

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027524

Facility Name: Manorcare at Naperville

Address: 200 West Martin Avenue Naperville 60540
 Number City Zip Code

County: DuPage

Telephone Number: (630) 355-4111 **Fax #** (630) 355-4156

HFS ID Number: 520886946010

Date of Initial License for Current Owners: 11/1/81

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2005 to 05/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Barry Lazarus</u>	
	(Title) <u>Vice President - Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Manorcare at Naperville

0027524 Report Period Beginning: 06/01/2005 Ending: 05/31/2006

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>43,070</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>43,070</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,641</u>	<u>6,600</u>	<u>17,515</u>	<u>34,756</u>	8
9	SNF/PED					9
10	ICF	<u>2,351</u>			<u>2,351</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,992</u>	<u>6,600</u>	<u>17,515</u>	<u>37,107</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.16%

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)

No

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 118 and days of care provided 12,933

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 5/31/06

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

Facility Name & ID Number Manorcare at Naperville # 0027524 Report Period Beginning: 06/01/2005 Ending: 05/31/2006

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	262,192	13,717	1,340	277,249	15,573	292,822		292,822		1
2	Food Purchase		174,379		174,379		174,379	(4,119)	170,260		2
3	Housekeeping	125,589	19,696	2,934	148,219		148,219		148,219		3
4	Laundry	47,446	18,231	281	65,958		65,958	(6,110)	59,848		4
5	Heat and Other Utilities			101,929	101,929	6,764	108,693		108,693		5
6	Maintenance	46,878	16,995	59,726	123,599		123,599		123,599		6
7	Other (specify):* Med Waste			1,159	1,159		1,159		1,159		7
8	TOTAL General Services	482,105	243,018	167,369	892,492	22,337	914,829	(10,229)	904,600		8
	B. Health Care and Programs										
9	Medical Director			26,575	26,575		26,575		26,575		9
10	Nursing and Medical Records	2,542,974	240,060	305,293	3,088,327	20,123	3,108,450	(17,746)	3,090,704		10
10a	Therapy		6,416	950,708	957,124		957,124		957,124		10a
11	Activities	108,046	3,831	3,235	115,112	1,040	116,152		116,152		11
12	Social Services	77,740		726	78,466		78,466		78,466		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,728,760	250,307	1,286,537	4,265,604	21,163	4,286,767	(17,746)	4,269,021		16
	C. General Administration										
17	Administrative	62,927		576,508	639,435	(261,274)	378,161		378,161		17
18	Directors Fees										18
19	Professional Services			27,668	27,668	(24,871)	2,797	(2,797)			19
20	Dues, Fees, Subscriptions & Promotions			87,622	87,622		87,622	(17,506)	70,116		20
21	Clerical & General Office Expenses	279,215	62,054	311,333	652,602	3,610	656,212	(247,930)	408,282		21
22	Employee Benefits & Payroll Taxes			698,895	698,895	50,410	749,305		749,305		22
23	Inservice Training & Education			3,158	3,158		3,158		3,158		23
24	Travel and Seminar			16,247	16,247		16,247		16,247		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			126,784	126,784		126,784		126,784		26
27	Other (specify):* Pers Purch Admin			43	43		43		43		27
28	TOTAL General Administration	342,142	62,054	1,848,258	2,252,454	(232,125)	2,020,329	(268,233)	1,752,096		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,553,007	555,379	3,302,164	7,410,550	(188,625)	7,221,925	(296,208)	6,925,717		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 Naperville #0027524 Report Period Beginning: 06/01/2005 Ending: 05/31/2006

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			320,749	320,749	19,089	339,838		339,838			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,596	13,596	169,536	183,132		183,132			32
33	Real Estate Taxes			76,427	76,427		76,427	(4,262)	72,165			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			99,776	99,776		99,776		99,776			35
36	Other (specify):*											36
37	TOTAL Ownership			510,548	510,548	188,625	699,173	(4,262)	694,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		437,394	95,914	533,308		533,308		533,308			39
40	Barber and Beauty Shops			14,267	14,267		14,267		14,267			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):* P/S IV Therapy		192,952		192,952		192,952		192,952			43
44	TOTAL Special Cost Centers		630,346	174,786	805,132		805,132		805,132			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,553,007	1,185,725	3,987,498	8,726,230		8,726,230	(300,470)	8,425,760			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: 06/01/2005

Ending: 05/31/2006

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	(4,119)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,110)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(121)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(17,746)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(125)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,797)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(246,134)	21		24
25	Fund Raising, Advertising and Promotional	(17,506)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,262)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg5A	(1,550)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (300,470)		\$	30

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))	\$ (300,470)		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

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Naperville

ID# 0027524

Report Period Beginning: 06/01/2005

Ending: 05/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Miscellaneous Income	\$ (1,550)	21
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	(1,550)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Naperville

0027524

Report Period Beginning:

06/01/2005

Ending:

05/31/2006

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	(4,119)	0	0	0	0	0	0	0	0	0	0	(4,119)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(6,110)	0	0	0	0	0	0	0	0	0	0	(6,110)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,229)	0	0	0	0	0	0	0	0	0	0	(10,229)	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	(17,746)	0	0	0	0	0	0	0	0	0	0	(17,746)	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	(17,746)	0	0	0	0	0	0	0	0	0	0	(17,746)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,797)	0	0	0	0	0	0	0	0	0	0	(2,797)	19
20	Fees, Subscriptions & Promotions	(17,506)	0	0	0	0	0	0	0	0	0	0	(17,506)	20
21	Clerical & General Office Expenses	(247,930)	0	0	0	0	0	0	0	0	0	0	(247,930)	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	(268,233)	0	0	0	0	0	0	0	0	0	0	(268,233)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(296,208)	0	0	0	0	0	0	0	0	0	0	(296,208)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Naperville

0027524

Report Period Beginning:

06/01/2005 Ending:

Summary B

05/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(4,262)	0	0	0	0	0	0	0	0	0	0	(4,262)	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	(4,262)	0	(4,262)	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)	(300,470)	0	(300,470)	45									

Facility Name & ID Number Manorcare at Naperville

0027524

Report Period Beginning: 06/01/2005 Ending: 05/31/2006

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 Home Office Allocation	\$ 576,508	HCR Manor Care, Inc.	100.00%	\$ 576,508	\$
2	V	Page					
3	V	e					
4	V						
5	V						
6	V	10a Therapy Management	18,868	Heartland Management Services	100.00%	18,868	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 595,376			\$ 595,376	\$ *

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

Facility Name & ID Number

Manorcare at Naperville

#

0027524

Report Period Beginning:

06/01/2005

Ending:

05/31/2006

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:

06/01/2005

Ending: 5/31/2006

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,501,870,392	357 Nurs. Facs	\$ 1,107,111	\$ 591,572	7,553,003	\$ 3,342	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	357 Nurs. Facs			7,553,003	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	357 Nurs. Facs	267,575		7,553,003	808	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	357 Nurs. Facs	2,395,925		7,553,003	5,956	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	357 Nurs. Facs	771,372	565,963	7,553,003	2,329	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	357 Nurs. Facs	3,944,092	2,235,491	7,553,003	9,804	6
7	17	General & Administrative - Direct	Accumulated Cost	2,501,870,392	357 Nurs. Facs	24,791,565	22,717,176	7,553,003	74,844	7
8	17	General & Administrative - Pooled	Accumulated Cost	3,038,404,432	357 Nurs. Facs	96,702,974	43,044,715	7,553,003	240,390	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	357 Nurs. Facs	6,363,513		7,553,003	19,211	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	357 Nurs. Facs	12,550,855		7,553,003	31,199	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	357 Nurs. Facs			7,553,003	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	357 Nurs. Facs	7,679,242		7,553,003	19,089	12
13										13
14	32	Interest				7,118,315			169,536	14
15		Non Nursing Home Allocations				18,729,660				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 182,422,199	\$ 69,154,917		\$ 576,508	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Conv. Sub. Debentures		x	Facility			\$ 2,263,461	\$		\$ 169,536	1									
2	National City Bank		x	Facility			217,534			13,596	2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$ 2,480,995	\$		\$ 183,132	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$ 2,480,995	\$		\$ 183,132	15									

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

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

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

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

B. Real Estate Taxes

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 2005 report.	\$	66,029	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.)	\$	69,075	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3,046	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	69,119	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.	\$	72,165	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	58,361	8
	2002	68,339	9
	2003	72,811	10
	2004	69,032	11
	2005	69,119	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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>34,559.34</u>	\$ <u>34,559.34</u>
2. <u>07-24-209-006</u>	<u>See Attached</u>	\$ <u>34,559.34</u>	\$ <u>34,559.34</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>69,118.68</u>	\$ <u>69,118.68</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Manorcare at Naperville

0027524 Report Period Beginning:

06/01/2005 Ending:

05/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,137 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, 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	<u>Facility</u>		<u>1981</u>	<u>\$ 32,377</u>	1
2					2
3	TOTALS			\$ 32,377	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98			1967	\$ 631,081	\$ 49,876		\$ 49,876		\$ 1,602,721	4
5	20			1988	1,159,909						5
6											6
7											7
8											8
Improvement Type**											
9						204,705		204,705		1,823,364	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

Facility Name & ID Number Manorcare at Naperville

0027524

Report Period Beginning:

06/01/2005 Ending: 05/31/2006

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	WALLVINYL/CORNERGUARDS	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	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	70

**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:

06/01/2005 Ending: 05/31/2006

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	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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:

06/01/2005 Ending: 05/31/2006

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	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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:

06/01/2005 Ending: 05/31/2006

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	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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:

06/01/2005 Ending: 05/31/2006

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	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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	EXTERIOR SERVICE DOOR	2004	979						22
23	INSTALL HOLLOW MENTAL DOO	2004	1,539						23
24	KITCHEN RENOVATION	2004	20,000						24
25	ROOF RETAINAGE	2004	4,990						25
26	KITCHEN RENOVATION	2004	14,400						26
27	CARPET	2004	593						27
28	ADD' COST FOR ROOF	2004	2,246						28
29	CARPET	2005	610						29
30	INSTALL DOORS	2005	5,315						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,545,381	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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:

06/01/2005 Ending: 05/31/2006

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		\$ 4,545,381	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	1
2	Renov - Site Preparation	2,005	47,133						2
3	Renov - Asphalt Paving	2,005	17,075						3
4	CONCRETE SLAB	2,005	2,085						4
5	OUTDOOR LIGHTING	2,005	2,890						5
6	sidewalk & railing	2,005	16,542						6
7	VWC	2,005	236						7
8	VWC	2,005	2,952						8
9	2 Fire rated access hatch	2,005	3,225						9
10	Electrical service	2,005	3,095						10
11	Renov - Carpentry-subcontr	2,005	54,735						11
12	Renov - HM Doors & Frames & Tile	2,005	18,760						12
13	Renov -Resilient Flooring	2,005	17,700						13
14	Renov -Wallcovering	2,005	21,697						14
15	Renov -General Overhead & Interest	2,005	23,169						15
16	Renov - Basic Electrical	2,005	6,835						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)		\$ 4,783,510	\$ 254,581		\$ 254,581	\$	\$ 3,426,085	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: 06/01/2005 Ending: 05/31/2006

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	\$ 1,044,516	\$ 66,168	\$ 66,168	\$		\$ 766,508	71
72	Current Year Purchases	136,423						72
73	Fully Depreciated Assets							73
74				19,089	19,089			74
75	TOTALS	\$ 1,180,939	\$ 66,168	\$ 85,257	\$ 19,089		\$ 766,508	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)	\$	5,996,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	320,749	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	339,838	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	19,089	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	4,192,593	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 99,776

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			\$ _____	\$ _____	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.

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

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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		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	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	hrs	\$	7,485	\$ 404,570	\$ 1,304	7,485	\$ 405,874	1
2	Licensed Speech and Language Development Therapist	10a	hrs		2,633	142,317	44	2,633	142,361	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		7,471	403,821	5,068	7,471	408,889	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				437,394		437,394	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S X-Ray & Lab	39, 3					95,914		95,914	13
14	TOTAL			\$	17,589	\$ 950,708	\$ 539,724	17,589	\$ 1,490,432	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.

Facility Name & ID Number Manorcare at Naperville# 0027524Report Period Beginning: 06/01/2005Ending: 05/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 05/31/2006

(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	\$ (37,633)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>448,476</u>)	1,643,696		3
4	Supply Inventory (priced at)	34,315		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,373		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,646,751	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,377		13
14	Buildings, at Historical Cost	4,783,511		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,180,940		16
17	Accumulated Depreciation (book methods)	(4,192,593)		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)	\$ 1,804,235	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,450,986	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 35,617	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	240,252		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,119		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	144,388		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 489,376	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	217,534		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)	\$ 217,534	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 706,910	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,744,076	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,450,986	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,493,303	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,493,303	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	575,197	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)	\$ 575,197	17
B. Transfers (Itemize):			
18		(324,424)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (324,424)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,744,076	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Naperville# 0027524Report Period Beginning: 06/01/2005Ending: 05/31/2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,718,198	1
2	Discounts and Allowances for all Levels	(1,439,436)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,278,762	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,465,341	6
7	Oxygen	156	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,465,497	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	1,696	12
13	Barber and Beauty Care	11,346	13
14	Non-Patient Meals	2,423	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	508,908	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,018	19
20	Radiology and X-Ray	13,400	20
21	Other Medical Services		21
22	Laundry	5,930	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 555,721	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,550	28
28a	Purch Disc Other Income	(112)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,438	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,301,427	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	892,492	31
32	Health Care	4,265,604	32
33	General Administration	2,252,454	33
B. Capital Expense			
34	Ownership	510,548	34
C. Ancillary Expense			
35	Special Cost Centers	805,132	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)*	\$ 8,726,230	40
41	Income before Income Taxes (line 30 minus line 40)**	575,197	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 575,197	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: 06/01/2005

Ending:

05/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,740	1,889	\$ 65,352	\$ 34.60	1
2	Assistant Director of Nursing	4,924	5,344	161,935	30.30	2
3	Registered Nurses	18,328	19,892	552,486	27.77	3
4	Licensed Practical Nurses	26,322	28,567	703,500	24.63	4
5	CNAs & Orderlies	71,771	77,895	983,515	12.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,127	8,826	108,046	12.24	10
11	Social Service Workers	3,713	4,029	77,740	19.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,795	22,678	262,192	11.56	15
16	Dishwashers					16
17	Maintenance Workers	2,121	2,304	46,878	20.35	17
18	Housekeepers	12,236	13,297	125,589	9.44	18
19	Laundry	5,221	5,671	47,446	8.37	19
20	Administrator	1,925	2,080	62,927	30.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,631	17,998	306,799	17.05	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	3,285	3,571	48,602	13.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	197,139	214,041	\$ 3,553,007 *	\$ 16.60	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		26,575	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,390	5,10,3	39
40	Physical Therapy Consultant		402,515	5,10a,3	40
41	Occupational Therapy Consultant		404,570	5,10a,3	41
42	Respiratory Therapy Consultant		1,306	5,10a,3	42
43	Speech Therapy Consultant		142,317	5,10a,3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 980,673		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,597	\$ 72,115	5,10,3	50
51	Licensed Practical Nurses	3,411	84,008	5,10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,008	\$ 156,123		53

Facility Name & ID Number Manorcare at Naperville

0027524

Report Period Beginning: 06/01/2005

Ending: 05/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Diane Lube	Administrator	0	\$ 62,927	Workers' Compensation Insurance	\$ 89,430	IDPH License Fee	\$ 2,446	
				Unemployment Compensation Insurance	63,903	Advertising: Employee Recruitment	6,356	
				FICA Taxes	262,501	Health Care Worker Background Check	7,399	
				Employee Health Insurance	245,318	(Indicate # of checks performed)		
				Employee Meals		Dues & Subscriptions	10,236	
				Illinois Municipal Retirement Fund (IMRF)*		Help Wanted	28,506	
				Empl. Appreciation	7,022	Advertising	31,982	
				401K	23,072	Public Relations	697	
				Other Empl. Benefits	4,927			
				Tuition Program	2,690	Less: Lobbying Expense	(2,519)	
				Empl. Uniforms	32	Less: Public Relations Expense	(697)	
				Home Office Allocation	50,410	Non-allowable advertising	(14,290)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 62,927				\$ 749,305			\$ 70,116	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Home Office Allocation			\$ 576,508	N/A			Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 576,508				\$			\$ 16,247	
C. Professional Services								
Vendor/Payee	Type		Amount					
Foote, Meyers, Mielke & Flowers	Legal		\$ 2,797				In-State Travel	16,247
Quality Care Consulting Svs.	Activities		1,040				Includes travel expenses to Home Office in Toledo, OH, for regional meetings.	
Carol Walters	Nursing		7,990				Seminar Expense	
MPRO	Admin.		3,610					
Roche Dietiticians, LLC	Dietary		12,231				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL	
\$ 27,668				\$			\$ 16,247	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Naperville

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 \$7,872
- (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? \$2,519
- (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. \$ 72,624 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. \$ 64,605
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. \$ (2,423)
- (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? _____
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.