

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0036376

Facility Name: Manorcare at Elk Grove Village

Address: 1920 Nerge Road Elk Grove Village 60007
 Number City Zip Code

County: Cook

Telephone Number: (847) 301-0550 **Fax #** (847) 301-0013

HFS ID Number: 520886946011

Date of Initial License for Current Owners: 07/30/90

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 06/01/06 to 05/31/07 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 A. 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 Elk Grove Village

0036376 Report Period Beginning: 06/01/06 Ending: 05/31/07

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>190</u>	Skilled (SNF)	<u>190</u>	<u>69,350</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>190</u>	TOTALS	<u>190</u>	<u>69,350</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>17,534</u>	<u>18,155</u>	<u>29,328</u>	<u>65,017</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>17,534</u>	<u>18,155</u>	<u>29,328</u>	<u>65,017</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.75%

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)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/30/90

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 190 and days of care provided 23,402

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 05/31/07

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

Facility Name & ID Number Manorcare at Elk Grove Village # 0036376 Report Period Beginning: 06/01/06 Ending: 05/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	503,726	32,930	18,355	555,011	5,050	560,061		560,061		1
2	Food Purchase		304,088		304,088		304,088	(2,890)	301,198		2
3	Housekeeping	249,737	35,360	8,389	293,486		293,486		293,486		3
4	Laundry	99,671	19,881	4,050	123,602		123,602	(876)	122,726		4
5	Heat and Other Utilities			254,852	254,852	11,837	266,689		266,689		5
6	Maintenance	83,030	21,684	128,453	233,167		233,167		233,167		6
7	Other (specify):* Medical Waste			1,266	1,266		1,266		1,266		7
8	TOTAL General Services	936,164	413,943	415,365	1,765,472	16,887	1,782,359	(3,766)	1,778,593		8
	B. Health Care and Programs										
9	Medical Director			32,500	32,500		32,500		32,500		9
10	Nursing and Medical Records	4,736,910	444,998	180,089	5,361,997	7,999	5,369,996		5,369,996		10
10a	Therapy	429,425	20,376	1,525,779	1,975,580		1,975,580	(35,323)	1,940,257		10a
11	Activities	175,439	9,731	2,101	187,271		187,271	(50)	187,221		11
12	Social Services	179,037		633	179,670		179,670		179,670		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,520,811	475,105	1,741,102	7,737,018	7,999	7,745,017	(35,373)	7,709,644		16
	C. General Administration										
17	Administrative	165,900		728,053	893,953	(153,845)	740,108		740,108		17
18	Directors Fees										18
19	Professional Services			12,614	12,614	(416)	12,198	(12,198)			19
20	Dues, Fees, Subscriptions & Promotions			218,260	218,260		218,260	(27,975)	190,285		20
21	Clerical & General Office Expenses	428,358	87,642	520,182	1,036,182	416	1,036,598	(455,561)	581,037		21
22	Employee Benefits & Payroll Taxes			1,142,850	1,142,850	87,281	1,230,131		1,230,131		22
23	Inservice Training & Education			5,621	5,621		5,621		5,621		23
24	Travel and Seminar			12,025	12,025		12,025		12,025		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			197,742	197,742		197,742		197,742		26
27	Other (specify):* Purch. Serv. Admin.			40	40		40	(40)			27
28	TOTAL General Administration	594,258	87,642	2,837,387	3,519,287	(66,564)	3,452,723	(495,774)	2,956,949		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,051,233	976,690	4,993,854	13,021,777	(41,678)	12,980,099	(534,913)	12,445,186		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 Elk Grove Village #0036376 Report Period Beginning: 06/01/06 Ending: 05/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			422,192	422,192	29,813	452,005	452,005			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(144)	(144)	11,865	11,721	11,721			32
33	Real Estate Taxes			432,177	432,177		432,177	432,177			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			94,870	94,870		94,870	94,870			35
36	Other (specify):* Gain/Loss on F/A										36
37	TOTAL Ownership			949,095	949,095	41,678	990,773	990,773			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			(65)	(65)		(65)	(65)			38
39	Ancillary Service Centers		979,877	3,275	983,152		983,152	983,152			39
40	Barber and Beauty Shops			29,140	29,140		29,140	29,140			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			104,025	104,025		104,025	104,025			42
43	Other (specify):* IV X-Ray & Lab		156,474	107,226	263,700		263,700	263,700			43
44	TOTAL Special Cost Centers		1,136,351	243,601	1,379,952		1,379,952	1,379,952			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,051,233	2,113,041	6,186,550	15,350,824		15,350,824	(534,913)	14,815,911		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 Elk Grove Village

0036376

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,890)	2		4
5	Telephone, TV & Radio in Resident Rooms	(799)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(876)	4		8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(420)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(40)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(18,720)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,198)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(433,991)	21		24
25	Fund Raising, Advertising and Promotional	(27,975)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,681)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (499,590)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,323)	10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,323)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (534,913)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Manorcare at Elk Grove Village

ID# 0036376

Report Period Beginning: 06/01/06

Ending: 05/31/07

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,076)	21	1
2	Misc. Income	(555)	21	2
3	Activity Income	(50)	11	3
4	Gain/Loss on Disposal of Fixed Assets		36	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,681)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Elk Grove Village

0036376

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	(2,890)	0	0	0	0	0	0	0	0	0	0	(2,890)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(876)	0	0	0	0	0	0	0	0	0	0	(876)	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	(3,766)	0	0	0	0	0	0	0	0	0	0	(3,766)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(35,323)	0	0	0	0	0	0	0	0	0	(35,323)	10a
11	Activities	(50)	0	0	0	0	0	0	0	0	0	0	(50)	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	(50)	(35,323)	0	(35,373)	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	(12,198)	0	0	0	0	0	0	0	0	0	0	(12,198)	19
20	Fees, Subscriptions & Promotions	(27,975)	0	0	0	0	0	0	0	0	0	0	(27,975)	20
21	Clerical & General Office Expenses	(455,561)	0	0	0	0	0	0	0	0	0	0	(455,561)	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):*	(40)	0	0	0	0	0	0	0	0	0	0	(40)	27
28	TOTAL General Administration	(495,774)	0	0	0	0	0	0	0	0	0	0	(495,774)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(499,590)	(35,323)	0	(534,913)	29								

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elk Grove Village

0036376

Report Period Beginning:

06/01/06 Ending:

Summary B

05/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(499,590)	(35,323)	0	(534,913)	45								

Facility Name & ID Number Manorcare at Elk Grove Village

0036376

Report Period Beginning:

06/01/06

Ending:

05/31/07

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

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 Allocation	\$ 728,053	HCR Manor Care, Inc.	100.00%	\$ 728,053	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	54,214	Heartland Management Services	100.00%	54,214	
7	V						
8	V	10a Therapy - PT, OT, & ST	1,177,423	Heartland Rehab Services	100.00%	1,142,100	(35,323)
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,959,690			\$ 1,924,367	\$ * (35,323)

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

Facility Name & ID Number Manorcare at Elk Grove Village # 0036376 Report Period Beginning: 06/01/06 Ending: 05/31/07

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 Elk Grove Village

0036376

Report Period Beginning:

06/01/06

Ending: 05/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization HCR Manor Care, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604-2617
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

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	2,604,994,312	369 Nurs. Fac.	\$	\$	14,115,311	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	1,156,548	625,878	14,115,311	5,050	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	500,452		14,115,311	2,712	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	2,089,736		14,115,311	9,125	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.			14,115,311	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	1,831,963	1,296,078	14,115,311	7,999	6
7	17	General & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	41,206,110	32,327,667	14,115,311	223,278	7
8	17	General & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	80,368,229	42,462,992	14,115,311	350,930	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	8,458,198		14,115,311	45,831	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	9,492,678		14,115,311	41,450	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.			14,115,311	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	6,827,559		14,115,311	29,813	12
13										13
14	32	Interest				4,662,634			11,865	14
15		Non-Nursing Home Allocations				22,389,200				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 178,983,307	\$ 76,712,615		\$ 728,053	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		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	Conv. Sub. Debentures		X	Facility			\$ 241,832	\$ 241,832		4.9100	\$ 11,865	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8	Interest Income										(144)	8					
9	TOTAL Facility Related						\$ 241,832	\$ 241,832			\$ 11,721	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 241,832	\$ 241,832			\$ 11,721	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 2006 report.	\$	<u>376,349</u>	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.)	\$	<u>406,269</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>29,920</u>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>403,621</u>	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 \$ <u>1,364</u> For <u>1999</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	<u>(1,364)</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>432,177</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<u>379,662</u>	8
	2003	<u>360,404</u>	9
	2004	<u>384,225</u>	10
	2005	<u>398,920</u>	11
	2006	<u>423,215</u>	12

Line 2: \$406,269 = \$199,461 for 1st half of 2006 + \$206,808 for 2nd half of 2005

Line 4: \$403,621 = \$179,866 for Jan-May 2007 + \$223,755 for 2nd half of 2006

Line 6: 1999 Tax Rate Objection Refund

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Elk Grove Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036376

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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-35-200-022-0000</u>	<u>Estimated - Tax bill not received yet.</u>	<u>\$ 423,215.00</u>	<u>\$ 423,215.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 423,215.00	\$ 423,215.00

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Elk Grove Village

0036376 Report Period Beginning:

06/01/06 Ending:

05/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,632 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

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

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

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

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

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

None

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>1990</u>	<u>\$ 853,628</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 853,628	3

Facility Name & ID Number Manorcare at Elk Grove Village# 0036376

Report Period Beginning:

06/01/06

Ending:

05/31/07**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	120			1990	\$ 5,025,494	\$ 188,398		\$ 188,398	\$	\$ 2,682,538	4
5	60			1996	1,726,800						5
6	10			2000	1,063,936						6
7	5/31/03 Audit Adjustment			2000	(277,211)						7
8											8
Improvement Type**											
9	Current Year Depreciation					76,500		76,500		1,314,894	9
10				1990	12,954						10
11				1991	41,034						11
12				1992	89,111						12
13				1993	29,775						13
14				1994	18,939						14
15				1995	182,383						15
16				1996	485,188						16
17				1997	111,890						17
18				1998	127,587						18
19				1999	60,314						19
20				2000	68,449						20
21				2001	5,850						21
22				2002	53,586						22
23		HOLLOW METAL DOOR		2003	975						23
24		ARCH & ENGINEERING COSTS		2003	975						24
25		BORDER		2003	162						25
26		VWC		2003	1,710						26
27		VWC		2003	219						27
28		ARCHITECTURAL ENGINEERING		2003	258						28
29		VWC		2003	427						29
30		NEW BATHROOM FLOORING & TILE		2003	22,640						30
31		ARCHITECT & ENGINEERING		2003	258						31
32		FLOORING		2003	4,599						32
33		VWC, BORDER, AND PAINTING		2003	3,317						33
34		ADDITIONAL COST FOR FLOORING		2003	2,820						34
35		ARCHITECT AND ENGINEERING COSTS		2003	2,064						35
36		WINDOW TREATMENT		2003	3,629						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 Elk Grove Village

0036376

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	<u>BORDER</u>	2003	\$ 54	\$		\$	\$	\$	37
38	<u>ARCHITECT AND ENGINEERING COSTS</u>	2003	455						38
39	<u>ELECTRICAL WORK</u>	2003	5,182						39
40	<u>VCT FLOORING</u>	2003	7,005						40
41	<u>BASE AND FLOOR TILE</u>	2003	4,118						41
42	<u>CARPET</u>	2004	609						42
43	<u>INSTALL CARPET</u>	2004	550						43
44	<u>PAVING</u>	2003	67,500						44
45	<u>CONCRETE WALK</u>	2003	3,822						45
46	<u>PAVING</u>	2004	7,500						46
47	<u>Renov. - General Construction Overhead & Interest</u>	2004	19,622						47
48	<u>Renov. - Carpeting</u>	2004	595						48
49	<u>Renov. - Painting</u>	2004	14,000						49
50	<u>Renov. - Wallcovering & Corner Guards</u>	2004	37,811						50
51	<u>Renov. - Carpentry</u>	2004	8,201						51
52	<u>Renov. - Plumbing</u>	2004	2,880						52
53	<u>Renov. - Electrical</u>	2004	2,931						53
54	<u>Carpet</u>	2004	1,324						54
55	<u>Ceramic Cove Base</u>	2004	3,360						55
56	<u>Renov. - Wood Doors & Hardware for Lobby</u>	2004	8,597						56
57	<u>Renov. - Electrical</u>	2004	2,484						57
58	<u>Electric Door Strike at Service Door</u>	2004	1,509						58
59	<u>CARPETING & DELIVERY OF CARPETTING</u>	2005	2,435						59
60	<u>REBUILD SHOWER STALLS (5)</u>	2006	14,000						60
61	<u>VWC, BASE, & CEILING TILES IN BREAK ROOM</u>	2006	2,470						61
62									62
63	<u>Ceramic Tile - Wall/Floor</u>	2006	3,300						63
64	<u>Wallcovering</u>	2006	3,605						64
65	<u>Plumbing Work on Sprinkler System</u>	2006	4,727						65
66	<u>Architecture/Engineering for Parking Lot</u>	2007	9,285						66
67	<u>Drywall Work</u>	2007	8,378						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,118,441	\$ 264,898		\$ 264,898	\$	\$ 3,997,432	70

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

Facility Name & ID Number Manorcare at Elk Grove Village # 0036376 Report Period Beginning: 06/01/06 Ending: 05/31/07

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	\$ 2,292,956	\$ 157,294	\$ 157,294	\$		\$ 1,688,900	71
72	Current Year Purchases	197,155						72
73	Fully Depreciated Assets							73
74	Home Office Depr.			29,813	29,813			74
75	TOTALS	\$ 2,490,111	\$ 157,294	\$ 187,107	\$ 29,813		\$ 1,688,900	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)	\$ 12,462,180	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 422,192	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 452,005	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,813	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,686,332	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 94,870 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. 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	N/A		\$ _____	\$ _____	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	2029 hrs	\$ 72,044	10,563	\$ 627,416	\$ 6,042	12,592	\$ 705,502	1
2	Licensed Speech and Language Development Therapist	10a	751 hrs	26,678	1,955	116,112	166	2,706	142,956	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	3808 hrs	135,164	12,206	725,030	14,168	16,014	874,362	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				979,877		979,877	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray & Lab	43, 3				107,226			107,226	13
14	TOTAL			\$ 233,886	24,724	\$ 1,575,784	\$ 1,000,253	31,312	\$ 2,809,923	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.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 15,486	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>553,034</u>)	2,360,971		3
4	Supply Inventory (priced at <u>03/31/07</u>)	79,161		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,639		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,459,257	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	853,628		13
14	Buildings, at Historical Cost	9,118,441		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,490,111		16
17	Accumulated Depreciation (book methods)	(5,686,332)		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): <u>Construction in Progress</u>	231,047		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,006,895	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,466,152	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 57,242	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	546,479		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	403,621		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payable</u>	493,780		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,501,122	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	70,575		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 70,575	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,571,697	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,894,455	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,466,152	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,135,716	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,135,716	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,839,255	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)	\$ 2,839,255	17
B. Transfers (Itemize):			
18	Change in Interdivision	(3,080,516)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3,080,516)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,894,455	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Elk Grove Village# 0036376Report Period Beginning: 06/01/06Ending: 05/31/07**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	\$ 15,270,863	1
2	Discounts and Allowances for all Levels	(2,876,467)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,394,396	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,970,422	6
7	Oxygen	2,744	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,973,166	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,076	12
13	Barber and Beauty Care	37,851	13
14	Non-Patient Meals	2,890	14
15	Telephone, Television and Radio	799	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,085,097	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	71,575	19
20	Radiology and X-Ray	621,800	20
21	Other Medical Services	580	21
22	Laundry	876	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,822,544	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	(27)	28
28a	Late Charges		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (27)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,190,079	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,765,472	31
32	Health Care	7,737,018	32
33	General Administration	3,519,287	33
B. Capital Expense			
34	Ownership	949,095	34
C. Ancillary Expense			
35	Special Cost Centers	1,275,927	35
36	Provider Participation Fee	104,025	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,350,824	40
41	Income before Income Taxes (line 30 minus line 40)**	2,839,255	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,839,255	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 Elk Grove Village

0036376

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	693	748	\$ 31,620	\$ 42.27	1
2	Assistant Director of Nursing	3,980	4,295	146,429	34.09	2
3	Registered Nurses	64,839	69,981	2,190,873	31.31	3
4	Licensed Practical Nurses	19,615	21,171	508,436	24.02	4
5	CNAs & Orderlies	139,423	150,788	1,760,940	11.68	5
6	CNA Trainees	3,214	3,450	36,156	10.48	6
7	Licensed Therapist	6,588	7,142	253,536	35.50	7
8	Rehab/Therapy Aides	7,216	7,823	161,557	20.65	8
9	Activity Director	12,862	13,904	175,439	12.62	9
10	Activity Assistants					10
11	Social Service Workers	7,427	8,028	179,037	22.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,264	42,448	503,726	11.87	15
16	Dishwashers					16
17	Maintenance Workers	4,030	4,351	83,030	19.08	17
18	Housekeepers	20,771	22,459	249,737	11.12	18
19	Laundry	9,371	10,134	99,671	9.84	19
20	Administrator	2,080	2,080	119,995	57.69	20
21	Assistant Administrator	1,673	1,673	45,905	27.44	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,318	23,609	428,358	18.14	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	5,089	5,499	76,788	13.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	369,453	399,583	\$ 7,051,233 *	\$ 17.65	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	32,500	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,974	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)		\$ 43,474		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,467	\$ 91,101	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,467	\$ 91,101		53

Facility Name & ID Number Manorcare at Elk Grove Village

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 \$12342
- (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 \$3720
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 118,993 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. \$ 104,025
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,890
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.