

		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: 0040998

Facility Name: Manorcare at Wilmette

Address: 432 Poplar Drive Wilmette 60091
 Number City Zip Code

County: Cook

Telephone Number: (847) 256-5000 **Fax #** (847) 256-0225

HFS ID Number: 520886946019

Date of Initial License for Current Owners: 06/12/95

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 Wilmette# 0040998 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	80	Skilled (SNF)	80	29,200	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	80	TOTALS	80	29,200	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,144	9,895	6,315	25,354	8
9	SNF/PED					9
10	ICF	396			396	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,540	9,895	6,315	25,750	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.18%

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/AF. Does the facility maintain a daily midnight census? YesG. 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 06/12/95

J. Was the facility purchased or leased after January 1, 1978?

YES Date 06/12/95 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number
of beds certified 80 and days of care provided 4,047Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRAU 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 Wilmette # 0040998 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	251,625	18,712	4,556	274,893	2,202	277,095		277,095			1
2	Food Purchase		132,015		132,015		132,015	(561)	131,454			2
3	Housekeeping	108,987	10,976	1,311	121,274		121,274		121,274			3
4	Laundry		3,351	754	4,105		4,105	(965)	3,140			4
5	Heat and Other Utilities			92,685	92,685	4,457	97,142		97,142			5
6	Maintenance	46,592	23,143	74,933	144,668		144,668		144,668			6
7	Other (specify):* Med Waste			151	151		151		151			7
8	TOTAL General Services	407,204	188,197	174,390	769,791	6,659	776,450	(1,526)	774,924			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	1,650,521	81,825	18,160	1,750,506	7,996	1,758,502	(1,505)	1,756,997			10
10a	Therapy		1,372	407,985	409,357		409,357		409,357			10a
11	Activities	39,126	1,465	3,847	44,438		44,438		44,438			11
12	Social Services	37,840		1,090	38,930		38,930		38,930			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,727,487	84,662	461,082	2,273,231	7,996	2,281,227	(1,505)	2,279,722			16
	C. General Administration											
17	Administrative	52,268		268,173	320,441	(60,452)	259,989		259,989			17
18	Directors Fees											18
19	Professional Services			15,694	15,694		15,694	(15,694)				19
20	Dues, Fees, Subscriptions & Promotions			89,524	89,524		89,524	(40,742)	48,782			20
21	Clerical & General Office Expenses	239,160	47,062	244,916	531,138		531,138	(201,322)	329,816			21
22	Employee Benefits & Payroll Taxes			394,194	394,194	33,218	427,412		427,412			22
23	Inservice Training & Education			469	469		469		469			23
24	Travel and Seminar			8,926	8,926		8,926		8,926			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			87,238	87,238		87,238		87,238			26
27	Other (specify):* P/S Admin.											27
28	TOTAL General Administration	291,428	47,062	1,109,134	1,447,624	(27,234)	1,420,390	(257,758)	1,162,632			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,426,119	319,921	1,744,606	4,490,646	(12,579)	4,478,067	(260,789)	4,217,278			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 Wilmette #0040998 Report Period Beginning: 06/01/2005 Ending: 05/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			300,624	300,624	12,579	313,203		313,203			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,932	13,932		13,932		13,932			32
33	Real Estate Taxes			234,372	234,372		234,372	58,405	292,777			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,787	24,787		24,787		24,787			35
36	Other (specify):* <i>G/L Assets Eq Earn</i>			398	398		398		398			36
37	TOTAL Ownership			574,113	574,113	12,579	586,692	58,405	645,097			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		176,448	15,753	192,201		192,201		192,201			39
40	Barber and Beauty Shops			8,252	8,252		8,252		8,252			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):* <i>IV Therapy Drugs</i>			9,143	9,143		9,143		9,143			43
44	TOTAL Special Cost Centers		176,448	76,948	253,396		253,396		253,396			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,426,119	496,369	2,395,667	5,318,155		5,318,155	(202,384)	5,115,771			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 Wilmette

0040998

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	(561)	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	(965)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,505)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(29)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,694)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(163,202)	21		24
25	Fund Raising, Advertising and Promotional	(39,225)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	58,405	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PG5A	(39,608)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (202,384)		\$	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))	\$ (202,384)		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 Wilmette

ID# 0040998

Report Period Beginning: 06/01/2005

Ending: 05/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Rental Income	\$ (38,003)	21	1
2	Miscellaneous Income	(88)	21	2
3	Public Relations	(1,517)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(39,608)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Wilmette

0040998

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	(561)	0	0	0	0	0	0	0	0	0	0	(561)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(965)	0	0	0	0	0	0	0	0	0	0	(965)	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	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	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	(1,505)	0	0	0	0	0	0	0	0	0	0	(1,505)	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	(1,505)	0	0	0	0	0	0	0	0	0	0	(1,505)	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	(15,694)	0	0	0	0	0	0	0	0	0	0	(15,694)	19
20	Fees, Subscriptions & Promotions	(40,742)	0	0	0	0	0	0	0	0	0	0	(40,742)	20
21	Clerical & General Office Expenses	(201,322)	0	0	0	0	0	0	0	0	0	0	(201,322)	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	(257,758)	0	0	0	0	0	0	0	0	0	0	(257,758)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(260,789)	0	0	0	0	0	0	0	0	0	0	(260,789)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Wilmette

0040998

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	58,405	0	0	0	0	0	0	0	0	0	0	58,405	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	58,405	0	58,405	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)	(202,384)	0	(202,384)	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
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	\$ 268,173	HCR Manor Care, Inc.	100.00%	\$ 268,173	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	9,613	Heartland Management Services	100.00%	9,613		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 277,786			\$ 277,786	\$ *	14

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

Facility Name & ID Number

Manorcare at Wilmette

#

0040998

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 Wilmette

0040998

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	369 Nurs Fac	\$ 1,107,111	\$ 591,572	4,977,023	\$ 2,202	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			4,977,023	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	267,575		4,977,023	532	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		4,977,023	3,925	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	4,977,023	1,535	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,944,092	2,235,491	4,977,023	6,461	6
7	17	General & Administrative - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,791,565	22,717,176	4,977,023	49,318	7
8	17	General & Administrative - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,702,974	43,044,715	4,977,023	158,403	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		4,977,023	12,659	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,855		4,977,023	20,559	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			4,977,023	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		4,977,023	12,579	12
13										13
14	32	Interest				7,118,315				14
15		Non Nursing Home Allocation				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		\$ 268,173	25

Facility Name & ID Number

Manorcare at Wilmette

0040998

Report Period Beginning:

06/01/2005

Ending:

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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		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	National City Bank						\$ 223,000	\$ 223,000			\$ 13,932	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 223,000	\$ 223,000			\$ 13,932	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 223,000	\$ 223,000			\$ 13,932	15					

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 163,712	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.)		\$ 225,200	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 61,488	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 231,289	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.		\$ 292,777	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	221,805	8
	2002	199,564	9
	2003	232,968	10
	2004	224,875	11
	2005	228,082	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 Wilmette COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040998

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>05-34-121-056-000</u>	<u>See Attached</u>	\$ <u>96,880.52</u>	\$ <u>96,880.52</u>
2. <u>05-34-121-041-000</u>	<u>See Attached</u>	\$ <u>3,853.93</u>	\$ <u>3,853.93</u>
3. <u>05-34-121-042-0000</u>	<u>See Attached</u>	\$ <u>1,383.77</u>	\$ <u>1,383.77</u>
4. <u>05-34-121-048-000</u>	<u>See Attached</u>	\$ <u>3,666.97</u>	\$ <u>3,666.97</u>
5. <u>05-34-121-050-000</u>	<u>See Attached</u>	\$ <u>3,136.38</u>	\$ <u>3,136.38</u>
6. <u>05-34-121-051-0000</u>	<u>See Attached</u>	\$ <u>3,515.77</u>	\$ <u>3,515.77</u>
7. <u>05-34-121-041-0000 & 05-34-121-04</u>	<u>See Attached</u>	\$ <u>5,387.06</u>	\$ <u>5,387.06</u>
8. <u>05-34-121-048-0000 & 05-34-121-05</u>	<u>See Attached</u>	\$ <u>6,997.43</u>	\$ <u>6,997.43</u>
9. <u>05-34-121-051-0000 & 05-34-121-05</u>	<u>See Attached</u>	\$ <u>103,259.93</u>	\$ <u>103,259.93</u>
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>228,081.76</u>	\$ <u>228,081.76</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 Wilmette

0040998 Report Period Beginning:

06/01/2005 Ending:

05/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,881 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

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>1995</u>	<u>\$ 500,819</u>	1
2					2
3	TOTALS			\$ 500,819	3

Facility Name & ID Number Manorcare at Wilmette

0040998

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 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	80		1995	1969	\$ 661,737	\$ 108,418		\$ 108,418	\$	\$ 1,164,407	4
5		CR 5/31/03 AUDIT ADJ	1995		3,635,000						5
6		CR 5/31/03 AUDIT ADJ	1995		40,000						6
7											7
8											8
		Improvement Type**									
9		BUILDING IMPROVEMENTS (Current year Depreciation)				136,539		136,539		867,375	9
10				1983	7,273						10
11				1985	17,043						11
12				1988	1,961						12
13				1989	7,178						13
14				1990	20,800						14
15				1991	2,428						15
16				1992	34,209						16
17				1993	55,467						17
18		INSTALL GARBAGE DISPOSAL/EJECTORS		1995	1,726						18
19		STORAGE TANKS		1995	7,303						19
20		PAINTING		1995	2,355						20
21		FLOOR/WALL TILE		1995	1,643						21
22		VERTICLE VESSELS		1995	21,838						22
23		CARPET CLEANING		1996	1,197						23
24		CAPITALIZED LABOR		1996	4,074						24
25		CR 5/31/99 AUDIT ADJ		1996	(4,074)						25
26		SIGN		1996	162						26
27		ELECTRICAL		1996	181,279						27
28		GENERAL REQUIREMENTS		1996	110,589						28
29		FLOORING/CEILING		1996	75,391						29
30		ARCHITECT/ENGINEER/LEGAL FEES		1996	52,531						30
31		CR 5/31/99 AUDIT ADJ		1996	(16,232)						31
32		CARPENTRY/MASONRY		1996	35,295						32
33		MILLWORK		1996	17,943						33
34		DOOR & WINDOW FRAMES		1996	26,753						34
35		FINISH STUD/DRYWALL		1996	8,964						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 Wilmette

0040998

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	PAINTING/WALLCOVERINGS	1996	\$ 28,690	\$		\$	\$	\$	37
38	PLUMBING	1996	63,189						38
39	HVAC	1996	22,253						39
40	CORNER GUARDS	1996	4,423						40
41	NURSE CALL STATION	1996	32,513						41
42	LIGHTING	1996	15,386						42
43	PERMITS	1996	4,646						43
44	CORPORATE OVERHEAD	1996	86,993						44
45	CR 5/31/99 AUDIT ADJ	1996	(86,993)						45
46	TRAVEL/DELIVERY	1996	13,507						46
47	SIGNS	1996	2,875						47
48	KICKPLATES	1996	1,697						48
49	CABLE/WIRING	1996	2,218						49
50	CARPET	1996	37,911						50
51	WALLCOVERINGS	1996	30,453						51
52	NEW COIL	1996	6,413						52
53	PIPING/INSULATION	1996	10,765						53
54	PUMP UPGRADE	1996	2,639						54
55	RANGE GUARD	1996	1,649						55
56	NURSE CALL SYSTEM	1997	7,208						56
57	ARCHITECT/ENGINEER FEES	1997	3,491						57
58	GENERAL CONTRACTOR	1997	21,640						58
59	FURNISH & INSTALL HEATER	1997	5,109						59
60	REPLACE DOORS/ALARM	1997	2,957						60
61	REPLACE WATER LINE	1997	2,423						61
62	CORPORATE OVERHEAD	1997	10,516						62
63	CR 5/31/99 AUDIT ADJ	1997	(10,516)						63
64	SITE PREP/LANDSCAPE	1997	11,180						64
65	FLOORING	1997	916						65
66	ROOFTOP A/C	1997	39,990						66
67	FACILITY PLAN ALLOC	1997	5,964						67
68	CR 5/31/99 AUDIT ADJ	1997	(5,964)						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,387,974	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	70

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

Facility Name & ID Number Manorcare at Wilmette

0040998

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		\$ 5,387,974	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	1
2	INSTALL NEW SUNROOM	1997	59,481						2
3	ASBESTOS REMOVAL	1997	19,675						3
4	ELECTRICAL	1997	4,156						4
5	ROOF WORK	1997	1,129						5
6	VINYL SHED	1997	803						6
7	ELECTRICAL	1998	17,790						7
8	PAINTING/ROOF/SIDING/CONCRETE	1998	20,304						8
9	BEAMS/STEEL	1998	4,320						9
10	CARPENTRY	1998	4,532						10
11	GENERAL CONTRACTOR FEES	1998	4,416						11
12	CARPET	1998	4,767						12
13	REMOVE & INSTALL DIFUSERS/DUCTS	1998	1,865						13
14	INSTALL DOORS	1998	4,466						14
15	CORPORATE OVERHEAD	1998	1,651						15
16	CR 5/31/99 AUDIT ADJ	1998	(1,651)						16
17	ENIGNEER/ARCHITECT FEES	1998	1,539						17
18	PLUMBING	1998	11,963						18
19	ELECTRICAL	1998	4,659						19
20	DEVELOPERS	1998	5,555						20
21	HVAC	1998	9,751						21
22	SIGN	1998	14,116						22
23	ROOFING	1998	3,725						23
24	PAVING	1998	17,975						24
25	PAINTING/WALLCOVERING	1999	1,418						25
26	FLOORING/CEILING	1999	3,964						26
27	HVAC	1999	6,727						27
28	DOOR/WINDOW	1999	2,938						28
29	ROOFING	1999	6,915						29
30	ARCHITECT	1999	15,472						30
31	KICKPLATES, HANDRAILS	1999	2,938						31
32	REMOVE OLD BOILER	1999	980						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,646,313	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	34

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

Facility Name & ID Number Manorcare at Wilmette

0040998

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		\$ 5,646,313	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	1
2	BUILDING DECORATIONS	1999	4,680						2
3	A/C UPGRADE	1999	17,360						3
4	BOILER CONTROLS	1999	23,650						4
5	ENGINEERING SERVICE	1999	779						5
6	VWC RES RMS/CORRIDORS	2000	8,025						6
7	ACCESS PANEL/AC UNIT	2000	520						7
8	AIR CONDITIONING UNIT	2000	4,121						8
9	ROOF REPAIRS	2000	1,065						9
10	EVELATOR UPGRADE	2000	590						10
11	CIRCUIT BOARD - FIRE ALARM	2000	2,461						11
12	ROOF INSPECTION	2001	650						12
13	INJECTOR PUMP	2001	2,697						13
14	FREIGHT ON CARPET	2001	316						14
15	CARPET	2001	6,426						15
16	FREIGHT ON CARPET	2001	55						16
17	CARPET	2001	2,790						17
18	CARPET	2001	2,141						18
19	FAN COIL UNITS	2001	41,483						19
20	CARPET	2001	2,374						20
21	ROOF	2001	4,086						21
22	ROOFING	2001	7,151						22
23	ROOF	2001	1,800						23
24	WINDOWS	2002	15,000						24
25	ROOF	2002	1,886						25
26	RENOVATION-OVERHEAD & INTEREST	2002	4,258						26
27	CR 5/31/03 AUDIT ADJ	2002	(4,258)						27
28	RENOVATION-GENERAL CONST & ELECT	2002	55,642						28
29	RENOVATION-CARPET	2002	13,724						29
30	STAINLESS STEEL WALLCOVER	2002	6,780						30
31	BOLLARDS AROUND COOLING TOWERS	2002	3,386						31
32	WINDOWS	2002	14,606						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,892,555	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	34

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

Facility Name & ID Number Manorcare at Wilmette

0040998

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		\$ 5,892,555	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	1
2	DOUBLE DOORS	2002	3,985						2
3	CARPET	2002	770						3
4	FREIGHT ON CARPET	2002	103						4
5	ROOF	2002	6,130						5
6	ROOF	2002	3,065						6
7	ROOF	2002	2,680						7
8	INSTALL CARPET	2002	458						8
9	INSTALL THREE DRAINS	2003	1,341						9
10	METAL STEEL DOOR	2003	1,000						10
11	METAL STEEL DOOR	2003	1,890						11
12	ARCHITECTURAL ENGINEERING	2003	602						12
13	ARCHITECTURAL ENGINEERING	2003	1,101						13
14	CARPET	2003	1,580						14
15	FREIGHT ON CARPET	2003	84						15
16	FREIGHT ON CARPET	2003	48						16
17	15 LIGHT FIXTURES	2003	3,600						17
18	BORDER	2003	629						18
19	BORDER	2003	131						19
20	VINYL WALL COVERING	2003	997						20
21	VINYL WALL COVERING	2003	581						21
22	BORDER	2003	179						22
23	BORDER	2003	149						23
24	VINYL WALL COVERING	2003	1,470						24
25	FREIGHT ON CARPET	2003	73						25
26	METAL DOOR AND INSTALLATION	2003	2,620						26
27	FLOORING AND VINYL WALL COV	2003	25,902						27
28	ARTWORK	2004	2,283						28
29	FREIGHT ON WINDOW TREATMENT	2004	97						29
30	CARPET	2004	1,580						30
31	FLOORING AND VINYL WALL COV	2004	400						31
32	CASH RECEIPT FOR CARPET	2004	(1,580)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,956,502	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	34

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

Facility Name & ID Number Manorcare at Wilmette

0040998

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		\$ 5,956,502	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	1
2	CONCRETE SLAB	2004	670						2
3	ARCH & ENGINEERING COST	2004	8,693						3
4	VWC	2004	1,270						4
5	FLOORING	2004	2,145						5
6	PAINTING	2004	11,005						6
7	Building Décor / 3 years Ta	2004	70						7
8	ARTWORK	2004	2,123						8
9	PAINTING	2004	4,635						9
10	Building Décor / 3 years Ta	2004	241						10
11	VWC	2004	990						11
12	INCANDESCENT EXPLOSION LI	2004	1,384						12
13	LAMP FIXTURES DUPLEX RECE	2004	5,450						13
14	HOBART OVEN	2004	2,436						14
15	INSTALL SINK & FAUCET	2005	1,110						15
16	CARPET	2005	1,350						16
17	FREIGHT ON CARPET	2005	77						17
18	CARPET	2005	1,733						18
19	Dumpster Corral	2005	14,222						19
20	PAINTING	2004	(4,635)						20
21	NEW CEILIN TILE	2005	4,314						21
22	INTERIOR RENOVATION	2005	6,000						22
23	CEILING PANELS	2005	1,875						23
24	INSTALL DOOR	2005	1,722						24
25	DOUBLE EGRESS DOOR	2005	5,755						25
26	Renov-Carpentry/Millwork	2005	70,189						26
27	Renov-Gen O/H & Int. on Construction	2005	70,345						27
28	Renov-Custom Casework	2005	3,860						28
29	Renov-Carpeting/Pads/ WC/Corner Guards	2005	14,643						29
30	Renov-Fire Sprinkler Sys.	2005	6,215						30
31	Renov-Plumbing	2005	2,247						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,198,635	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	34

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

Facility Name & ID Number Manorcare at Wilmette

0040998

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		\$ 6,198,635	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	1
2	Renov-Basic Electrical	2005	12,120						2
3	2 Btyan Boilers	2005	45,280						3
4	Light Fixtures	2005	2,534						4
5	Fire system	2005	25,895						5
6	INSTALL RESET CONTROL	2005	2,105						6
7	Renov-Gen O/H & Int. on Construction	2006	34,385						7
8	Renov-Carp./Lobby Fin./Doors/Windows/HVAC	2006	78,084						8
9	Renov-HM Doors/Frames/Plumbing	2006	35,064						9
10	Renov-Resilient Flooring	2006	30,265						10
11	Renov-Carpet/Pads/WC/Corner Guards	2006	9,666						11
12	Renov - Basic Electrical	2006	16,811						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)		\$ 6,490,843	\$ 244,957		\$ 244,957	\$	\$ 2,031,782	34

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

Facility Name & ID Number Manorcare at Wilmette # 0040998 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	\$ 1,297,245	\$ 55,667	\$ 55,667	\$		\$ 1,040,911	71
72	Current Year Purchases	99,215						72
73	Fully Depreciated Assets							73
74				12,579	12,579			74
75	TOTALS	\$ 1,396,460	\$ 55,667	\$ 68,246	\$ 12,579		\$ 1,040,911	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)	\$ 8,388,122	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 300,624	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,203	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,579	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,072,693	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.

Facility Name & ID Number Manorcare at Wilmette

0040998

Report Period Beginning: 06/01/2005

Ending: 05/31/2006

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: \$ 24,787

Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	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	\$	1,853	\$ 125,294	\$ 147	1,853	\$ 125,441	1
2	Licensed Speech and Language Development Therapist	10a	hrs		1,284	86,824	44	1,284	86,868	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		2,896	195,867	1,181	2,896	197,048	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 prescrpts				176,448		176,448	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				15,753			15,753	13
14	TOTAL			\$	6,033	\$ 423,738	\$ 177,820	6,033	\$ 601,558	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 Wilmette# 0040998Report Period Beginning: 06/01/2005

Ending:

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	\$ 37,021	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (155,052))	697,598		3
4	Supply Inventory (priced at)	20,382		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,671		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 756,672	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	500,819		13
14	Buildings, at Historical Cost	6,490,842		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,396,461		16
17	Accumulated Depreciation (book methods)	(3,072,693)		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)	\$ 5,315,429	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,072,101	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 28,471	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,903		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	231,289		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>	49,346		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 520,009	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	223,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1,038		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 224,038	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 744,047	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,328,054	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,072,101	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,882,549	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,882,549	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(476,643)	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)	\$ (476,643)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(77,852)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (77,852)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,328,054	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Wilmette# 0040998Report 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	\$ 5,127,139	1
2	Discounts and Allowances for all Levels	(1,034,797)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,092,342	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	572,500	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 572,500	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	561	12
13	Barber and Beauty Care	10,341	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	38,003	16
17	Sale of Drugs	125,658	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,155	21
22	Laundry	965	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 176,683	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(97)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (97)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	89	28
28a	Purch Disc Other Income	(5)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 84	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,841,512	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	769,791	31
32	Health Care	2,273,231	32
33	General Administration	1,447,624	33
B. Capital Expense			
34	Ownership	574,113	34
C. Ancillary Expense			
35	Special Cost Centers	253,396	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)*	\$ 5,318,155	40
41	Income before Income Taxes (line 30 minus line 40)**	(476,643)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (476,643)	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 Wilmette

0040998

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	1,921	2,074	\$ 74,043	\$ 35.70	1
2	Assistant Director of Nursing	2,016	2,177	61,225	28.12	2
3	Registered Nurses	15,183	16,389	440,717	26.89	3
4	Licensed Practical Nurses	14,609	15,769	361,462	22.92	4
5	CNAs & Orderlies	54,482	58,811	698,568	11.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,973	4,292	39,126	9.12	10
11	Social Service Workers	2,145	2,314	37,840	16.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,490	20,025	251,625	12.57	15
16	Dishwashers					16
17	Maintenance Workers	2,264	2,446	46,592	19.05	17
18	Housekeepers	8,781	9,489	108,987	11.49	18
19	Laundry					19
20	Administrator	1,424	1,424	52,268	36.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,007	15,192	239,160	15.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,025	1,108	14,506	13.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,320	151,510	\$ 2,426,119 *	\$ 16.01	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				36
37	Medical Records Consultant	Monthly	30,000	5,9,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,370	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,370		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 Wilmette

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$4,503
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? \$1,441
- (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. \$ 29,754 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. \$ 43,800
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (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.