



Facility Name & ID Number Manorcare at Naperville

# 0027524 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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>118</u>	Skilled (SNF)	<u>118</u>	<u>43,188</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,188</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>13,588</u>	<u>5,328</u>	<u>10,761</u>	<u>29,677</u>	8
9	SNF/PED					9
10	ICF	<u>5,139</u>	<u>2,540</u>	<u>654</u>	<u>8,333</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,727</u>	<u>7,868</u>	<u>11,415</u>	<u>38,010</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.01%

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)

Day Care

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 11/1/81

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 87 and days of care provided 8,895

Medicare Intermediary CareFirst

**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: 5/31/04

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

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Naperville # 0027524 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
<b>A. General Services</b>											
1	Dietary	271,140	14,314	1,615	287,069	2,130	289,199		289,199		1
2	Food Purchase		160,389		160,389		160,389	(2,550)	157,839		2
3	Housekeeping	120,621	18,978	140	139,739		139,739		139,739		3
4	Laundry	47,943	16,391	298	64,632		64,632		64,632		4
5	Heat and Other Utilities			101,976	101,976	7,761	109,737	(2,095)	107,642		5
6	Maintenance	42,472	15,315	91,103	148,890		148,890		148,890		6
7	Other (specify):*			1,384	1,384		1,384		1,384		7
8	<b>TOTAL General Services</b>	482,176	225,387	196,516	904,079	9,891	913,970	(4,645)	909,325		8
<b>B. Health Care and Programs</b>											
9	Medical Director			19,750	19,750		19,750		19,750		9
10	Nursing and Medical Records	2,301,803	192,902	124,086	2,618,791	49,563	2,668,354		2,668,354		10
10a	Therapy	459,823	6,083	54,848	520,754		520,754		520,754		10a
11	Activities	105,027	5,803	4,585	115,415		115,415		115,415		11
12	Social Services	49,583			49,583		49,583		49,583		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,916,236	204,788	203,269	3,324,293	49,563	3,373,856		3,373,856		16
<b>C. General Administration</b>											
17	Administrative	87,858		538,673	626,531	(296,470)	330,061		330,061		17
18	Directors Fees										18
19	Professional Services			13,621	13,621	(6,558)	7,063	(7,063)			19
20	Dues, Fees, Subscriptions & Promotions			85,015	85,015	(1,750)	83,265	(12,361)	70,904		20
21	Clerical & General Office Expenses	283,650	56,217	37,715	377,582		377,582	(2,346)	375,236		21
22	Employee Benefits & Payroll Taxes			668,132	668,132	51,642	719,774		719,774		22
23	Inservice Training & Education			5,789	5,789		5,789		5,789		23
24	Travel and Seminar			5,570	5,570		5,570		5,570		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			132,165	132,165		132,165		132,165		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	371,508	56,217	1,486,680	1,914,405	(253,136)	1,661,269	(21,770)	1,639,499		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,769,920	486,392	1,886,465	6,142,777	(193,682)	5,949,095	(26,415)	5,922,680		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 &amp; ID Number

Manorcare at Naperville

#0027524

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	
	<b>D. Ownership</b>											
30	Depreciation			321,142	321,142	27,985	349,127		349,127			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,668	13,668	165,697	179,365	(1,471)	177,894			32
33	Real Estate Taxes			77,980	77,980		77,980	(4,055)	73,925			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			64,330	64,330		64,330		64,330			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			477,120	477,120	193,682	670,802	(5,526)	665,276			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			1,115	1,115		1,115		1,115			38
39	Ancillary Service Centers		272,686	125	272,811		272,811		272,811			39
40	Barber and Beauty Shops			16,697	16,697		16,697		16,697			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,782	64,782		64,782		64,782			42
43	Other (specify):* <a href="#">See Attached Schedule</a>		80,704	41,271	121,975		121,975		121,975			43
44	<b>TOTAL Special Cost Centers</b>		353,390	123,990	477,380		477,380		477,380			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,769,920	839,782	2,487,575	7,097,277		7,097,277	(31,941)	7,065,336			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 Naperville

# 0027524

Report Period Beginning: 06/01/03

Ending: 05/31/04

**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	(2,550)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,095)	5		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	(1,471)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(346)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,240)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(282)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,063)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(478)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,055)	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,361)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (31,941)		\$	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)</b>	\$ (31,941)		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 Naperville

ID# 0027524

Report Period Beginning: 06/01/03

Ending: 05/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Naperville# 0027524

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

	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	(2,550)	0	0	0	0	0	0	0	0	0	0	(2,550)	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	(2,095)	0	0	0	0	0	0	0	0	0	0	(2,095)	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>(4,645)</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>(4,645)</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	(7,063)	0	0	0	0	0	0	0	0	0	0	(7,063)	19
20	Fees, Subscriptions & Promotions	(12,361)	0	0	0	0	0	0	0	0	0	0	(12,361)	20
21	Clerical & General Office Expenses	(2,346)	0	0	0	0	0	0	0	0	0	0	(2,346)	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>(21,770)</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>(21,770)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(26,415)</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>(26,415)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Naperville# 0027524

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)
	<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	(1,471)	0	0	0	0	0	0	0	0	0	0	(1,471) 32
33	Real Estate Taxes	(4,055)	0	0	0	0	0	0	0	0	0	0	(4,055) 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>(5,526)</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>(5,526) 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>(31,941)</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>(31,941) 45</b>

Facility Name & ID Number Manorcare at Naperville

# 0027524

Report Period Beginning:

06/01/03

Ending:

05/31/04

VII. RELATED PARTIES

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

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

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	\$ 538,673			\$ 538,673	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	20,017			20,017		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 558,690			\$ 558,690	\$ *	14

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

Facility Name & ID Number      Manorcare at Naperville      #      0027524      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

Facility Name & ID Number Manorcare at Naperville # 0027524 Report Period Beginning: 06/01/03 Ending: 05/31/04

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Facs.	\$	6,479,743	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Facs.	940,169	6,479,743	2,130	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Facs.	288,728	6,479,743	779	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Facs.	3,082,391	6,479,743	6,982	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Facs.	11,758,547	6,479,743	7,451,541	31,707
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Facs.	6,213,377	6,479,743	3,630,889	14,075
7	17	General & Administrative - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Facs.	17,137,345	6,479,743	15,146,077	46,211
8	17	General & Administrative - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Facs.	84,524,208	6,479,743	36,356,103	191,466
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Facs.	4,283,731	6,479,743	4,283,731	11,551
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Facs.	17,698,741	6,479,743	17,698,741	40,091
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Facs.		6,479,743		0
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Facs.	12,354,014	6,479,743	12,354,014	27,985
13									13
14	32	Interest				11,412,188		11,412,188	165,697
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 169,693,439	\$ 63,094,199	\$ 538,674	25

Facility Name & ID Number Manorcare at Naperville # 0027524 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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Conv. Sub. Debentures		x	Facility			\$ 2,263,461	\$		\$ 165,697	1							
2	Bank of Amer/National City		x	Facility			217,534			13,656	2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6											6							
7											7							
8											8							
9	<b>TOTAL Facility Related</b>						\$ 2,480,995	\$		\$ 179,353	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>						\$ 2,480,995	\$		\$ 179,353	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 Naperville**# **0027524** Report Period Beginning: **06/01/03** Ending: **05/31/04****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 2003 report.			\$	74,630	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.)			\$	70,575	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(4,055)	3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	72,811	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>			\$	5,169	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.			\$	73,925	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1999	60,299	8		
		2000	58,361	9		
		2001	58,361	10		
		2002	68,339	11		
		2003	72,811	12		
<b>This is the result of a reassessment of the 2003 real estate tax value.</b>						
				<b>FOR OHF USE ONLY</b>		
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, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Manorcare at Naperville COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0027524

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 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>07-24-209-006</u>	<u>See Attached</u>	\$ <u>36,405.52</u>	\$ <u>36,405.52</u>
2. <u>07-24-209-006</u>	<u>See Attached</u>	\$ <u>36,405.52</u>	\$ <u>36,405.52</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>72,811.04</u>	\$ <u>72,811.04</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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.

Facility Name & ID Number Manorcare at Naperville

# 0027524 Report Period Beginning:

06/01/03 Ending:

05/31/04

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 29,951 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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		1981	\$ 32,377	1
2					2
3	TOTALS			\$ 32,377	3

Facility Name &amp; ID Number Manorcare at Naperville

# 0027524

Report Period Beginning:

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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	98		1967		\$ 631,081	\$ 85,328		\$ 85,328		\$ 1,502,969	4
5	20		1988		1,159,909						5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9						173,886		173,886		1,420,499	9
10			1988		171,883						10
11			1989		25,448						11
12			1990		68,243						12
13			1991		407,793						13
14			1992		89,065						14
15			1993		123,500						15
16			1994		101,520						16
17			1995		139,752						17
18		REMODEL/UPGRADE RESIDENT ROOMS	1996		37,545						18
19		CORPORATE OVERHEAD-RESIDENT ROOMS	1996		7,272						19
20		PLUMBING REPAIRS	1996		1,341						20
21		WALLCOVERINGS	1996		3,590						21
22		CONCRETE WALKWAY/DRIVEWAY	1996		7,489						22
23		ELECTRICAL/LIGHTING	1996		12,176						23
24		WALLCOVERINGS	1996		15,435						24
25		PLUMBING	1996		4,900						25
26		CARPETING	1996		5,738						26
27		SECURITY SYSTEM	1996		1,668						27
28		FRONT ENTRANCE REPAIR	1996		2,551						28
29		REMODEL NURSES STATION	1996		12,886						29
30		PAINTING	1996		2,968						30
31		WALK-IN FREEZER	1996		15,411						31
32		ROOF REPAIRS	1997		2,823						32
33		CARPET & INSTALLATION	1997		3,701						33
34		WALLCOVERINGS	1997		11,798						34
35		CABINETRY	1997		15,765						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

Page 12A

Facility Name & ID Number    Manorcare at Naperville#    0027524

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	ELECTRICAL	1997	\$ 10,658	\$		\$	\$	\$		37
38	REMOVE WALL HEATER	1997	2,592							38
39	REPLACE CEILING TILES	1997	12,471							39
40	SHOWER ROOM RENOVATION	1997	14,484							40
41	NURSES STATION REMODEL	1997	3,000							41
42	DOORS/INSTALLATION/SIGNS	1997	3,888							42
43	DECORATING	1997	20,000							43
44	INSTALL SUNDECK	1997	4,495							44
45	CORPORATE OVERHEAD	1997	10,516							45
46	RETIREMENTS	1988	(26,934)							46
47	RETIREMENTS	1992	(4,410)							47
48	INSTALL B & G PUMPS	1997	4,089							48
49	INSTALL CONDENSING UNIT	1997	1,380							49
50	INSTALL DOORS/CASING	1997	6,050							50
51	INSTALL BOILER	1997	68,932							51
52	FACILITY PLAN ALLOC	1997	5,965							52
53	NURSE CALL SYSTEM	1997	1,430							53
54	WALL REPAIRS/DRYWALL	1997	5,450							54
55	INSTALL WALL CABINET	1997	3,193							55
56	INSTALL TV & PHONE JACKS	1997	1,992							56
57	WATER HEATER	1997	8,000							57
58	NURSES STATION WORK	1997	2,487							58
59	ROOF WORK	1997	1,809							59
60	SECURITY SYSTEM	1997	23,833							60
61	WALL VINYL/CORNER GUARDS	1997	2,982							61
62	REMOVE & REPLACE SIDEWALK	1997	16,092							62
63	CARPENTRY WORK	1997	3,346							63
64	PROFESSIONAL FEES	1997	678							64
65	LIGHTING	1997	783							65
66	PLUMBING	1997	1,184							66
67	ROOF WORK	1998	52,386							67
68	CARPENTRY WORK	1998	4,239							68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,350,311	\$ 259,214		\$ 259,214	\$	\$ 2,923,468		70

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number    Manorcare at Naperville

#    0027524

Report Period Beginning:

06/01/03

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Page 12B

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## 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	\$ 3,350,311	\$ 259,214		\$ 259,214		\$ 2,923,468		1
2	CARPETING/FLOORING	1998 32,974							2
3	PAINTING/WALLCOVERINGS	1998 20,295							3
4	ELECTRICAL	1998 3,746							4
5	REMOVE & INSTALL PHONE SYSTEM	1998 4,790							5
6	REPLACE ALARM PANEL	1998 2,065							6
7	DECORATING	1998 28,802							7
8	GENERAL CONTRACTOR FEES	1998 4,167							8
9	CORPORATE OVERHEAD	1998 1,651							9
10	PLUMBING	1998 1,704							10
11	REMOVE & INSTALL RETROFITS	1998 3,559							11
12	FLOORING	1998 18,406							12
13	PLUMBING	1998 13,632							13
14	LIGHTING FIXTURES	1998 1,436							14
15	ELECTRICAL	1998 19,502							15
16	HVAC	1998 1,990							16
17	PAINTING/WALLCOVER	1998 3,879							17
18	GENERAL CONTRACTORS FEES	1998 8,900							18
19	DOORS/WINDOWS	1998 11,403							19
20	ROOFING	1998 109,296							20
21	FINISH/STUD	1998 8,118							21
22	CARPENTRY	1998 6,227							22
23	SIGNAGE	1998 17,066							23
24	DECORATING (CORRECTION TO LINE7,PAGE 12B)	1998 (4,392)							24
25	FINISH/STUD	1999 28,613							25
26	PAINTING/WALLCOVERING	1999 10,000							26
27	ELECTRICAL	1999 1,626							27
28	SIGNAGE	1999 4,109							28
29	MILLWORK	1999 909							29
30	REPAIR BOILER	1999 5,995							30
31	WELDER/GENERATOR	1999 2,367							31
32	HVAC	1999 1,356							32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,724,502	\$ 259,214		\$ 259,214		\$ 2,923,468		34

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

Facility Name &amp; ID Number    Manorcare at Naperville

#    0027524

Report Period Beginning:

06/01/03

Ending:

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## 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		\$ 3,724,502	\$ 259,214		\$ 259,214	\$	\$ 2,923,468	1
2	BI - Air Separator/Boiler Piping	1999	4,366						2
3	INSTALL DAMPERS	1999	6,925						3
4	FURNISHINGS	1999	10						4
5	ACCESS PANELS/DRYWALL	1999	7,467						5
6	EXTERIOR LIGHTING	1999	15,290						6
7	CARPET	1999	5,034						7
8	DOOR HARDWARE	1999	371						8
9	DOOR HARDWARE	1999	737						9
10	GUTTERS	2000	23,027						10
11	CONCRETE WORK	1999	4,447						11
12	CONCRETE SIDEWALK	1999	3,540						12
13	CONCRETE BRIDGE	1999	15,660						13
14	FASCIA	2000	2,559						14
15	RESIDENT RM BUILT-IN CABINETS	2000	1,595						15
16	PAINTING - EXTERIOR BLDG	2000	4,525						16
17	SECURE CARE SYSTEM	2000	17,096						17
18	DOOR & FRAME	2000	2,419						18
19	THERMOSTAT	2000	1,125						19
20	DOOR & EXHAUST PIPING	2000	3,113						20
21	CONCRETE FLOOR - KITCHEN	2000	860						21
22	PIPING - HOT WATER	2000	2,425						22
23	ELECTRICAL	2000	1,557						23
24	DOORS	2000	6,817						24
25	EXHAUST FAN	2001	4,194						25
26	DOORS	2001	480						26
27	ROOF INSPECTION	2001	650						27
28	5/31/99 Audit Adjustment	2002	(20,388)						28
29	Sealant on Windows	2001	5,300						29
30	Carpentry-Renovation	2002	70,192						30
31	Carpet, VWC, Corner Guards	2002	84,317						31
32	Doors and Drywall	2002	11,422						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,011,633	\$ 259,214		\$ 259,214	\$	\$ 2,923,468	34

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

Facility Name &amp; ID Number Manorcare at Naperville

# 0027524

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		\$ 4,011,633	\$ 259,214		\$ 259,214	\$	\$ 2,923,468	1
2	ROOF	2002	17,964						2
3	SMOKE WALL	2003	5,866						3
4	VWC-Vinyl Wallcovering	2003	327						4
5	ROOF	2002	15,719						5
6	ROOF	2002	8,982						6
7	Renovation-Paving	2004	6,053						7
8	CARPET	2003	538						8
9	vec-Vinyl Wallcovering	2003	534						9
10	FREIGHT ON CARPET	2003	43						10
11	BORDER	2003	99						11
12	VWC-Vinyl Wallcovering	2003	700						12
13	CARPET	2003	809						13
14	VWC-Vinyl Wallcovering	2003	327						14
15	VWC-Vinyl Wallcovering	2003	2,075						15
16	VWC-Vinyl Wallcovering	2003	7,961						16
17	VWC-Vinyl Wallcovering	2003	493						17
18	CARPET	2003	1,794						18
19	METAL DOORS	2003	6,557						19
20	DOORS	2003	9,688						20
21	Renovation-Interest	2003	5,743						21
22	Renovation-Development Cost	2003	63,684						22
23	Renovation-Flooring	2003	1,270						23
24	Renovation-HVAC	2003	38,041						24
25	Renovation-A/C Thru Wall	2003	1,014						25
26	Renovation-Basic Electrical	2003	104,524						26
27	Renovation-Engineering	2003	11,737						27
28	Renovation-Plan Reviews	2003	3,142						28
29	VWC-Vinyl Wallcovering	2003	327						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,327,643	\$ 259,214		\$ 259,214	\$	\$ 2,923,468	34

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

**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		\$ 4,327,643	\$ 259,214		\$ 259,214	\$	\$ 2,923,468	1
2	Renovation-General O/H	2004	34,670						2
3	Renovation-Interest	2004	2,459						3
4	Renovation--Carpentry Sub-Contracting	2004	26,147						4
5	Renovation-Millwork	2004	4,530						5
6	Renovation-HM Doors/Frames	2004	17,940						6
7	Renovation-Basic Electrical	2004	4,726						7
8	Renovation-Ceramic Tile	2004	11,799						8
9	Renovation-Resilient Floor	2004	16,580						9
10	Renovation-Carpet & Pads	2004	786						10
11	Renovation-Wall Coverings	2004	5,962						11
12	Renovation- Corner Guards	2004	83						12
13	CREDIT ON Vinyl Wallcovering	2004	(26)						13
14	CREDIT ON Vinyl Wallcovering	2003	(327)						14
15	Renovation-General O/H	2004	5,869						15
16	Renovation-Interest	2004	247						16
17	Renovation-HM Doors/Frames	2004	4,752						17
18	Renovation-Resilient Floor	2004	22,203						18
19	Renovation-Carpet & Pads	2004	684						19
20	Renovation-Wall Covering	2004	5,343						20
21	Renovation-Basic Electric	2004	2,639						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)		\$ 4,494,710	\$ 259,214		\$ 259,214	\$	\$ 2,923,468	34

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

Facility Name & ID Number Manorcare at Naperville

# 0027524

Report Period Beginning:

06/01/03

Ending:

05/31/04

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	\$ 842,350	\$ 61,928	\$ 61,928			\$ 641,761	71
72	Current Year Purchases	99,394						72
73	Fully Depreciated Assets							73
74				27,985	27,985			74
75	TOTALS	\$ 941,744	\$ 61,928	\$ 89,913	\$ 27,985		\$ 641,761	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)	\$ 5,468,831	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 321,142	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 349,127	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,985	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,565,229	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	<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>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</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: \$ 64,330 Description: O2 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.

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

**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	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	7883	hrs	\$ 215,044	343	\$ 8,576	\$ 1,849	8,226	\$ 225,469	1
2	Licensed Speech and Language Development Therapist	10a	1783	hrs	48,633	828	20,692	78	2,611	69,403	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	7190	hrs	196,146	1,023	25,580	4,156	8,213	225,882	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				272,686		272,686	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	39,3					125			125	13
14	TOTAL				\$ 459,823	2,194	\$ 54,973	\$ 278,769	19,050	\$ 793,565	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 Naperville

# 0027524

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 27,319	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (126,869) )	931,854		3
4	Supply Inventory (priced at )	1,896		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,831		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>	\$ 969,900	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,377		13
14	Buildings, at Historical Cost	4,494,711		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	941,744		16
17	Accumulated Depreciation (book methods)	(3,565,229)		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>	\$ 1,903,603	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,873,503	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 72,768	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	362,412		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,811		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Accrued Payables</b>	94,107		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 602,098	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	217,534		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>	\$ 217,534	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 819,632	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,053,871	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,873,503	\$	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>1,796,166</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>1,796,166</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(170,060)	<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>(170,060)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	<b>427,765</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>427,765</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,053,871</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Naperville

# 0027524

Report Period Beginning: 06/01/03

Ending:

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,999,621	1
2	Discounts and Allowances for all Levels	(2,040,457)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,959,164	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,668,822	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,668,822	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	612	12
13	Barber and Beauty Care	15,841	13
14	Non-Patient Meals	1,938	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	258,483	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,819	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	8,131	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 297,824	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	282	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 282	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Income	1,471	28
28a	Late Charges	(346)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,125	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,927,217	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	904,079	31
32	Health Care	3,324,293	32
33	General Administration	1,914,405	33
<b>B. Capital Expense</b>			
34	Ownership	477,120	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	477,380	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>	\$ 7,097,277	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(170,060)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (170,060)	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 Naperville**

# **0027524**

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	2,009	2,163	\$ 67,227	\$ 31.08	1
2	Assistant Director of Nursing	3,869	4,166	110,884	26.62	2
3	Registered Nurses	17,149	18,464	472,672	25.60	3
4	Licensed Practical Nurses	22,543	24,271	534,118	22.01	4
5	Nurse Aides & Orderlies	86,132	92,735	1,095,464	11.81	5
6	Nurse Aide Trainees	889	889	7,876	8.86	6
7	Licensed Therapist	15,287	16,568	451,947	27.28	7
8	Rehab/Therapy Aides					8
9	Activity Director	8,878	9,558	105,027	10.99	9
10	Activity Assistants					10
11	Social Service Workers	3,534	3,799	49,583	13.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,712	24,555	271,140	11.04	15
16	Dishwashers					16
17	Maintenance Workers	2,094	2,256	42,472	18.83	17
18	Housekeepers	12,411	13,400	120,621	9.00	18
19	Laundry	5,686	6,124	47,943	7.83	19
20	Administrator	2,440	2,080	87,858	42.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,405	16,919	283,650	16.77	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	1,681	1,809	21,438	11.85	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	222,719	239,756	\$ 3,769,920 *	\$ 15.72	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	19,750	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,248	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)	\$	23,998		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,613	\$ 66,888	5,10,3	50
51	Licensed Practical Nurses	1,790	39,397	5,10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	4,403	\$ 106,285		53





Facility Name & ID Number Manorcare at Naperville# 0027524Report 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 \$5,627
- (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? \$1,750
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 68,721 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. \$ 64,782  
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? No Indicate the amount. \$ (1,938)
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_
- 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.