estate Taxes			47,653	47,653		47,653	1,130	48,783			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,631	13,631		13,631		13,631			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			267,494	267,494	89,049	356,543	1,130	357,673			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,665	7,009	96,674		96,674		96,674			39
40	Barber and Beauty Shops		768	10,190	10,958		10,958		10,958			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):*		19,572		19,572		19,572		19,572			43
44	<b>TOTAL Special Cost Centers</b>		110,005	60,999	171,004		171,004		171,004			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,869,605	399,357	1,528,782	3,797,744		3,797,744	(33,310)	3,764,434			45

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

Facility Name & ID Number **MANORCARE AT ELGIN**

# **0027466**

Report Period Beginning: **06/01/01**

Ending: **05/31/02**

**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	(700)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,946)	21		10
11	Discounts, Allowances, Rebates & Refunds	(25)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,422)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(751)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,413)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,088)	21		24
25	Fund Raising, Advertising and Promotional	(22,085)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,130	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (33,310)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (33,310)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

MANORCARE AT ELGIN

ID# 0027466

Report Period Beginning: 06/01/01

Ending: 05/31/02

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
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31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MANORCARE AT ELGIN# 0027466 Report Period Beginning:06/01/01

Ending:

05/31/02**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(700)	0	0	0	0	0	0	0	0	0	0	(700)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(700)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(700)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,413)	0	0	0	0	0	0	0	0	0	0	(3,413)	19
20	Fees, Subscriptions & Promotions	(22,085)	0	0	0	0	0	0	0	0	0	0	(22,085)	20
21	Clerical & General Office Expenses	(8,242)	0	0	0	0	0	0	0	0	0	0	(8,242)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(33,740)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(33,740)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(34,440)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(34,440)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number MANORCARE AT ELGIN# 0027466 Report Period Beginning:06/01/01 Ending:05/31/02

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	1,130	0	0	0	0	0	0	0	0	0	0	1,130 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>1,130</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,130 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(33,310)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(33,310) 45</b>

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
Manor Care, 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	\$ 243,818	HCR Manor Care, Inc.	100.00%	\$ 243,818	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	3,751	Heartland Management Services	100.00%	3,751		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 247,569			\$ 247,569	\$ *	14

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

Facility Name & ID Number      MANORCARE AT ELGIN      #      0027466      Report Period Beginning:      06/01/01      Ending:      05/31/02

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number MANORCARE AT ELGIN # 0027466 Report Period Beginning: 06/01/01 Ending: 05/31/02

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 Manor Care, Inc.  
 Street Address 333 North Summit St.  
 City / State / Zip Code Toledo, OH. 43604  
 Phone Number (419)252-5500  
 Fax Number (419)254-5494

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	2,026,840,883	357 Nurs. Fac.	\$	3,339,244	\$	0	1
2	1	Dietary - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	680,609	406,990	3,339,244	937	2
3	5	Utilities - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	154,435		3,339,244	254	3
4	5	Utilities - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	3,051,710		3,339,244	4,202	4
5	10	Nursing - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	10,993,908	7,606,940	3,339,244	18,113	5
6	10	Nursing - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	1,902,166	1,264,589	3,339,244	2,619	6
7	17	General & Admin - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	14,112,784	11,038,075	3,339,244	23,251	7
8	17	General & Admin - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	71,533,109	46,622,737	3,339,244	98,496	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	2,156,484		3,339,244	3,553	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	2,428,174		3,339,244	3,343	10
11	30	Depreciation - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	101,489		3,339,244	167	11
12	30	Depreciation - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	17,241,472		3,339,244	23,740	12
13										13
14	32	Interest				65,142			65,142	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 124,421,482	\$ 66,939,331		\$ 243,818	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	Conv. Sub. Debentures		X	Facility			\$ 935,949	\$ 935,949			\$ 65,142	1
2												2
3												3
4												4
5												5
<b>Working Capital</b>												
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 935,949	\$ 935,949			\$ 65,142	9
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 935,949	\$ 935,949			\$ 65,142	15

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

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

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

Facility Name & ID Number **MANORCARE AT ELGIN**# **0027466** Report Period Beginning: **06/01/01** Ending: **05/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , 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 2001 report.		\$	46,523	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.)		\$	47,653	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	1,130	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	47,653	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	48,783	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	43,279	8	
		1998	44,019	9	
		1999	46,220	10	
		2000	46,523	11	
		2001	47,653	12	
<b>FOR OHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2001	\$	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:** 2001 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 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 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 2002 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.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME MANORCARE AT ELGIN COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0027466

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 2001 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 2001.

(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>06-14-476-028</u>	<u>See Attached</u>	\$ <u>49,125.64</u>	\$ <u>49,125.64</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>49,125.64</u>	\$ <u>49,125.64</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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,881 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).

N/A

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>1967</u>	<u>\$ 107,499</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 107,499</b>	<b>3</b>

Facility Name & ID Number MANORCARE AT ELGIN# 0027466

Report Period Beginning:

06/01/01

Ending:

05/31/02**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	73		1967	1965	\$ 562,637	\$ 33,970		\$ 33,970	\$	\$ 620,593	4
5	7			1991	325,282						5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>BUILDING IMPROVEMENTS (Current Year Depreciation)</b>					123,815		123,815		907,414	9
10			1987		60,759						10
11			1988		164,890						11
12			1989		26,729						12
13			1990		64,209						13
14			1991		99,431						14
15			1992		76,437						15
16			1993		62,901						16
17			1994		59,739						17
18			1995		141,422						18
19		CORPORATE OVERHEAD-ARCADIA RENOV	1996		7,272						19
20		REPLACE CALL STATION	1996		940						20
21		INSTALL TELSET	1996		1,062						21
22		SECURE CARE DOOR	1996		1,393						22
23		WALLVINYL	1996		7,598						23
24		ARCADIA RENOVATION	1996		1,448						24
25		CARPET	1996		2,153						25
26		ARCADIA RENOVATION	1996		31,328						26
27		DOORS	1996		2,428						27
28		ANNUCIATOR BOX	1996		2,674						28
29		RE-TILE 2ND FLOOR, UTILITY ROOM, BATHROOM	1996		23,688						29
30		ELEVATOR SERVICE	1996		3,200						30
31		LIGHTING	1996		4,998						31
32		LANDSCAPE	1996		6,608						32
33		REMODELING	1996		5,335						33
34		REPAIR HOT WATER HEATER	1996		4,041						34
35		INSTALL DOOR EXIT ALARM	1996		1,943						35
36											36

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

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

See Page 12A, Line 70 for total

## STATE OF ILLINOIS

Facility Name & ID Number MANORCARE AT ELGIN# 0027466

Report Period Beginning:

06/01/01

Ending:

Page 12A

05/31/02**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	TILE & GROUT	1996	\$ 3,877	\$		\$	\$	\$		37
38	FENCE	1996	4,625							38
39	KITCHEN REPAIRS	1996	1,928							39
40	PLUMBING/RE-MODEL BATHROOM	1997	17,552							40
41	CEILING REPLACEMENT	1997	10,543							41
42	WALL BACKING/KITCHEN	1997	2,894							42
43	DECORATING	1997	5,135							43
44	NURSES STATION WORK	1997	9,133							44
45	CARPET	1997	6,324							45
46	WALLCOVERINGS	1997	2,032							46
47	ASPHALT WORK	1997	3,934							47
48	CORPORATE OVERHEAD-NURSES STATION	1997	10,515							48
49	RETIREMENTS	1987	(49,105)							49
50	RETIREMENTS	1992	(6,489)							50
51	RETIREMENTS (DECORATING)	1997	(2,568)							51
52	CARPET & INSTALLATION	1997	6,011							52
53	BASEMENT CEILING WORK	1997	1,146							53
54	HVAC WORK	1997	16,458							54
55	INSTALL DOORS	1997	5,607							55
56	INSTALL WATER CONDITIONER	1997	7,051							56
57	FACILITY PLAN ALLOC.	1997	5,964							57
58	AWNING	1997	1,535							58
59	CABINETS	1997	1,377							59
60	SPRINKLER/SMOKE DETECTOR WORK	1997	1,878							60
61	PARKING LOT REPAIRS/SEALCOAT	1997	7,104							61
62	ELECTRICAL WORK/WIRING	1998	12,961							62
63	CARPENTRY - KITCHEN CABINETS	1998	6,435							63
64	PLUMBING WORK	1998	100,949							64
65	ROOFING/SIDING WORK	1998	18,393							65
66	INSTALL DOORS/WINDOWS	1998	3,255							66
67	DRYWALL/FINISHES	1998	8,246							67
68	GENERAL CONTRACTORS FEES	1998	50,517							68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,027,762	\$ 157,785		\$ 157,785	\$	\$ 1,528,007		70

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

## STATE OF ILLINOIS

Facility Name & ID Number MANORCARE AT ELGIN# 0027466

Report Period Beginning:

06/01/01

Ending:

Page 12B

05/31/02

## 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		\$ 2,027,762	\$ 157,785		\$ 157,785	\$	\$ 1,528,007	1
2	WALL/VINYL	1998	26,268						2
3	CARPET	1998	1,790						3
4	CORPORATE OVERHEAD	1998	1,651						4
5	HVAC WORK (EXHAUST FAN)	1998	3,184						5
6	PLUMBING	1998	1,727						6
7	ELECTRICAL (CORRECTION LINE 62, PAGE 12A)	1998	(1,953)						7
8	ELECTRICAL	1998	1,242						8
9	HVAC WORK	1998	7,245						9
10	PAINTING/WALLCOVER	1998	19,710						10
11	FINISH STUD	1998	32,568						11
12	MILLWORK	1998	23,950						12
13	ROOFING	1998	505						13
14	PAVING	1998	9,256						14
15	SIGNAGE	1998	11,863						15
16	UPGRADE FIRE WET SYSTEM	1999	1,026						16
17	TELEPHONE SYSTEM	1999	1,154						17
18	HOT WATER TANK	1999	5,151						18
19	REPAIR HOT WATER TANK	1999	1,660						19
20	2 CLEAR THERMOPANES	1999	1,405						20
21	MJ ROST FREIGHT	2000	127						21
22	FRAME IN & INSTALL SET OF DOORS	1999	1,744						22
23	LAND IMPROVEMENTS	1999	12,960						23
24	CONCRETE PAD & CLEANUP	1999	10,810						24
25	SEAL/COAT ASPHALT	1999	1,440						25
26	ASBESTOS PIPING	2000	230						26
27	ASBESTOS PIPING WORK	2000	2,070						27
28	DEVELOPERS COST - ARCADIA I RENOV	2000	28,055						28
29	INTERIOR DEMOLITION - ARCADIA I	2000	14,981						29
30	CARPENTRY - ARCADIA I RENOV	2000	8,375						30
31	ACCOUSTICAL CEILING TILE - ARCADIA I	2000	4,300						31
32	CARPETING & PADS - ARCADIA I RENOV	2000	21,762						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,284,019	\$ 157,785		\$ 157,785	\$	\$ 1,528,007	34

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

Facility Name & ID Number MANORCARE AT ELGIN# 0027466

Report Period Beginning:

06/01/01

Ending:

05/31/02**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 12B, Carried Forward	\$ 2,284,019	\$ 157,785		\$ 157,785		\$ 1,528,007		1
2	WALLCOVER & CORNER GUARD - ARCADIA I	2000 24,526							2
3	SPRINKLERS - ARCADIA I RENOV	2000 609							3
4	BASIC ELECTRICAL - ARCADIA I RENOV	2000 16,889							4
5	WALL TILE	2000 1,250							5
6	INSTALL DISHWASHER	2000 2,600							6
7	ASBESTOS FROM PIPING IN BASEMENT	2001 925							7
8	PIPES & VALVES UNIT VENTILATOR	2001 7,411							8
9	2 GAS FIRE WATER HEATERS	2001 10,500							9
10	INSTALL PANIC HARDWARE	2000 1,072							10
11	PIPES & VALVES UNIT VENTILATOR	2001 901							11
12	2 GAS FIRE WATER HEATERS	2001 1,322							12
13	PUMP MOTOR	2001 12,400							13
14	FENCE	2001 1,800							14
15	EXTERIOR PAINTING	2001 5,940							15
16	PAINTING, VCT. & CARPET	2001 6,477							16
17	FREIGHT ON CARPET	2001 347							17
18	VWC	2001 66							18
19	VWC	2001 1,763							19
20	FREIGHT ON CARPET	2001 135							20
21	CARPET	2001 6,742							21
22	PAINTING, VCT. & CARPET	2001 6,010							22
23	PAINTING, VCT. & CARPET	2002 2,405							23
24	CARPET	2001 5,597							24
25	CARPET	2001 276							25
26	VWC	2001 985							26
27	VWC	2001 273							27
28	CARPET	2002 356							28
29	ARTWORK	2002 994							29
30	WALLCOVERINGS	2002 1,228							30
31	PAINTING, VCT. & CARPET	2002 3,564							31
32	WALLCOVERINGS	2001 240							32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,409,621	\$ 157,785		\$ 157,785		\$ 1,528,007		34

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

STATE OF ILLINOIS

Facility Name & ID Number MANORCARE AT ELGIN

# 0027466

Report Period Beginning:

06/01/01

Ending:

Page 12D

05/31/02

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 12C, Carried Forward	\$ 2,409,621	\$ 157,785		\$ 157,785		\$ 1,528,007		1
2	WINDOW TREATMENTS	2002 1,165							2
3	CARPET	2002 3,161							3
4	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996 (7,272)	(727)		(727)		(4,545)		4
5	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997 (10,516)	(1,052)		(1,052)		(5,433)		5
6	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997 (3,206)	(321)		(321)		(1,550)		6
7	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997 (2,759)	(276)		(276)		(1,218)		7
8	C/R 5/31/99 AUDIT ADJ.-MONTHLY CAP BUDGET	1998 (1,651)	(165)		(165)		(660)		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)	\$ 2,388,544	\$ 155,245		\$ 155,245		\$ 1,514,601		34

\*\*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	\$ 587,762	\$ 50,965	\$ 50,965	\$		\$ 443,428	71
72	Current Year Purchases	56,683						72
73	Fully Depreciated Assets							73
74	H.O. Allocation			23,907	23,907			74
75	TOTALS	\$ 644,445	\$ 50,965	\$ 74,872	\$ 23,907		\$ 443,428	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)	\$ 3,140,488	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 206,210	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 230,117	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 23,907	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,958,029	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: \_\_\_\_\_  
 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:	<u>N/A</u>			\$ _____			3
4	Additions				\$ _____			4
5					\$ _____			5
6					\$ _____			6
7	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</u>	\$ _____

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: \$ 13,631 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc  
 (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

**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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Units of Service	Cost	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
						Units	Cost					
1	Licensed Occupational Therapist	10a	1650	hrs	\$ 37,044	103	\$ 2,565	\$ 918	1,753	\$ 40,527	1	
2	Licensed Speech and Language Development Therapist	10a	805	hrs	18,070	77	1,922	0	882	19,992	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	2582	hrs	57,970	201	5,018	1,314	2,783	64,302	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				89,665		89,665	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify): P/S Dentist,Lab,X-Ray	39,3					7,009			7,009	13	
14	<b>TOTAL</b>				\$ 113,084	380	\$ 16,514	\$ 91,897	5,417	\$ 221,495	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

Page 17

Facility Name &amp; ID Number MANORCARE AT ELGIN

# 0027466

Report Period Beginning: 06/01/01

Ending:

05/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/02

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (39,525)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (135,741) )	622,112		3
4	Supply Inventory (priced at )	8,537		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,374		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 600,498	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	107,499		13
14	Buildings, at Historical Cost	2,388,544		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	644,445		16
17	Accumulated Depreciation (book methods)	(1,958,029)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,182,459	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,782,957	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 12,029	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,882		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,653		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	43,615		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 281,179	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 281,179	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,501,778	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,782,957	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,566,574</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,566,574</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>27,097</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>27,097</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Changes in Interdivision</b>	<b>(91,893)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(91,893)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,501,778</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,992,654	1
2	Discounts and Allowances for all Levels	(525,675)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,466,979	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	250,802	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 250,802	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	700	12
13	Barber and Beauty Care	10,686	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,647	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,600	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	13,506	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 103,139	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,830	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,830	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc Income</b>	91	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 91	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,824,841	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	611,446	31
32	Health Care	1,745,218	32
33	General Administration	1,002,582	33
<b>B. Capital Expense</b>			
34	Ownership	267,494	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	171,004	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,797,744	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	27,097	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 27,097	43

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

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

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

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

Facility Name & ID Number **MANORCARE AT ELGIN**

# **0027466**

Report Period Beginning: **06/01/01**

Ending:

**05/31/02**

**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	1,616	1,734	\$ 45,823	\$ 26.43	1
2	Assistant Director of Nursing	1,232	1,321	35,081	26.56	2
3	Registered Nurses	9,282	9,956	218,417	21.94	3
4	Licensed Practical Nurses	10,610	11,381	203,373	17.87	4
5	Nurse Aides & Orderlies	50,840	54,535	606,619	11.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,135	4,358	97,851	22.45	7
8	Rehab/Therapy Aides	1,261	1,329	15,233	11.46	8
9	Activity Director	5,971	6,415	49,573	7.73	9
10	Activity Assistants					10
11	Social Service Workers	1,952	2,098	29,921	14.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,861	18,066	175,176	9.70	15
16	Dishwashers					16
17	Maintenance Workers	1,844	1,979	31,270	15.80	17
18	Housekeepers	10,104	10,851	84,066	7.75	18
19	Laundry	1,646	1,769	11,163	6.31	19
20	Administrator	2,038	2,080	62,844	30.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,317	13,523	179,744	13.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,799	1,944	23,451	12.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,508	143,339	\$ 1,869,605 *	\$ 13.04	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	12,600	5,9,3	36
37	Medical Records Consultant	Monthly	360	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,667	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	17,627		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	11,030	\$ 241,989	5,10,3	50
51	Licensed Practical Nurses	72	1,280	5,10,3	51
52	Nurse Aides		43,421		52
53	TOTAL (lines 50 - 52)	11,101	\$ 286,690		53





Facility Name & ID Number MANORCARE AT ELGIN# 0027466Report Period Beginning: 06/01/01Ending: 05/31/02**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 \$4,395
- (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? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,264 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. \$ 43,800  
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? N/A 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. \$ \_\_\_\_\_
- 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.