

		FOR BHF USE				

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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: 0042648

Facility Name: Manorcare of Northbrook

Address: 3300 Milwaukee Avenue Northbrook 60062
 Number City Zip Code

County: Cook

Telephone Number: (847) 795-9700 **Fax #** (847) 795-9600

HFS ID Number: 520886946022

Date of Initial License for Current Owners: 03/22/99

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, CPA **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 06/01/05 to 05/31/06 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 of 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 of Northbrook# 0042648 Report Period Beginning: 06/01/05 Ending: 05/31/06

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>158</u>	Skilled (SNF)	<u>158</u>	<u>57,670</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>158</u>	TOTALS	<u>158</u>	<u>57,670</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>15,435</u>	<u>11,494</u>	<u>15,991</u>	<u>42,920</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,435</u>	<u>11,494</u>	<u>15,991</u>	<u>42,920</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.42%

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 3/22/99

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

YES Date _____ NO

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

YES NO If YES, enter number
of beds certified 158 and days of care provided 12,357Medicare 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: 05/31/06

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

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/05 Ending: 05/31/06

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	335,472	22,354	672	358,498	3,416	361,914		361,914		1
2	Food Purchase		206,546		206,546		206,546	(1,961)	204,585		2
3	Housekeeping	204,888	31,322	437	236,647		236,647		236,647		3
4	Laundry	77,777	14,069		91,846		91,846	(2,295)	89,551		4
5	Heat and Other Utilities			126,277	126,277	6,914	133,191		133,191		5
6	Maintenance	53,321	22,164	31,643	107,128		107,128		107,128		6
7	Other (specify):* Medical Waste			2,108	2,108		2,108		2,108		7
8	TOTAL General Services	671,458	296,455	161,137	1,129,050	10,330	1,139,380	(4,256)	1,135,124		8
	B. Health Care and Programs										
9	Medical Director			28,630	28,630		28,630		28,630		9
10	Nursing and Medical Records	2,813,864	245,466	35,277	3,094,607	12,401	3,107,008	(13,083)	3,093,925		10
10a	Therapy	523	9,624	826,952	837,099		837,099		837,099		10a
11	Activities	88,668	11,940	2,362	102,970		102,970		102,970		11
12	Social Services	122,240		1,021	123,261		123,261		123,261		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,025,295	267,030	894,242	4,186,567	12,401	4,198,968	(13,083)	4,185,885		16
	C. General Administration										
17	Administrative	88,462		415,977	504,439	(93,769)	410,670		410,670		17
18	Directors Fees										18
19	Professional Services			18,770	18,770	(1,114)	17,656	(17,656)			19
20	Dues, Fees, Subscriptions & Promotions			96,834	96,834		96,834	(41,470)	55,364		20
21	Clerical & General Office Expenses	262,912	55,428	172,369	490,709	1,114	491,823	(138,607)	353,216		21
22	Employee Benefits & Payroll Taxes			758,579	758,579	51,526	810,105		810,105		22
23	Inservice Training & Education			5,212	5,212		5,212		5,212		23
24	Travel and Seminar			4,228	4,228		4,228		4,228		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			170,885	170,885		170,885		170,885		26
27	Other (specify):*							(11)	(11)		27
28	TOTAL General Administration	351,374	55,428	1,642,854	2,049,656	(42,243)	2,007,413	(197,744)	1,809,669		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,048,127	618,913	2,698,233	7,365,273	(19,512)	7,345,761	(215,083)	7,130,678		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 of Northbrook #0042648 Report Period Beginning: 06/01/05 Ending: 05/31/06

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			474,778	474,778	19,512	494,290		494,290			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(4,357)	(4,357)			32
33	Real Estate Taxes			210,324	210,324		210,324	(238,167)	(27,843)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			128,887	128,887		128,887		128,887			35
36	Other (specify):*											36
37	TOTAL Ownership			813,989	813,989	19,512	833,501	(242,524)	590,977			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		383,030	68,961	451,991		451,991		451,991			39
40	Barber and Beauty Shops			28,602	28,602		28,602		28,602			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):* IV Therapy Drugs		113,426		113,426		113,426		113,426			43
44	TOTAL Special Cost Centers		496,456	184,068	680,524		680,524		680,524			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,048,127	1,115,369	3,696,290	8,859,786		8,859,786	(457,607)	8,402,179			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 of Northbrook

0042648

Report Period Beginning: 06/01/05

Ending: 05/31/06

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	(1,961)	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	(2,295)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,357)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	6,695	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(13,039)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,656)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(140,358)	21		24
25	Fund Raising, Advertising and Promotional	(41,470)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(238,167)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,999)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (457,607)		\$	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))	\$ (457,607)		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 of Northbrook

ID# 0042648

Report Period Beginning: 06/01/05

Ending: 05/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Phone	\$ (653)	21	1
2	Customer Reimbursement	(4,291)	21	2
3	Transportation Revenue	(44)	10	3
4	Personal Purchases	(11)	27	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	(4,999)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	(1,961)	0	0	0	0	0	0	0	0	0	0	(1,961)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,295)	0	0	0	0	0	0	0	0	0	0	(2,295)	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	(4,256)	0	0	0	0	0	0	0	0	0	0	(4,256)	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	(13,083)	0	0	0	0	0	0	0	0	0	0	(13,083)	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	(13,083)	0	0	0	0	0	0	0	0	0	0	(13,083)	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	(17,656)	0	0	0	0	0	0	0	0	0	0	(17,656)	19
20	Fees, Subscriptions & Promotions	(41,470)	0	0	0	0	0	0	0	0	0	0	(41,470)	20
21	Clerical & General Office Expenses	(138,607)	0	0	0	0	0	0	0	0	0	0	(138,607)	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):*	(11)	0	0	0	0	0	0	0	0	0	0	(11)	27
28	TOTAL General Administration	(197,744)	0	0	0	0	0	0	0	0	0	0	(197,744)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(215,083)	0	0	0	0	0	0	0	0	0	0	(215,083)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/05 Ending:

Summary B

05/31/06

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	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,357)	0	0	0	0	0	0	0	0	0	0	0	(4,357)	32
33	Real Estate Taxes	(238,167)	0	0	0	0	0	0	0	0	0	0	0	(238,167)	33
34	Rent-Facility & Grounds	0	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	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(242,524)	0	(242,524)	37										
	Ancillary Expense														
	E. Special Cost Centers														
38	Medically Necessary Transportation	0	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	0	39
40	Barber and Beauty Shops	0	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	0	41
42	Provider Participation Fee	0	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	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(457,607)	0	(457,607)	45										

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/05

Ending:

05/31/06

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 Corporation of America (See H.O. Cost Report)	Toledo, OH			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	See Home Office Allocation	\$ 415,977	HCR ManorCare, Inc	100.00%	\$ 415,977	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	14,744	Heartland Management Services	100.00%	14,744	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 430,721			\$ 430,721	\$ *

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

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/05 Ending: 05/31/06

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 of Northbrook

0042648

Report Period Beginning: 06/01/05

Ending: 05/31/06

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 St
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252-5500
 Fax Number (419) 254-5494

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	\$ 1,107,111	\$ 591,572	7,720,114	\$ 3,416	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac			7,720,114	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	267,575		7,720,114	826	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	2,395,925		7,720,114	6,088	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	771,372	565,963	7,720,114	2,380	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	3,944,092	2,235,491	7,720,114	10,021	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	24,791,565	22,717,176	7,720,114	76,500	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	96,703,374	43,044,715	7,720,114	245,708	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac	6,363,513		7,720,114	19,636	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	12,550,855		7,720,114	31,890	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs Fac			7,720,114	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs Fac	7,679,242		7,720,114	19,512	12
13										13
14	32	Interest				7,118,315				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 163,692,939	\$ 69,154,917		\$ 415,977	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						\$	\$			\$	1
2												2
3												3
4												4
5									Interest Income		(4,357)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$ (4,357)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$ (4,357)	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.			\$	278,607	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.)			\$	40,440	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(238,167)	3
4.	Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	186,042	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.)			\$	24,282	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.			\$	(27,843)	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
	2001	<u>245,778</u>	<u>8</u>			
	2002	<u>240,453</u>	<u>9</u>			
	2003	<u>241,893</u>	<u>10</u>			
	2004	<u>171,251</u>	<u>11</u>			
	2005	<u>186,042</u>	<u>12</u>			
				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 of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042648

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>04-30-200-028-0000</u>	<u>See Attached</u>	\$ <u>453,098.56</u>	\$ <u>186,042.27</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>453,098.56</u>	\$ <u>186,042.27</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? X YES 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 of Northbrook

0042648 Report Period Beginning:

06/01/05 Ending:

05/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,393 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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>1999</u>	<u>\$ 1,885,717</u>	1
2			<u>2003</u>	<u>32,884</u>	2
3	TOTALS			\$ 1,918,601	3

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	148			1999	\$ 8,207,461	\$ 229,500		\$ 229,500		\$ 1,283,770	4
5		CR 5/31/01 AUDIT ADJ		1999	494,486						5
6	10			2003	478,057						6
7											7
8											8
		Improvement Type**									
9		BUILDING IMPROVEMENTS (Current Year Depreciation)				100,803		100,803		278,361	9
10				1999	531						10
11		CR 5/31/01 AUDIT ADJ		1999	(531)						11
12				1999	1,470						12
13		CR 5/31/01 AUDIT ADJ		1999	(1,470)						13
14				1999	73						14
15		CR 5/31/01 AUDIT ADJ		1999	(73)						15
16				1999	449						16
17		CR 5/31/01 AUDIT ADJ		1999	(449)						17
18		SECURE CARE SYSTEM		2000	14,841						18
19		MAGNETIC DOOR HOLDER		2000	1,134						19
20		ACCESS DOORS - FIRE DAMPERS		2000	2,473						20
21		ENGINEER COST V#3413 RESIDENT'S ROOMS		2000	14,790						21
22		WALLCOVERING-2ND FL RESIDENTS R		2000	1,398						22
23		ADD'L CONSTRUCTION COST-RESIDENTS ROOMS		2000	205						23
24		CIRCUITRY SECURE CARE SYSTEM		2000	1,374						24
25		SITWORK		2000	1,036,860						25
26		CR 5/31/01 AUDIT ADJ		2000	(1,036,860)						26
27		FENCE		2000	965						27
28		BLOCKING AND PULLY SYSTEM		2001	977						28
29		ELECTRICAL ON GENERATOR		2001	1,298						29
30		FREIGHT ON CARPET		2001	103						30
31		CARPET		2001	484						31
32		CARPET		2001	626						32
33		GEN OVERHEAD,ARCHITECT,ENGINEER COSTS		2003	395,966						33
34		MILLWORK		2003	2,646						34
35		CARPET		2003	3,248						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 of Northbrook

0042648

Report Period Beginning:

06/01/05

Ending:

05/31/06

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

1	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	2003	\$ 840	\$		\$	\$	\$	37
38	2003	188						38
39	2003	2,275						39
40	2003	60						40
41	2003	69						41
42	2003	835						42
43	2003	848						43
44	2003	1,680						44
45	2003	738						45
46	2003	2,450						46
47	2003	69						47
48	2003	148						48
49	2003	620						49
50	2003	201						50
51	2003	3,647						51
52	2003	71,550						52
53	2004	1,800						53
54	2004	30						54
55	2004	1,093						55
56	2004	707						56
57	2004	125						57
58	2004	62						58
59	2004	12,653						59
60	2004	7,980						60
61	2004	989						61
62	2004	77						62
63	2004	407						63
64	2004	672						64
65	2004	801						65
66	2004	1,382						66
67	2004	660						67
68	2004	2,097						68
69	2004	450						69
70	TOTAL (lines 4 thru 69)	\$ 9,740,735	\$ 330,303		\$ 330,303	\$	\$ 1,562,131	70

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

Facility Name & ID Number Manorcare of Northbrook

0042648

Report Period Beginning:

06/01/05

Ending:

05/31/06

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,740,735	\$ 330,303		\$ 330,303	\$	\$ 1,562,131	1
2	CARPET	2005	4,450						2
3	VINYL SHEET FOR NURSE STATION	2005	14,330						3
4	DOOR HINGES	2005	1,975						4
5	WALLCOVERING	2006	1,650						5
6	PAINTING & CORNER GUARDS	2003	15,000						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	TOTAL (lines 1 thru 33)		\$ 9,778,141	\$ 330,303		\$ 330,303	\$	\$ 1,562,131	34

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

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/05 Ending: 05/31/06

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	\$ 1,350,792	\$ 144,475	\$ 144,475	\$		\$ 753,371	71
72	Current Year Purchases	46,872						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			19,512	19,512			74
75	TOTALS	\$ 1,397,664	\$ 144,475	\$ 163,987	\$ 19,512		\$ 753,371	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)	\$	13,094,406	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	474,778	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	494,290	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	19,512	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,315,502	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /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: \$ 128,887 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	21 hrs	\$ 523	7,151	\$ 371,833	\$ 1,728	7,172	\$ 374,084	1
2	Licensed Speech and Language Development Therapist	10a	hrs		1,575	81,901	111	1,575	82,012	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		7,162	372,426	7,785	7,162	380,211	4
5	Physician Care		visits							5
6	Dental Care	39	visits			134			134	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				383,030		383,030	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-Lab, X-Ray, Inhal	10,Col 3, 39				69,619			69,619	13
14	TOTAL			\$ 523	15,888	\$ 895,913	\$ 392,654	15,909	\$ 1,289,090	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 of Northbrook# 0042648Report Period Beginning: 06/01/05

Ending:

05/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 05/31/06

(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	\$ (92,621)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (238,179))	1,468,444		3
4	Supply Inventory (priced at)	54,380		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,259		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,433,462	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,918,601		13
14	Buildings, at Historical Cost	9,778,142		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,397,664		16
17	Accumulated Depreciation (book methods)	(2,315,502)		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)	\$ 10,778,905	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,212,367	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 132,774	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	296,173		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	279,063		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	181,007		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 889,017	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 889,017	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 11,323,350	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,212,367	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,345,273	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,345,273	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	994,010	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)	\$ 994,010	17
B. Transfers (Itemize):			
18	Change in Interdivision	(1,015,933)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,015,933)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,323,350	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Northbrook# 0042648Report Period Beginning: 06/01/05Ending: 05/31/06**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	\$ 9,132,581	1
2	Discounts and Allowances for all Levels	(1,506,023)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,626,558	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,787,448	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,787,448	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	465	12
13	Barber and Beauty Care	42,079	13
14	Non-Patient Meals	1,507	14
15	Telephone, Television and Radio	653	15
16	Rental of Facility Space		16
17	Sale of Drugs	364,379	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,011	19
20	Radiology and X-Ray		20
21	Other Medical Services	44	21
22	Laundry	2,295	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 435,433	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	4,349	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,349	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,853,796	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,129,050	31
32	Health Care	4,186,567	32
33	General Administration	2,049,656	33
B. Capital Expense			
34	Ownership	813,989	34
C. Ancillary Expense			
35	Special Cost Centers	680,524	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)*	\$ 8,859,786	40
41	Income before Income Taxes (line 30 minus line 40)**	994,010	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 994,010	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 of Northbrook

0042648

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	1,671	1,806	\$ 63,016	\$ 34.89	1
2	Assistant Director of Nursing	3,120	3,373	98,697	29.26	2
3	Registered Nurses	35,102	37,944	1,034,644	27.27	3
4	Licensed Practical Nurses	15,571	16,832	370,762	22.03	4
5	CNAs & Orderlies	90,604	97,940	1,164,315	11.89	5
6	CNA Trainees					6
7	Licensed Therapist	15	21	523	24.90	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,196	8,871	88,668	10.00	10
11	Social Service Workers	6,140	6,625	122,240	18.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,323	26,476	335,472	12.67	15
16	Dishwashers					16
17	Maintenance Workers	2,213	2,397	53,321	22.24	17
18	Housekeepers	17,523	18,966	204,888	10.80	18
19	Laundry	8,386	9,078	77,777	8.57	19
20	Administrator	2,217	2,217	88,462	39.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,471	16,019	262,912	16.41	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	5,792	6,269	82,430	13.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,344	254,834	\$ 4,048,127 *	\$ 15.89	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	28,630	Ln9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,630		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 of Northbrook

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Report Period Beginning: 06/01/05

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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	
<u>Terri Bowen</u>	<u>Administrator</u>	<u>0</u>	\$ <u>88,462</u>	<u>Workers' Compensation Insurance</u>	\$ <u>13,730</u>	<u>IDPH License Fee</u>	\$ <u>3,769</u>	
				<u>Unemployment Compensation Insurance</u>	<u>68,323</u>	<u>Advertising: Employee Recruitment</u>	<u>13,697</u>	
				<u>FICA Taxes</u>	<u>299,484</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>329,777</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>192</u> <u>3,837</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>38</u>	
				<u>Other Employee Benefits</u>	<u>299</u>	<u>Association Dues</u>	<u>8,816</u>	
				<u>Payroll Overhead Allocated</u>	<u>0</u>	<u>Advertising</u>	<u>65,941</u>	
				<u>401K</u>	<u>39,535</u>	<u>Public Relations</u>	<u>736</u>	
				<u>Tuition Program</u>	<u>6,797</u>	<u>Less: Non-Allowable Association Dues</u>	<u>(2,821)</u>	
				<u>Employee Uniforms</u>	<u>634</u>	<u>Less: Public Relations Expense</u>	<u>(736)</u>	
				<u>Home Office Allocation</u>	<u>51,526</u>	<u>Non-allowable advertising</u>	<u>(37,913)</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)								
\$ <u>88,462</u>				\$ <u>810,105</u>			\$ <u>55,364</u>	
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
<u>Home Office</u>			\$ <u>415,977</u>			\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	<u>4,228</u>
							<u>Includes travel expense to the Home Office in Toledo, OH for regional meeting</u>	
							<u>Seminar Expense</u>	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			Entertainment Expense	
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
\$ <u>415,977</u>				\$			\$ <u>4,228</u>	
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>Foote, Meyers, Mielke</u>	<u>Legal Fees</u>		<u>17,656</u>					
<u>Physicians Credit Bureau</u>	<u>Accounting Fees</u>		<u>184</u>					
<u>Lawrence J Harman</u>	<u>Special Cons</u>		<u>200</u>					
<u>Quality Care Consulting</u>	<u>Special Cons</u>		<u>730</u>					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ <u>18,770</u>								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare of Northbrook

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 \$ 8,816
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$ 2,821
- (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. \$ 91,667 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. \$ 86,505
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. \$ (1,507)
- (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? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.