

Facility Name & ID Number Manorcare at Elgin

0027466 Report Period Beginning: 06/01/03 Ending: 05/31/04

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 10/01/03

	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)	44	15,616	1
2		Skilled Pediatric (SNF/PED)			2
3	37	Intermediate (ICF)	44	15,616	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	88	31,232	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient		4 Other	Total	
		Private Pay				
8	SNF	444	2,639	4,692	7,775	8
9	SNF/PED					9
10	ICF	13,423	4,292	1,840	19,555	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,867	6,931	6,532	27,330	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.51%

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 44 and days of care provided 4,052

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: 12/31/04 Fiscal Year: 05/31/04

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

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06/01/03 Ending: 05/31/04

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	200,765	16,489	3,645	220,899	1,378	222,277		222,277		1
2	Food Purchase		146,340		146,340		146,340	(420)	145,920		2
3	Housekeeping	89,815	19,558	3,486	112,859		112,859		112,859		3
4	Laundry	23,679	11,984	2,186	37,849		37,849		37,849		4
5	Heat and Other Utilities			105,413	105,413	5,022	110,435		110,435		5
6	Maintenance	34,663	8,495	58,588	101,746		101,746		101,746		6
7	Other (specify):* Med Waste			546	546		546		546		7
8	TOTAL General Services	348,922	202,866	173,864	725,652	6,400	732,052	(420)	731,632		8
	B. Health Care and Programs										
9	Medical Director			12,600	12,600		12,600		12,600		9
10	Nursing and Medical Records	1,449,728	102,916	75,786	1,628,430	29,626	1,658,056	(15,225)	1,642,831		10
10a	Therapy	184,053	4,170	92,544	280,767		280,767		280,767		10a
11	Activities	55,531	2,172	649	58,352		58,352		58,352		11
12	Social Services	35,906		232	36,138		36,138		36,138		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,725,218	109,258	181,811	2,016,287	29,626	2,045,913	(15,225)	2,030,688		16
	C. General Administration										
17	Administrative	78,659		308,212	386,871	(154,414)	232,457		232,457		17
18	Directors Fees										18
19	Professional Services			16,903	16,903	(12,659)	4,244	(4,244)			19
20	Dues, Fees, Subscriptions & Promotions			64,150	64,150		64,150	(25,876)	38,274		20
21	Clerical & General Office Expenses	170,230	38,147	25,318	233,695	12,659	246,354	(13,159)	233,195		21
22	Employee Benefits & Payroll Taxes			417,627	417,627	33,417	451,044		451,044		22
23	Inservice Training & Education			5,061	5,061		5,061		5,061		23
24	Travel and Seminar			6,849	6,849		6,849		6,849		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			89,058	89,058		89,058		89,058		26
27	Other (specify):*										27
28	TOTAL General Administration	248,889	38,147	933,178	1,220,214	(120,997)	1,099,217	(43,279)	1,055,938		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,323,029	350,271	1,288,853	3,962,153	(84,971)	3,877,182	(58,924)	3,818,258		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:

06/01/03

Ending:

05/31/04

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			258,583	258,583	18,109	276,692		276,692			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8	8	66,862	66,870	(8)	66,862			32
33	Real Estate Taxes			54,266	54,266		54,266	(48,295)	5,971			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,976	7,976		7,976		7,976			35
36	Other (specify):*											36
37	TOTAL Ownership			320,833	320,833	84,971	405,804	(48,303)	357,501			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,679	13,220	103,899		103,899	(435)	103,464			39
40	Barber and Beauty Shops			9,369	9,369		9,369		9,369			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,214	47,214		47,214		47,214			42
43	Other (specify):*		6,448		6,448		6,448		6,448			43
44	TOTAL Special Cost Centers		97,127	69,803	166,930		166,930	(435)	166,495			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,323,029	447,398	1,679,489	4,449,916		4,449,916	(107,662)	4,342,254			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(420)	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	(504)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,620)	21		13
14	Non-Care Related Interest	(8)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(13,497)	10		16
17	Non-Care Related Fees	(1,394)	21		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	(4,244)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,641)	21		24
25	Fund Raising, Advertising and Promotional	(24,747)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(48,295)	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Pg5A	(3,292)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,662)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (107,662)		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 at Elgin

ID# 0027466

Report Period Beginning: 06/01/03

Ending: 05/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	P/S Dentistry	\$ (435)	39	1
2	P/S Phyeh Serv	(1,728)	10	2
3	Assoc Dues	(1,129)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,292)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Elgin# 0027466 Report Period Beginning:06/01/03Ending: 05/31/04

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	(420)	0	0	0	0	0	0	0	0	0	0	(420)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(420)	0	0	0	0	0	0	0	0	0	0	(420)	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	(15,225)	0	0	0	0	0	0	0	0	0	0	(15,225)	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	(15,225)	0	0	0	0	0	0	0	0	0	0	(15,225)	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	(4,244)	0	0	0	0	0	0	0	0	0	0	(4,244)	19
20	Fees, Subscriptions & Promotions	(25,876)	0	0	0	0	0	0	0	0	0	0	(25,876)	20
21	Clerical & General Office Expenses	(13,159)	0	0	0	0	0	0	0	0	0	0	(13,159)	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	(43,279)	0	0	0	0	0	0	0	0	0	0	(43,279)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,924)	0	0	0	0	0	0	0	0	0	0	(58,924)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Elgin

0027466

Report Period Beginning:

06/01/03

Ending:

05/31/04

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	(8)	0	0	0	0	0	0	0	0	0	0	(8) 32
33	Real Estate Taxes	(48,295)	0	0	0	0	0	0	0	0	0	0	(48,295) 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	(48,303)	0	0	0	0	0	0	0	0	0	0	(48,303) 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	(435)	0	0	0	0	0	0	0	0	0	0	(435) 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	(435)	0	0	0	0	0	0	0	0	0	0	(435) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(107,662)	0	0	0	0	0	0	0	0	0	0	(107,662) 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
	100	Health Care & Retirement Corporation of America	Toledo,OH			
Manor Care, Inc.		(See H.O Cost Report)				

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 308,212	HCR Manor Care, Inc.	100.00%	\$ 308,212	\$
2	V	Page						
3	V	8						
4	V							
5	V							
6	V	10a	Therapy Management	10,335	Heartland Management Services	100.00%	10,335	
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 318,547			\$ 318,547	\$ *	

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

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06/01/03 Ending: 05/31/04

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	\$ 0	4,192,993	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	940,169	509,589	4,192,993	1,378
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	288,728	4,192,993	4,192,993	504
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	3,082,391	4,192,993	4,192,993	4,518
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	11,758,547	7,451,541	4,192,993	20,518
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	6,213,377	3,630,890	4,192,993	9,108
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	17,137,345	15,146,077	4,192,993	29,903
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	84,524,208	36,356,102	4,192,993	123,896
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	4,283,731	4,192,993	4,192,993	7,475
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	17,698,741	4,192,993	4,192,993	25,943
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.		4,192,993	4,192,993	(0)
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	12,354,014	4,192,993	4,192,993	18,109
13									
14	32	Interest				11,412,188			66,862
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 169,693,439	\$ 63,094,199		\$ 308,212

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06/01/03 Ending: 05/31/04

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
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X	Facility			\$ 935,949	\$ 935,949			\$ 66,862	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 935,949	\$ 935,949			\$ 66,862	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 935,949	\$ 935,949			\$ 66,862	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2003 report.		\$ 102,561	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.)		\$ 54,266	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (48,295)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 54,266	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 5,971	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999	46,220	8
	2000	46,523	9
	2001	47,653	10
	2002	75,672	11
	2003	54,266	12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2003 \$	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:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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,

2003 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 Costs

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(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>27,719.46</u>	\$ <u>27,719.46</u>
2. <u>06-14-476-028</u>	<u>See Attached</u>	\$ <u>27,719.46</u>	\$ <u>27,719.46</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>55,438.92</u>	\$ <u>55,438.92</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,442 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant 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 ground: (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	Facility		1967	\$ 107,499	1
2			2003	21,362	2
3	TOTALS			\$ 128,861	3

Facility Name & ID Number Manorcare at Elgin# 0027466

Report Period Beginning:

06/01/03

Ending:

05/31/04**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	\$ 40,813		\$ 40,813	\$	\$ 695,376	4
5	7		1991	325,282						5
6	8		2003	547,438						6
7										7
8										8
Improvement Type**										
9	Building Improvements (Current Year Depreciation)				162,043		162,043		1,184,398	9
10			1987	60,759						10
11	RETIREMENTS		1987	(49,105)						11
12			1988	164,890						12
13			1989	26,729						13
14			1990	64,209						14
15			1991	99,431						15
16			1992	76,437						16
17	RETIREMENTS		1992	(6,489)						17
18			1993	62,901						18
19			1994	59,739						19
20			1995	141,422						20
21	CORPORATE OVERHEAD-ARCADIA RENOV		1996	7,272						21
22	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR		1996	(7,272)						22
23	REPLACE CALL STATION		1996	940						23
24	INSTALL TELSET		1996	1,062						24
25	SECURE CARE DOOR		1996	1,393						25
26	WALLVINYL		1996	7,598						26
27	ARCADIA RENOVATION		1996	1,448						27
28	CARPET		1996	2,153						28
29	ARCADIA RENOVATION		1996	31,328						29
30	DOORS		1996	2,428						30
31	ANNUNCIATOR BOX		1996	2,674						31
32	RE-TILE 2ND FLOOR, UTILITY ROOM, BATHROOM		1996	23,688						32
33	ELEVATOR SERVICE		1996	3,200						33
34	LIGHTING		1996	4,998						34
35	LANDSCAPE		1996	6,608						35
36	REMODELING		1996	5,335						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 at Elgin# 0027466

Report Period Beginning:

06/01/03

Ending:

05/31/04**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	REPAIR HOT WATER HEATER	1996	\$ 4,041	\$		\$	\$	\$		37
38	INSTALL DOOR EXIT ALARM	1996	1,943							38
39	TILE & GROUT	1996	3,877							39
40	FENCE	1996	4,625							40
41	KITCHEN REPAIRS	1996	1,928							41
42	PLUMBING/RE-MODEL BATHROOM	1997	17,552							42
43	CEILING REPLACEMENT	1997	10,543							43
44	WALL BACKING/KITCHEN	1997	2,894							44
45	DECORATING	1997	5,135							45
46	NURSES STATION WORK	1997	9,133							46
47	CARPET	1997	6,324							47
48	WALLCOVERINGS	1997	2,032							48
49	ASPHALT WORK	1997	3,934							49
50	CORPORATE OVERHEAD-NURSES STATION	1997	10,515							50
51	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)							51
52	RETIREMENTS (DECORATING)	1997	(2,568)							52
53	CARPET & INSTALLATION	1997	6,011							53
54	BASEMENT CEILING WORK	1997	1,146							54
55	HVAC WORK	1997	16,458							55
56	INSTALL DOORS	1997	5,607							56
57	INSTALL WATER CONDITIONER	1997	7,051							57
58	FACILITY PLAN ALLOC.	1997	5,964							58
59	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)							59
60	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)							60
61	AWNING	1997	1,535							61
62	CABINETS	1997	1,377							62
63	SPRINKLER/SMOKE DETECTOR WORK	1997	1,878							63
64	PARKING LOT REPAIRS/SEALCOAT	1997	7,104							64
65	ELECTRICAL WORK/WIRING	1998	12,961							65
66	CARPENTRY - KITCHEN CABINETS	1998	6,435							66
67	PLUMBING WORK	1998	100,949							67
68	ROOFING/SIDING WORK	1998	18,393							68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,489,429	\$ 202,856		\$ 202,856	\$	\$ 1,879,774		70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Manorcare at Elgin

0027466

Report Period Beginning:

06/01/03

Ending:

05/31/04

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		\$ 2,489,429	\$ 202,856		\$ 202,856	\$	\$ 1,879,774	1
2	INSTALL DOORS/WINDOWS	1998	3,255						2
3	DRYWALL/FINISHES	1998	8,246						3
4	GENERAL CONTRACTORS FEES	1998	50,517						4
5	WALL VINYL	1998	26,268						5
6	CARPET	1998	1,790						6
7	CORPORATE OVERHEAD	1998	1,651						7
8	C/R 5/31/99 AUDIT ADJ - MONTHLY CAP BUDGET	1998	(1,651)						8
9	HVAC WORK (EXHAUST FAN)	1998	3,184						9
10	PLUMBING	1998	1,727						10
11	ELECTRICAL (CORRECTION LINE 62, PAGE 12A)	1998	(1,953)						11
12	ELECTRICAL	1998	1,242						12
13	HVAC WORK	1998	7,245						13
14	PAINTING/WALLCOVER	1998	19,710						14
15	FINISH STUD	1998	32,568						15
16	MILLWORK	1998	23,950						16
17	ROOFING	1998	505						17
18	PAVING	1998	9,256						18
19	SIGNAGE	1998	11,863						19
20	UPGRADE FIRE WET SYSTEM	1999	1,026						20
21	TELEPHONE SYSTEM	1999	1,154						21
22	HOT WATER TANK	1999	5,151						22
23	REPAIR HOT WATER TANK	1999	1,660						23
24	2 CLEAR THERMOPANES	1999	1,405						24
25	FRAME IN & INSTALL SET OF DOORS	1999	1,744						25
26	LAND IMPROVEMENTS	1999	12,960						26
27	CONCRETE PAD & CLEANUP	1999	10,810						27
28	SEALCOAT ASPHALT	1999	1,440						28
29	MJ ROST FREIGHT	2000	127						29
30	ASBESTOS PIPING	2000	230						30
31	ASBESTOS PIPING WORK	2000	2,070						31
32	DEVELOPERS COST - ARCADIA I RENOV	2000	28,055						32
33	C/R 5/31/03 AUDIT ADJ #1 - OVERHEAD & INTEREST	2000	(28,055)						33
34	TOTAL (lines 1 thru 33)		\$ 2,728,580	\$ 202,856		\$ 202,856	\$	\$ 1,879,774	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:

06/01/03

Ending:

05/31/04**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		\$ 2,728,580	\$ 202,856		\$ 202,856	\$	\$ 1,879,774	1
2	INTERIOR DEMOLITION - ARCADIA I	2000	14,981						2
3	CARPENTRY - ARCADIA I RENOV	2000	8,375						3
4	ACCOUSTICAL CEILING TILE - ARCADIA I	2000	4,300						4
5	CARPETING & PADS - ARCADIA I RENOV	2000	21,762						5
6	WALLCOVER & CORNER GUARD - ARCADIA I	2000	24,526						6
7	SPRINKLERS - ARCADIA I RENOV	2000	609						7
8	BASIC ELECTRICAL - ARCADIA I RENOV	2000	16,889						8
9	WALL TILE	2000	1,250						9
10	INSTALL DISHWASHER	2000	2,600						10
11	INSTALL PANIC HARDWARE	2000	1,072						11
12	ASBESTOS FROM PIPING IN BASEMENT	2001	925						12
13	PIPES & VALVES UNIT VENTILATOR	2001	7,411						13
14	2 GAS FIRE WATER HEATERS	2001	10,500						14
15	PIPES & VALVES UNIT VENTILATOR	2001	901						15
16	2 GAS FIRE WATER HEATERS	2001	1,322						16
17	PUMP MOTOR	2001	12,400						17
18	FENCE	2001	1,800						18
19	EXTERIOR PAINTING	2001	5,940						19
20	PAINTING, VCT. & CARPET	2001	6,477						20
21	FREIGHT ON CARPET	2001	347						21
22	VWC	2001	66						22
23	VWC	2001	1,763						23
24	FREIGHT ON CARPET	2001	135						24
25	CARPET	2001	6,742						25
26	PAINTING, VCT. & CARPET	2001	6,010						26
27	CARPET	2001	5,597						27
28	CARPET	2001	276						28
29	VWC	2001	985						29
30	VWC	2001	273						30
31	WALLCOVERINGS	2001	240						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,895,055	\$ 202,856		\$ 202,856	\$	\$ 1,879,774	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:

06/01/03

Ending:

05/31/04**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		\$ 2,895,055	\$ 202,856		\$ 202,856	\$	\$ 1,879,774	1
2	PAINTING, VCT, & CARPET	2002	2,405						2
3	CARPET	2002	356						3
4	ARTWORK	2002	994						4
5	C/R 5/31/03 AUDIT ADJ #3 - RECLASS ARTWORK TO EQUIP.	2002	(994)						5
6	WALLCOVERINGS	2002	1,228						6
7	PAINTING, VCT, & CARPET	2002	3,564						7
8	WINDOW TREATMENTS	2002	1,165						8
9	CARPET	2002	3,161						9
10	ARTWORK	2002	849						10
11	C/R 5/31/03 AUDIT ADJ #3 - RECLASS ARTWORK TO EQUIP.	2002	(849)						11
12	FREIGHT ON BORDER	2002	10						12
13	OVERHEAD & INTEREST	2002	2,607						13
14	C/R 5/31/03 AUDIT ADJ #2 - OVERHEAD & INTEREST	2002	(2,607)						14
15	GENERAL CONSTRUCTION & ELECTRICAL	2002	51,388						15
16	WALLCOVERING	2002	1,471						16
17	FREIGHT ON CARPET	2002	70						17
18	INTERIOR REDECORATING	2002	3,865						18
19	INTERIOR REDECORATING	2002	539						19
20	CARPET	2002	3,358						20
21	BORDER	2002	341						21
22	BORDER	2002	306						22
23	VWC	2002	955						23
24	SIDEWALK AND FLAGPOLE	2002	7,950						24
25	WINDOW TREATMENTS	2003	2,265						25
26	COVE BASE	2003	3,086						26
27	RISER PIPE REPLACEMENT	2003	94,830						27
28	15 DOORS	2003	10,500						28
29	PAINTING, BORDER, VCT FLO	2003	1,010						29
30	VWC	2003	771						30
31	VWC	2003	545						31
32	VWC	2003	152						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,090,345	\$ 202,856		\$ 202,856	\$	\$ 1,879,774	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:

06/01/03

Ending:

05/31/04

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 12D, Carried Forward		\$ 3,090,345	\$ 202,856		\$ 202,856	\$	\$ 1,879,774	1
2	PAINTING AND BORDER	2003	463						2
3	PAINTING AND BORDER	2003	5,887						3
4	WALLCOVERINGS	2003	399						4
5	15 DOORS	2003	7,790						5
6	LAUNDRY ROOM DOORS	2003	4,266						6
7	NEW ADDITION	2003	253,434						7
8	NEW ADDITION	2003	9,623						8
9	NEW ADDITION	2003	2,359						9
10	VWC, FLOORING, PAINTING	2003	15,124						10
11	VINYL CEILING & PAINTING	2003	6,274						11
12	ADJUST ASSETS 1583 & 1598 CARPET	2003	(6,519)						12
13	PAINTING AND BORDER	2003	5,887						13
14	ADDITIONAL COST - DOORS	2003	2,312						14
15	TRIM HANDLE (COURTYARD DOOR)	2003	428						15
16	DOORS	2003	2,650						16
17	EXTERIOR DOORS	2003	3,000						17
18	EXTERIOR DOORS	2004	2,000						18
19	EXTERIOR DOORS TERRAINAGE	2004	680						19
20	NEW ADDITION	2003	7,020						20
21	NEW ADDITION	2003	144,374						21
22	OUTSIDE LIGHT	2003	1,782						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)		\$ 3,559,577	\$ 202,856		\$ 202,856	\$	\$ 1,879,774	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	\$ 707,816	\$ 55,727	\$ 55,727	\$		\$ 549,548	71
72	Current Year Purchases	154,542						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			18,109	18,109			74
75	TOTALS	\$ 862,358	\$ 55,727	\$ 73,836	\$ 18,109		\$ 549,548	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,550,796	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 258,583	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 276,692	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,109	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,429,322	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			3
4	Additions				\$ _____			4
5					\$ _____			5
6					\$ _____			6
7	TOTAL				\$ _____			7

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

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

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: \$ 7,976 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	TOTAL		\$ _____	\$ _____	21

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>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

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

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

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

- (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.

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	

- (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	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A	94 hrs	\$ 2,787	1,293	\$ 72,139	\$ 1,366	1,387	\$ 76,292	1
2	Licensed Speech and Language Development Therapist	10A	703 hrs	20,779	117	6,525	135	820	27,439	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	5431 hrs	160,487	237	13,230	2,669	5,668	176,386	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts				90,679		90,679	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 X-Ray,Lab	10a,39,Col.3				13,870			13,870	13
14	TOTAL			\$ 184,053	1,647	\$ 105,764	\$ 94,849	7,875	\$ 384,666	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 at Elgin

0027466

Report Period Beginning: 06/01/03

Ending:

05/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/04

(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	\$ 503	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (15,142))	537,237		3
4	Supply Inventory (priced at)	2,025		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,156		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 541,921	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	128,860		13
14	Buildings, at Historical Cost	3,559,577		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	862,358		16
17	Accumulated Depreciation (book methods)	(2,429,322)		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): CIP			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,121,473	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,663,394	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 78,080	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,330		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,266		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	31,488		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 393,164	\$	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)	\$ 393,164	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,270,230	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,663,394	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,269,559	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,269,559	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(181,082)	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)	\$ (181,082)	17
	B. Transfers (Itemize):		
18	Change In Interdivision	1,181,753	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,181,753	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,270,230	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin

0027466

Report Period Beginning: 06/01/03

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05/31/04

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	\$ 4,614,750	1
2	Discounts and Allowances for all Levels	(1,195,073)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,419,677	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	747,334	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 747,334	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	420	12
13	Barber and Beauty Care	9,882	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	89,158	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	709	19
20	Radiology and X-Ray	805	20
21	Other Medical Services		21
22	Laundry	1,689	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 102,663	23
D. Non-Operating Revenue			
24	Contributions	50	24
25	Interest and Other Investment Income***	(1,394)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (1,344)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	504	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 504	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,268,834	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	725,652	31
32	Health Care	2,016,287	32
33	General Administration	1,220,214	33
B. Capital Expense			
34	Ownership	320,833	34
C. Ancillary Expense			
35	Special Cost Centers	166,930	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)*	\$ 4,449,916	40
41	Income before Income Taxes (line 30 minus line 40)**	(181,082)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (181,082)	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: 06/01/03

Ending: 05/31/04

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	2,063	2,198	\$ 63,259	\$ 28.78	1
2	Assistant Director of Nursing	2,028	2,161	56,267	26.04	2
3	Registered Nurses	17,446	18,589	437,057	23.51	3
4	Licensed Practical Nurses	9,635	10,266	216,992	21.14	4
5	Nurse Aides & Orderlies	51,973	55,378	660,007	11.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,360	5,530	163,390	29.55	7
8	Rehab/Therapy Aides	1,691	1,744	20,663	11.85	8
9	Activity Director	6,500	6,941	55,531	8.00	9
10	Activity Assistants					10
11	Social Service Workers	2,113	2,250	35,906	15.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,857	22,103	200,765	9.08	15
16	Dishwashers					16
17	Maintenance Workers	1,886	2,014	34,663	17.21	17
18	Housekeepers	9,454	10,097	89,815	8.90	18
19	Laundry	3,189	3,403	23,679	6.96	19
20	Administrator	2,393	2,080	78,659	37.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,875	12,095	170,230	14.07	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	1,101	1,175	16,146	13.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,564	158,024	\$ 2,323,029 *	\$ 14.70	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				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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	12,600		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,697	\$ 39,893	5,10,3	50
51	Licensed Practical Nurses	288	6,089	5,10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,985	\$ 45,982		53

Facility Name & ID Number Manorcare at Elgin# 0027466Report Period Beginning: 06/01/03Ending: 05/31/04**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 \$3,663
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$1,129
- (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. \$ 43,189 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 X NO _____ 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. \$ 47,214
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 benefit: 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.