

Facility Name & ID Number Manorcare at Peoria

0027599 Report Period Beginning: 06/01/04 Ending: 05/31/05

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	144	Skilled (SNF)	144	52,560	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	144	TOTALS	144	52,560	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 Medicaid Recipient	4 Private Pay	Other		
8	SNF	6,605	16,833	19,751	43,189	8
9	SNF/PED					9
10	ICF		3,273	1,549	4,822	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,605	20,106	21,300	48,011	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.35%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 128 and days of care provided 15,288

Medicare Intermediary Care First of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

STATE OF ILLINOIS

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	235,814	28,456	21,782	286,052	2,925	288,977		288,977		1
2	Food Purchase		253,463		253,463		253,463	(832)	252,631		2
3	Housekeeping	175,284	17,870	6,100	199,254		199,254		199,254		3
4	Laundry	38,588	3,826	1,636	44,050		44,050		44,050		4
5	Heat and Other Utilities			157,287	157,287	6,749	164,036	(9,931)	154,105		5
6	Maintenance	43,373	31,845	104,255	179,473		179,473		179,473		6
7	Other (specify):* Medical Waste			930	930		930		930		7
8	TOTAL General Services	493,059	335,460	291,990	1,120,509	9,674	1,130,183	(10,763)	1,119,420		8
B. Health Care and Programs											
9	Medical Director			25,800	25,800		25,800		25,800		9
10	Nursing and Medical Records	2,402,138	202,200	158,360	2,762,698	49,891	2,812,589	(33,301)	2,779,288		10
10a	Therapy	385,222	5,939	281,487	672,648		672,648		672,648		10a
11	Activities	73,207	15,695	3,313	92,215		92,215		92,215		11
12	Social Services	137,819		1,581	139,400		139,400		139,400		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,998,386	223,834	470,541	3,692,761	49,891	3,742,652	(33,301)	3,709,351		16
C. General Administration											
17	Administrative	83,115		450,102	533,217	(183,736)	349,481		349,481		17
18	Directors Fees										18
19	Professional Services			11,969	11,969	(401)	11,568	(11,568)			19
20	Dues, Fees, Subscriptions & Promotions			72,203	72,203		72,203	(42,817)	29,386		20
21	Clerical & General Office Expenses	220,928	54,055	598,493	873,476	401	873,877	(575,877)	298,000		21
22	Employee Benefits & Payroll Taxes			827,413	827,413	45,868	873,281		873,281		22
23	Inservice Training & Education			2,897	2,897		2,897		2,897		23
24	Travel and Seminar			16,624	16,624		16,624		16,624		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			158,739	158,739		158,739		158,739		26
27	Other (specify):*										27
28	TOTAL General Administration	304,043	54,055	2,138,440	2,496,538	(137,868)	2,358,670	(630,262)	1,728,408		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,795,488	613,349	2,900,971	7,309,808	(78,303)	7,231,505	(674,326)	6,557,179		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 Peoria

#0027599

Report Period Beginning:

06/01/04

Ending:

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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			415,590	415,590	19,949	435,539		435,539			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,744	75,744	58,354	134,098	(2,659)	131,439			32
33	Real Estate Taxes			88,926	88,926		88,926	2,258	91,184			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			60,621	60,621		60,621		60,621			35
36	Other (specify):*											36
37	TOTAL Ownership			640,881	640,881	78,303	719,184	(401)	718,783			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		522,839	56,705	579,544		579,544		579,544			39
40	Barber and Beauty Shops			12,881	12,881		12,881		12,881			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,840	78,840		78,840		78,840			42
43	Other (specify):* Therapy Drugs		95,992		95,992		95,992		95,992			43
44	TOTAL Special Cost Centers		618,831	148,426	767,257		767,257		767,257			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,795,488	1,232,180	3,690,278	8,717,946		8,717,946	(674,727)	8,043,219			45

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

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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	(832)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,931)	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	(2,659)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(33,301)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,721)	21		18
19	Entertainment				19
20	Contributions	50	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,568)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(568,509)	21		24
25	Fund Raising, Advertising and Promotional	(42,817)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	2,258	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,697)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (674,727)		\$	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))	\$ (674,727)		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 Peoria

ID# 0027599
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Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Customer Reimbursement	\$ (1,999)	21	1
2	Transportation Revenue	(698)	21	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	(2,697)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Peoria# 0027599

Report Period Beginning:

06/01/04

Ending:

05/31/05

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	(832)	0	0	0	0	0	0	0	0	0	0	(832)	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	(9,931)	0	0	0	0	0	0	0	0	0	0	(9,931)	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	(10,763)	0	0	0	0	0	0	0	0	0	0	(10,763)	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	(33,301)	0	0	0	0	0	0	0	0	0	0	(33,301)	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	CNA 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	(33,301)	0	0	0	0	0	0	0	0	0	0	(33,301)	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	(11,568)	0	0	0	0	0	0	0	0	0	0	(11,568)	19
20	Fees, Subscriptions & Promotions	(42,817)	0	0	0	0	0	0	0	0	0	0	(42,817)	20
21	Clerical & General Office Expenses	(575,877)	0	0	0	0	0	0	0	0	0	0	(575,877)	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	(630,262)	0	0	0	0	0	0	0	0	0	0	(630,262)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(674,326)	0	0	0	0	0	0	0	0	0	0	(674,326)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Peoria

0027599

Report Period Beginning:

06/01/04

Ending:

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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	(2,659)	0	0	0	0	0	0	0	0	0	0	(2,659) 32
33	Real Estate Taxes	2,258	0	0	0	0	0	0	0	0	0	0	2,258 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	(401)	0	0	0	0	0	0	0	0	0	0	(401) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(674,727)	0	0	0	0	0	0	0	0	0	0	(674,727) 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
Manor Care, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See						1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a						6
		Home Office Allocation	\$ 450,102	HCR Manor Care, Inc	100.00%	\$ 450,102		
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 479,283			\$ 479,283	\$ *	14

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

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 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	2,364,266,309	369 Nurs Fac	\$	7,932,525	\$	0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	1,043,233	571,891	7,932,525	2,925	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	223,707	7,932,525	751	751	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,139,042	8,226,246	7,932,525	5,998	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	12,987,607	1,199,059	7,932,525	43,576	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,252,260	15,056,893	7,932,525	6,315	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	16,611,139	43,509,256	7,932,525	55,733	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	75,121,310	7,932,525	210,633	210,633	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	3,924,545	7,932,525	13,168	13,168	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	11,662,215	7,932,525	32,700	32,700	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac		7,932,525	0	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	7,114,804	7,932,525	19,949	19,949	12
13										13
14	32	Interest				10,002,527		58,354	58,354	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 143,082,389	\$ 68,563,345	\$	450,102	25

Facility Name & ID Number Manorcare at Peoria# 0027599

Report Period Beginning:

06/01/04

Ending:

05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Conv Sub Debentures		X	Facility			\$ 897,108	\$ 897,108			\$ 58,354	1						
2		National City Bank		X	Facility			1,211,834	1,211,834			75,744	2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8									Interest Income			(2,659)	8						
9		TOTAL Facility Related						\$ 2,108,942	\$ 2,108,942			\$ 131,439	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$ 2,108,942	\$ 2,108,942			\$ 131,439	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 Peoria**# **0027599** Report Period Beginning: **06/01/04** Ending: **05/31/05****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2004 report.			\$	84,056	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.)			\$	86,314	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	2,258	3
4.	Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	88,926	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.			\$	91,184	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2000	68,083	8		
		2001	71,014	9		
		2002	78,530	10		
		2003	83,585	11		
		2004	88,926	12		
					FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2004	\$		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: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0027599

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>14-16-451-008</u>	<u>See Attached</u>	\$ <u>43,449.97</u>	\$ <u>43,449.97</u>
2. <u>14-16-451-009</u>	<u>See Attached</u>	\$ <u>83.05</u>	\$ <u>83.05</u>
3. <u>14-16-451-011</u>	<u>See Attached</u>	\$ <u>324.85</u>	\$ <u>324.85</u>
4. <u>14-16-451-018</u>	<u>See Attached</u>	\$ <u>306.94</u>	\$ <u>306.94</u>
5. <u>14-16-451-019</u>	<u>See Attached</u>	\$ <u>298.39</u>	\$ <u>298.39</u>
6. <u>14-16-451-008</u>	<u>See Attached</u>	\$ <u>43,449.97</u>	\$ <u>43,449.97</u>
7. <u>14-16-451-009</u>	<u>See Attached</u>	\$ <u>83.05</u>	\$ <u>83.05</u>
8. <u>14-16-451-011</u>	<u>See Attached</u>	\$ <u>324.85</u>	\$ <u>324.85</u>
9. <u>14-16-451-018</u>	<u>See Attached</u>	\$ <u>306.94</u>	\$ <u>306.94</u>
10. <u>14-16-451-019</u>	<u>See Attached</u>	\$ <u>298.39</u>	\$ <u>298.39</u>
	TOTALS	\$ <u>88,926.40</u>	\$ <u>88,926.40</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Manorcare at Peoria# 0027599 Report Period Beginning:06/01/04 Ending:05/31/05**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 31,772 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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		1981,1998, 20	\$ 236,851	1
2	Facility		2004	42,897	2
3	TOTALS			\$ 279,748	3

Facility Name & ID Number Manorcare at Peoria

0027599

Report Period Beginning:

06/01/04

Ending:

05/31/05

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	104		1963	\$ 834,425	\$ 141,074		\$ 141,074		\$ 1,747,353
5	10		1987	479,517					
6	10		1992	711,949					
7	10		1998	911,507					
8	10		2002	913,140					
Improvement Type**									
9	Building Improvements (Current year Depreciation)				154,321		154,321		1,428,975
10			1978	65,310					
11			1979	23,480					
12			1981	63,642					
13			1982	10,239					
14			1983	6,057					
15			1984	9,737					
16			1985	9,518					
17			1987	65,867					
18	RETIREMENTS		1987	(33,597)					
19			1988	15,166					
20			1989	176,034					
21			1990	35,994					
22			1991	125,588					
23			1992	134,218					
24	RETIREMENTS		1992	(18,859)					
25			1993	29,944					
26			1994	78,083					
27			1995	44,937					
28	ELECTRICAL WORK		1995	5,075					
29	CARPET		1995	5,237					
30	PAINTING		1995	18,789					
31	WALLVINYL		1995	7,203					
32	CERAMIC TILE & INSTALLATION		1995	2,283					
33	BATHROOM RENOVATION		1995	4,388					
34	BATHROOM RENOVATION		1995	6,989					
35	FIRE ALARMS/SMOKE DETECTORS		1995	689					
36	HVAC WORK		1995	500					

*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 Peoria# 0027599

Report Period Beginning:

06/01/04

Ending:

05/31/05**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	PAVING/REPAIRS	1995	\$ 1,425	\$		\$	\$	\$		37
38	CAPITALIZED LABOR-BATHROOM	1996	7,272							38
39	CR 5/31/99 AUDIT ADJ-CAPITAL LABOR	1996	(7,272)							39
40	ROOF WORK	1996	1,374							40
41	HOLDING TANK/VALVES	1996	1,942							41
42	DOORS	1996	398							42
43	CARPET	1996	13,137							43
44	TILE	1996	2,036							44
45	WALLCOVERINGS	1996	11,574							45
46	INSTALL TWO BOILERS	1996	12,289							46
47	HERITAGE RENOVATIONS	1996	7,965							47
48	ELECTRICAL/LIGHTING	1996	1,611							48
49	INSTALL CABINETS	1996	12,758							49
50	HEATING/AC WORK	1996	3,759							50
51	EXIT DEVICES	1996	1,765							51
52	DOORS/SIGNS	1996	2,802							52
53	LIGHTING	1997	1,572							53
54	CARPET & INSTALLATION	1997	3,230							54
55	SIDING	1997	2,335							55
56	WALLCOVERINGS	1997	6,104							56
57	INSTALL EXHAUST FAN/LIGHT	1997	2,211							57
58	NITEL SX-200 SYSTEM	1997	23,641							58
59	PAGING SYSTEM	1997	5,333							59
60	ROOFTOP A/C	1997	10,968							60
61	CARPET	1997	829							61
62	CEILING WORK	1997	2,385							62
63	ROOF REPAIRS	1997	2,177							63
64	ALLOC FAC. PLAN-HERITAGE	1997	2,758							64
65	CR 5/31/99 AUDIT ADJ-ALLOC FAC PLAN	1997	(2,758)							65
66	ELECTRIC	1997	2,687							66
67	WATER HEATER/WATER LINE	1997	1,166							67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,882,526	\$ 295,395		\$ 295,395	\$	\$ 3,176,328		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 Peoria

0027599

Report Period Beginning:

06/01/04

Ending:

05/31/05

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		\$ 4,882,526	\$ 295,395		\$ 295,395		\$ 3,176,328	1
2	FLOORING/CEILING	1998	3,448						2
3	CARPETING	1998	3,020						3
4	PAINTING	1998	3,020						4
5	WALLCOVERINGS	1998	3,020						5
6	INSTALL HANDRAILS	1998	4,875						6
7	INSTALL DOORS/LOCKS	1998	2,820						7
8	CORPORATE OVERHEAD-HERITAGE ADDTN	1998	1,702						8
9	CR 5/31/99 AUDIT ADJ-ALLOC FAC PLAN	1998	(1,702)						9
10	FINISH/STUD	1998	45,863						10
11	CR 5/31/03 AUDIT ADJ 2A-RELCASS FINISH/STUD TO BUILDING	1998	(45,863)						11
12	SITE/DEMOLITION	1998	86,230						12
13	CR 5/31/03 AUDIT ADJ 2B-SITE/DEMOLITION	1998	(86,230)						13
14	LANDSCAPING	1998	5,310						14
15	ROOFING	1998	53,000						15
16	CR 5/31/03 AUDIT ADJ 2C-ROOFING	1998	(53,000)						16
17	ELECTRICAL	1998	841						17
18	AIR CONDITIONING	1998	5,617						18
19	CARPETING	1998	1,994						19
20	GENERAL CONTRACTOR-HERITAGE ADDTN	1998	2,524						20
21	CR 5/31/03 AUDIT ADJ 2D-CONTRACTOR FEES	1998	(2,524)						21
22	PAINTING/WALLCOVERING	1998	531						22
23	PLUMBING	1998	7,900						23
24	SIGNAGE	1998	11,862						24
25	GAZEBO	1998	1,325						25
26	50 GAL AMTEK	1999	1,699						26
27	AIR CONDITIONING	1999	1,940						27
28	LAND IMPROVEMENTS-ARCADIA REN	1999	6,099						28
29	LAND IMPROVEMENTS-ARCADIA REN	1999	315						29
30	CONCRETE PAD	1999	713						30
31	EXIT DOOR ALARM	1999	547						31
32	RUSKIN PAMPER	1999	896						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,950,318	\$ 295,395		\$ 295,395		\$ 3,176,328	34

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

Facility Name & ID Number Manorcare at Peoria

0027599

Report Period Beginning:

06/01/04

Ending:

05/31/05

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		\$ 4,950,318	\$ 295,395		\$ 295,395	\$	\$ 3,176,328	1
2	HOT WATER LINE	1999	780						2
3	FURNISHINGS	1999	557						3
4	CR 5/31/03 AUDIT ADJ-FURNISHINGS	1999	(557)						4
5	SMOKING SHELTER	1999	4,950						5
6	BUILDING IMPROVEMENTS-ARCADIA	1999	1,821						6
7	BUILDING IMPROVEMENTS-ARCADIA	1999	780						7
8	LOCKS	1999	4,509						8
9	SMOKING SHELTER	1999	4,950						9
10	RETENTION	1999	29,415						10
11	CR 5/31/03 AUDIT ADJ 3A-RETENTION	1999	(29,415)						11
12	CAMERA SECURITY	1999	3,469						12
13	DOOR	1999	1,011						13
14	FLOOR	1999	774						14
15	ENGINEER/DESIGNER FEES-ARCADIA RENOV	1999	693						15
16	ELECTRICAL CONTRACT-ARCADIA RENOV	1999	450						16
17	PIPING	1999	2,730						17
18	HVAC	1999	1,034						18
19	SECURITY SYSTEM-SECOND HALF	2000	3,468						19
20	FLOOR TILE-RESIDENT ROOM	2000	3,870						20
21	POWERS VALVE	2000	670						21
22	SECURE CARE	2000	1,019						22
23	CR 5/31/03 AUDIT ADJ 3C-RECLASS FROM 2001	2000	40,091						23
24	CR 5/31/03 AUDIT ADJ 3D-RECLASS FROM 2001	2000	29,375						24
25	CR 5/31/03 AUDIT ADJ 3F-RECLASS FROM 2001	2000	14,674						25
26	A/C DUCTLESS SYSTEM	2001	3,774						26
27	VCT - DINING ROOM	2001	4,168						27
28	PAINTING / RETAINAGE	2001	98						28
29	PAINTING	2001	882						29
30	PAINTING	2001	1,000						30
31	GENERAL OVERHEAD-MEDICARE RENOV	2001	57,004						31
32	CR 5/31/03 AUDIT ADJ 3B-GENERAL OVERHEAD	2001	(57,004)						32
33	DRAPES, SHADES, BLINDS	2001	10,662						33
34	TOTAL (lines 1 thru 33)		\$ 5,092,020	\$ 295,395		\$ 295,395	\$	\$ 3,176,328	34

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

Facility Name & ID Number Manorcare at Peoria

0027599

Report Period Beginning:

06/01/04

Ending:

05/31/05

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		\$ 5,092,020	\$ 295,395		\$ 295,395	\$	\$ 3,176,328	1
2	CEILING,KICKERBOARD-MEDICARE RENOV	2001	31,746						2
3	CARPET,PAINT,WALLPAPER-MEDICARE RENOV	2001	59,734						3
4	CR 5/31/03 AUDIT ADJ 3C-MEDICARE RENOV	2001	(485)						4
5	CR 5/31/03 AUDIT ADJ 3C-RECLASS TO 2000	2001	(40,091)						5
6	HVAC AND ELECTRICAL	2001	7,683						6
7	PAINT, WALLPAPER	2001	3,470						7
8	DRYWALL,DOOR,CARPENTRY-ARCADIA RENOV	2001	34,121						8
9	WALLPAPER,CARPET-ARCADIA RENOV	2001	58,729						9
10	CR 5/31/03 AUDIT ADJ 3D-ARCADIA RENOV	2001	(4,989)						10
11	CR 5/31/03 AUDIT ADJ 3D-RECLASS TO 2000	2001	(29,375)						11
12	PAINTING-ARCADIA RENOV	2001	12,554						12
13	PLUMBING,ELECTRICAL-ARCADIA RENOV	2001	107,746						13
14	GENERAL OVERHEAD-ARCADIA RENOV	2001	150,192						14
15	CR 5/31/03 AUDIT ADJ 3E-ARCADIA RENOV	2001	(150,192)						15
16	DRAPES,ARTWORK-ARCADIA RENOV	2001	21,753						16
17	CR 5/31/03 AUDIT ADJ 3F-ARCADIA RENOV	2001	(844)						17
18	CR 5/31/03 AUDIT ADJ 3F- RECLASS TO EQUIPMENT	2001	(6,235)						18
19	CR 5/31/03 AUDIT ADJ 3F-RECLASS TO 2000	2001	(14,674)						19
20	WALLS,FLOOR,DOOR FOR LAUNDRY	2001	9,000						20
21	WALLS,FLOOR,DOOR FOR LAUNDRY	2001	4,250						21
22	FLOORING	2001	18,030						22
23	FLOORING	2001	1,052						23
24	CARPET,VINYL WALL COVERING	2001	11,143						24
25	ROOF	2001	184,141						25
26	CR 5/31/03 AUDIT ADJ 4B-OVERHEAD	2001	(1,800)						26
27	CR 5/31/03 AUDIT ADJ 4B-INTEREST	2001	(345)						27
28	SOIL/CONCRETE TEST, FEES	2001	15,756						28
29	GC - SITE WORK	2001	269,327						29
30	CR 5/31/03 AUDIT ADJ 4C- RECLASS TO BUILDING	2001	(239,457)						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,603,960	\$ 295,395		\$ 295,395	\$	\$ 3,176,328	34

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

Facility Name & ID Number Manorcare at Peoria

0027599

Report Period Beginning:

06/01/04

Ending:

05/31/05

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		\$ 5,603,960	\$ 295,395		\$ 295,395	\$	\$ 3,176,328	1
2	VWC,FLOORING	2002	8,790						2
3	CABINETS	2002	9,529						3
4	ADDTL CONSTRUCTION COST	2002	117						4
5	CR 5/31/03 AUDIT ADJ 5A-ADDTL CONST COSTS	2002	(117)						5
6	ADDTL CONSTRUCTION COST	2002	560						6
7	CR 5/31/03 AUDIT ADJ 5A-ADDTL CONST COSTS	2002	(560)						7
8	ADDTL CONSTRUCTION COST	2002	109						8
9	WINDOW TREATMENTS	2002	7,067						9
10	ROOFING	2002	1,486						10
11	ADDTL COSTS OF ARCADIA RE	2002	1,274						11
12	ADDTL COSTS OF ARCADIA RE	2002	2,867						12
13	VCT FLOORING	2002	1,484						13
14	VCT FLOORING	2002	1,367						14
15	VCT FLOORING	2002	1,192						15
16	RETAINAGE ON NEW CONSTRUCTION	2002	5,000						16
17	CR 5/31/03 AUDIT ADJ 5B-RETAINAGE	2002	(5,000)						17
18	VWC,FLOORING	2002	1,182						18
19	VWC	2003	133						19
20	FLOORING / WALLCOVERING	2003	95,423						20
21	VWC	2003	685						21
22	FREIGHT ON VWC	2003	433						22
23	KITCHEN DOOR	2003	2,874						23
24	VCT FLOORING	2003	1,110						24
25	VWC & PAINTING	2004	3,500						25
26	AWNING	2004	2,950						26
27	FENCED IN COURTYARD	2005	10,500						27
28	INSTALL GUTTER	2005	5,800						28
29	VINYL WALL COVERING	2004	220						29
30	VINYL WALL COVERING	2004	297						30
31	VINYL WALL COVERING	2004	241						31
32	VINYL WALL COVERING	2004	206						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,764,677	\$ 295,395		\$ 295,395	\$	\$ 3,176,328	34

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

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Peoria

0027599

Report Period Beginning:

06/01/04

Ending:

Page 12F

05/31/05

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 12E, Carried Forward		\$ 5,764,677	\$ 295,395		\$ 295,395	\$	\$ 3,176,328	1
2	VINYL WALL COVERING	2004	362						2
3	VINYL WALL COVERING	2004	1,004						3
4	INSTALL CABINETS	2004	10,272						4
5	PAINTING AND WALLCOVERING	2004	7,200						5
6	VINYL WALL COVERING	2004	1,593						6
7	VINYL TILE AND VINYL WALL COVERING	2004	10,000						7
8	VINYL TILE AND VINYL WALL COVERING	2004	274						8
9	PAINTING AND WALLCOVERING	2005	800						9
10	VINYL WALL COVERING	2004	1,004						10
11	LABOR, PERMITS FOR REHAB ROOM RENOV	2004	2,650						11
12	PAINT DOORS, FRAMES, HEATERS	2004	5,800						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,805,637	\$ 295,395		\$ 295,395	\$	\$ 3,176,328	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	\$ 1,447,641	\$ 120,195	\$ 120,195			\$ 1,046,734	71
72	Current Year Purchases	194,773						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			19,949	19,949			74
75	TOTALS	\$ 1,642,414	\$ 120,195	\$ 140,144	\$ 19,949		\$ 1,046,734	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12L, if applicable)	\$ 7,727,799	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12L, if applicable)	\$ 415,590	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12L, if applicable)	\$ 435,539	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12L, if applicable)	\$ 19,949	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L, if applicable)	\$ 4,223,062	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 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

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>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</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: \$ 60,621 Description: O2 Concentrators, Wheelchairs, Gerichairs, Electric Beds, Etc.
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>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 CNA _____</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 CNA _____</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	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	5284	hrs	\$ 133,323	4,099	\$ 102,487	\$ 2,116	9,383	\$ 237,926	1	
2	Licensed Speech and Language Development Therapist	10a	2710	hrs	68,372	1,745	43,634	207	4,455	112,213	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	7274	hrs	183,527	5,415	135,366	3,616	12,689	322,509	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				522,839		522,839	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify): X-Ray, Lab	10, Col 3, 39					56,705			56,705	13	
14	TOTAL				\$ 385,222	11,259	\$ 338,192	\$ 528,778	26,527	\$ 1,252,192	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Manorcare at Peoria

0027599

Report Period Beginning: 06/01/04

Ending:

05/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/05

(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	\$ 14,893	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance (875,622))	1,903,699		3
4 Supply Inventory (priced at)	47,229		4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	38,542		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,004,363	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	279,748		13
14 Buildings, at Historical Cost	5,805,637		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	1,642,414		16
17 Accumulated Depreciation (book methods)	(4,223,062)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,504,737	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,509,100	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 138,429	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	353,758		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)	88,926		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Other Accrued Expenses	79,543		36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 660,656	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	1,211,834		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)	\$ 1,211,834	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,872,490	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 3,636,610	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,509,100	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,021,875	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,021,875	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,784,325	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,784,325	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(1,169,590)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,169,590)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,636,610	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,963,036	1
2	Discounts and Allowances for all Levels	(1,093,598)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,869,438	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,051,375	6
7	Oxygen	(315)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,051,060	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	610	12
13	Barber and Beauty Care	12,821	13
14	Non-Patient Meals	222	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	526,222	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,983	19
20	Radiology and X-Ray	19,699	20
21	Other Medical Services	1,557	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 579,114	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	150	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 150	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	2,509	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,509	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,502,271	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,120,509	31
32	Health Care	3,692,761	32
33	General Administration	2,496,538	33
B. Capital Expense			
34	Ownership	640,881	34
C. Ancillary Expense			
35	Special Cost Centers	767,257	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)*	\$ 8,717,946	40
41	Income before Income Taxes (line 30 minus line 40)**	1,784,325	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,784,325	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 Peoria

0027599

Report Period Beginning: 06/01/04

Ending:

05/31/05

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	3,674	4,017	\$ 115,623	\$ 28.78	1
2	Assistant Director of Nursing	6,158	6,732	162,496	24.14	2
3	Registered Nurses	14,383	15,725	383,328	24.38	3
4	Licensed Practical Nurses	28,258	30,894	633,603	20.51	4
5	CNAs & Orderlies	95,793	104,732	1,064,320	10.16	5
6	CNA Trainees					6
7	Licensed Therapist	13,631	14,764	372,463	25.23	7
8	Rehab/Therapy Aides	1,169	1,267	12,759	10.07	8
9	Activity Director					9
10	Activity Assistants	5,927	6,489	73,207	11.28	10
11	Social Service Workers	7,347	8,026	137,819	17.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,344	24,412	235,814	9.66	15
16	Dishwashers					16
17	Maintenance Workers	2,267	2,467	43,373	17.58	17
18	Housekeepers	17,684	19,321	175,284	9.07	18
19	Laundry	4,945	5,401	38,588	7.14	19
20	Administrator	2,935	2,935	83,115	28.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,559	14,047	220,928	15.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,667	2,936	42,768	14.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,741	264,165	\$ 3,795,488 *	\$ 14.37	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	25,800	Ln 9, Col 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)	\$	25,800		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Manorcare at Peoria# 0027599Report Period Beginning: 06/01/04Ending: 05/31/05**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 \$ 6,969
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$ 2,249
- (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. \$ 66,144 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 during this cost report period. \$ 78,840
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (222)
- (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.