

		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:** 0027490

**Facility Name:** Manorcare at Kankakee

**Address:** 900 West River Place Kankakee 60901  
 Number City Zip Code

**County:** Kankakee

**Telephone Number:** (815) 933-1711 **Fax #** (815) 933-2065

**HFS ID Number:** 520886946003

**Date of Initial License for Current Owners:** 11/01/81

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<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.

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

Phone # (217) 782-1630

Facility Name & ID Number Manorcare at Kankakee

# 0027490 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>107</u>	Skilled (SNF)	<u>107</u>	<u>39,055</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>107</u>	TOTALS	<u>107</u>	<u>39,055</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>16,239</u>	<u>6,028</u>	<u>11,832</u>	<u>34,099</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>16,239</u>	<u>6,028</u>	<u>11,832</u>	<u>34,099</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.31%

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)

Adult Day Care

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

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

YES  NO

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

YES  NO

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

Date started 11/01/81

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

YES  Date 11/01/81 NO

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

YES  NO  If YES, enter number of beds certified 107 and days of care provided 8,242

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 Kankakee      #      0027490      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
	<b>A. General Services</b>										
1	Dietary	183,305	16,135	7,242	206,682	1,779	208,461		208,461		1
2	Food Purchase		156,228		156,228		156,228	(70)	156,158		2
3	Housekeeping	87,371	15,567	74	103,012		103,012		103,012		3
4	Laundry	40,775	7,997	871	49,643		49,643	(4,795)	44,848		4
5	Heat and Other Utilities			138,339	138,339	4,169	142,508		142,508		5
6	Maintenance	36,295	22,819	74,783	133,897		133,897		133,897		6
7	Other (specify):* <b>Medical Waste</b>			823	823		823		823		7
8	<b>TOTAL General Services</b>	<b>347,746</b>	<b>218,746</b>	<b>222,132</b>	<b>788,624</b>	<b>5,948</b>	<b>794,572</b>	<b>(4,865)</b>	<b>789,707</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,720,563	150,452	18,693	1,889,708	6,708	1,896,416	(9,503)	1,886,913		10
10a	Therapy	141,024	5,775	305,375	452,174		452,174	(7,629)	444,545		10a
11	Activities	47,972	553	217	48,742		48,742	(175)	48,567		11
12	Social Services	86,263			86,263		86,263		86,263		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,995,822</b>	<b>156,780</b>	<b>332,685</b>	<b>2,485,287</b>	<b>6,708</b>	<b>2,491,995</b>	<b>(17,307)</b>	<b>2,474,688</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	75,683		293,677	369,360	(91,427)	277,933		277,933		17
18	Directors Fees										18
19	Professional Services			26,625	26,625	(3,890)	22,735	(22,735)			19
20	Dues, Fees, Subscriptions & Promotions			48,662	48,662		48,662	(14,404)	34,258		20
21	Clerical & General Office Expenses	139,359	38,965	69,691	248,015		248,015	(58,339)	189,676		21
22	Employee Benefits & Payroll Taxes			502,442	502,442	30,743	533,185		533,185		22
23	Inservice Training & Education			1,476	1,476		1,476		1,476		23
24	Travel and Seminar			10,796	10,796		10,796		10,796		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,614	96,614		96,614		96,614		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>215,042</b>	<b>38,965</b>	<b>1,049,983</b>	<b>1,303,990</b>	<b>(64,574)</b>	<b>1,239,416</b>	<b>(95,478)</b>	<b>1,143,938</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,558,610</b>	<b>414,491</b>	<b>1,604,800</b>	<b>4,577,901</b>	<b>(51,918)</b>	<b>4,525,983</b>	<b>(117,650)</b>	<b>4,408,333</b>		<b>29</b>

\*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 Kankakee #0027490 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
	<b>D. Ownership</b>										
30	Depreciation			220,217	220,217	10,499	230,716		230,716		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(264)	(264)	41,419	41,155		41,155		32
33	Real Estate Taxes			44,562	44,562		44,562		44,562		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			10,663	10,663		10,663		10,663		35
36	Other (specify):* Gain/Loss on F/A										36
37	<b>TOTAL Ownership</b>			275,178	275,178	51,918	327,096		327,096		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		269,303		269,303		269,303		269,303		39
40	Barber and Beauty Shops			6,886	6,886		6,886		6,886		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			58,583	58,583		58,583		58,583		42
43	Other (specify):* IV   X-Ray & Lab		23,563	21,358	44,921		44,921		44,921		43
44	<b>TOTAL Special Cost Centers</b>		292,866	86,827	379,693		379,693		379,693		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,558,610	707,357	1,966,805	5,232,772		5,232,772	(117,650)	5,115,122		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 Kankakee

# 0027490

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	\$ (9,503)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(70)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,128)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,795)	4		8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(2)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(137)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(242)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,140)	21		18
19	Entertainment				19
20	Contributions	(660)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(22,735)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,924)	21		24
25	Fund Raising, Advertising and Promotional	(14,404)	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	(1,281)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (110,021)		\$	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)	(7,629)	10a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (7,629)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (117,650)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Kankakee

ID# 0027490

Report Period Beginning: 06/01/06

Ending: 05/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (787)	21	1
2	Misc. Income	(319)	21	2
3	Activity Income	(175)	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	<b>Total</b>	(1,281)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Manorcare at Kankakee

# 0027490

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(70)	0	0	0	0	0	0	0	0	0	0	(70)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,795)	0	0	0	0	0	0	0	0	0	0	(4,795)	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	<b>TOTAL General Services</b>	<b>(4,865)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,865)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(9,503)	0	0	0	0	0	0	0	0	0	0	(9,503)	10
10a	Therapy	0	(7,629)	0	0	0	0	0	0	0	0	0	(7,629)	10a
11	Activities	(175)	0	0	0	0	0	0	0	0	0	0	(175)	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	<b>TOTAL Health Care and Programs</b>	<b>(9,678)</b>	<b>(7,629)</b>	<b>0</b>	<b>(17,307)</b>	<b>16</b>								
	<b>C. General Administration</b>													
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	(22,735)	0	0	0	0	0	0	0	0	0	0	(22,735)	19
20	Fees, Subscriptions & Promotions	(14,404)	0	0	0	0	0	0	0	0	0	0	(14,404)	20
21	Clerical & General Office Expenses	(58,339)	0	0	0	0	0	0	0	0	0	0	(58,339)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(95,478)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(95,478)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(110,021)</b>	<b>(7,629)</b>	<b>0</b>	<b>(117,650)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Kankakee

# 0027490

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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(110,021)</b>	<b>(7,629)</b>	<b>0</b>	<b>(117,650)</b>	<b>45</b>								

Facility Name & ID Number Manorcare at Kankakee

# 0027490

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					
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a	Home Allocation	HCR Manor Care, Inc.	100.00%	293,677	
7	V						
8	V	10a	Therapy Management	Heartland Management Services	100.00%	13,539	
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		254,330	Heartland Rehab Services	100.00%	246,701	(7,629)
			561,546			553,917	* (7,629)

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

Facility Name & ID Number Manorcare at Kankakee # 0027490 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 Kankakee

# 0027490

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.	\$	\$	4,971,739	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	1,156,548	625,878	4,971,739	1,779	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	500,452		4,971,739	955	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	2,089,736		4,971,739	3,214	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.			4,971,739	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	1,831,963	1,296,078	4,971,739	2,818	6
7	17	General & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	41,206,110	32,327,667	4,971,739	78,644	7
8	17	General & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	80,368,229	42,462,992	4,971,739	123,606	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	8,458,198		4,971,739	16,143	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	9,492,678		4,971,739	14,600	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.			4,971,739	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	6,827,559		4,971,739	10,499	12
13										13
14	32	Interest				4,662,634			41,419	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		\$ 293,677	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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Conv. Sub. Debentures		X	Facility			\$ 844,222	\$ 844,222		4.9100	\$ 41,419	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8	Interest Income										(264)	8
9	<b>TOTAL Facility Related</b>						\$ 844,222	\$ 844,222			\$ 41,155	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 844,222	\$ 844,222			\$ 41,155	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.)



**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 Kankakee COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0027490

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>16-09-31-412-001</u>	<u>See Attached</u>	<u>\$ 44,694.36</u>	<u>\$ 44,694.36</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	<b>\$ 44,694.36</b>	<b>\$ 44,694.36</b>

**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 Kankakee

# 0027490 Report Period Beginning:

06/01/06 Ending:

05/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 19,938 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>1981</u>	<u>\$ 29,077</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 29,077</b>	<b>3</b>

**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	88			1969	\$ 566,769	\$ 9,418		\$ 9,418		\$ 914,449	4
5	9			1988	533,782						5
6	10			1990	60,931						6
7											7
8											8
<b>Improvement Type**</b>											
9	<b>Building Improvements (Current Year Depreciation)</b>					131,590		131,590		1,617,026	9
10				1980	14,866						10
11				1981	90,159						11
12				1982	16,908						12
13				1983	11,723						13
14				1985	33,632						14
15				1987	56,199						15
16		RETIREMENTS		1987	(30,337)						16
17				1988	65,707						17
18				1989	92,574						18
19				1990	34,128						19
20				1991	13,615						20
21				1992	46,361						21
22		RETIREMENTS		1992	(5,120)						22
23				1993	359,644						23
24				1994	26,647						24
25				1995	85,884						25
26				1996	4,830						26
27				1996	2,444						27
28				1996	2,647						28
29				1996	7,272						29
30		C/R 5/31/99 AUDIT ADJ 1a - CAPITALIZED LABOR		1996	(7,272)						30
31				1996	6,000						31
32				1996	2,362						32
33				1996	3,921						33
34				1996	26,843						34
35				1996	1,104						35
36				1996	2,793						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 &amp; ID Number Manorcare at Kankakee

# 0027490

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	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	1996	\$ 11,690	\$		\$	\$	\$	37
38	1996	7,061						38
39	1996	3,860						39
40	1996	1,730						40
41	1996	2,295						41
42	1996	6,811						42
43	1997	10,515						43
44	1997	(10,515)						44
45	1997	2,271						45
46	1997	2,911						46
47	1997	12,873						47
48	1997	1,790						48
49	1997	6,068						49
50	1997	1,927						50
51	1997	10,539						51
52	1997	22,190						52
53	1997	3,465						53
54	1997	5,964						54
55	1997	(5,964)						55
56	1997	57,390						56
57	1997	5,000						57
58	1997	1,419						58
59	1997	3,782						59
60	1998	6,739						60
61	1998	8,286						61
62	1998	4,000						62
63	1998	7,000						63
64	1998	2,211						64
65	1998	1,651						65
66	1998	(1,651)						66
67	1998	20,198						67
68	1998	3,000						68
69	1998	3,390						69
70		\$ 2,346,912	\$ 141,008		\$ 141,008	\$	\$ 2,531,475	70

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

Facility Name &amp; ID Number Manorcare at Kankakee

# 0027490

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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,346,912	\$ 141,008		\$ 141,008	\$	\$ 2,531,475	1
2	CARPETING	1998	1,169						2
3	ELECTRICAL/LIGHTING	1998	149						3
4	PAINTING/WALLCOVERING	1998	552						4
5	GENERAL CONTRACTOR FEES	1998	2,507						5
6	SIGNAGE	1998	11,862						6
7	HVAC	1998	3,135						7
8	LANDSCAPING	1998	4,950						8
9	PAINTING/WALLCOVERING	1999	819						9
10	SIGNAGE	1999	1,725						10
11	SECURE CARE SYSTEM	1999	1,278						11
12	COMPRESSOR CHILLER	1999	6,505						12
13	PAGER/SPEAKER SYSTEM	1999	3,900						13
14	NEW DOOR FRAME	1999	1,581						14
15	HOT WATER COMPRESSOR	1999	45,135						15
16	CARPENTRY & ROOFING	2000	148,330						16
17	CARPETING & PADS	2000	12,448						17
18	C/R 5/31/03 AUDIT ADJ #1a - Carpet & Pads	2000	(235)						18
19	WALLCOVERING	2000	48,471						19
20	C/R 5/31/03 AUDIT ADJ #1b - Wallcoverings	2000	(272)						20
21	C/R 5/31/03 AUDIT ADJ #1c - Reclass Equipment	2000	(9,179)						21
22	DEVELOPERS COST - ARCADIA DINING	2000	38,406						22
23	C/R 5/31/03 AUDIT ADJ #1d -Dev. Cost Arcadia Dining	2000	(38,406)						23
24	BORDER	2000	134						24
25	C/R 5/31/03 AUDIT ADJ #1e - Border	2000	(8)						25
26	WALLVINYL - ARCADIA DINING	2000	819						26
27	WALLCOVERING	2000	156						27
28	PAINTING/WALLCOVERING - ARCADIA DINING	2000	3,410						28
29	CARPET	2000	188						29
30	2 A/C UNIT	2001	1,431						30
31	INSTALL SPRINKLER SYSTEM	2001	2,465						31
32	DRAPES	2001	1,520						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,641,857	\$ 141,008		\$ 141,008	\$	\$ 2,531,475	34

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

Facility Name &amp; ID Number Manorcare at Kankakee

# 0027490

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	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,641,857	\$ 141,008		\$ 141,008	\$	\$ 2,531,475	1
2	<b>DOORS</b>	2001	1,056						2
3	<b>FREIGHT ON WALLCOVERINGS</b>	2001	205						3
4	<b>C/R 5/31/03 AUDIT ADJ #1f - Freight on Wallcoverings</b>	2001	(53)						4
5	<b>VWC</b>	2001	5,136						5
6	<b>NEW LANDSCAPING</b>	2001	9,200						6
7	<b>VWC</b>	2001	2,713						7
8	<b>C/R 5/31/03 AUDIT ADJ #2h - VWC</b>	2001	(160)						8
9	<b>INTERIOR - FLOORING &amp; VWC (Audit Adj #2g) Change Yr</b>	2001	20,613						9
10	<b>INTERIOR - FLOORING &amp; VWC (Audit Adj #2g) Change Yr</b>	2002	5,064						10
11	<b>INTERIOR - FLOORING &amp; VWC</b>	2002	20,256						11
12	<b>C/R 5/31/03 AUDIT ADJ #2e - Overhead &amp; Interest</b>	2002	(20,256)						12
13	<b>INTERIOR - FLOORING &amp; VWC</b>	2002	69,157						13
14	<b>C/R 5/31/03 AUDIT ADJ #2f - Interior Flooring &amp; VWC</b>	2002	(206)						14
15	<b>C/R 5/31/03 AUDIT ADJ #2f - Interior Flooring &amp; VWC</b>	2002	(289)						15
16	<b>WALLCOVERING AND BORDER</b>	2002	2,400						16
17	<b>WALL BORDER</b>	2002	89						17
18	<b>VWC</b>	2002	538						18
19	<b>WALL BORDER</b>	2002	28						19
20	<b>INTERIOR - FLOORING &amp; VWC (Audit Adj #2a) Change Yr</b>	2002	24,133						20
21	<b>PLUMBING AND ELECTRICAL (Audit Adj #2c) Change Yr</b>	2002	8,576						21
22	<b>INTERIOR - FLOORING &amp; VWC (Audit Adj #2b) Change Yr</b>	2002	34,302						22
23	<b>INTERIOR - FLOORING &amp; VWC (Audit Adj #2b) Change Yr</b>	2003	26,714						23
24	<b>C/R 5/31/03 AUDIT ADJ #2b - Interior Flooring &amp; VWC</b>	2003	(450)						24
25	<b>C/R 5/31/03 AUDIT ADJ #2b - Interior Flooring &amp; VWC</b>	2003	(909)						25
26	<b>WINDOW TREATMENTS</b>	2003	1,845						26
27	<b>OVERHEAD &amp; INTEREST</b>	2003	6,809						27
28	<b>C/R 5/31/03 AUDIT ADJ #2j - Overhead &amp; Interest</b>	2003	(6,809)						28
29	<b>OVERHEAD &amp; INTEREST</b>	2003	450						29
30	<b>C/R 5/31/03 AUDIT ADJ #2d - Overhead &amp; Interest</b>	2003	(450)						30
31	<b>RETROADDITION \$133 disallowed per audit</b>	2003							31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,851,559	\$ 141,008		\$ 141,008	\$	\$ 2,531,475	34

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

Facility Name &amp; ID Number Manorcare at Kankakee

# 0027490

Report Period Beginning:

06/01/06

Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,851,559	\$ 141,008		\$ 141,008	\$	\$ 2,531,475	1
2	TILE FLOORING	2003	1,946						2
3	FLOORING	2003	2,384						3
4	DOORS	2003	14,965						4
5	FENCE	2003	8,250						5
6	ceramic tile	2004	2,385						6
7	RENOVATION/ 406-01404C \$13,607 disallowed per audit	2005							7
8	PEDIMAT MATTING	2005	1,455						8
9									9
10	Enterance/Porch - add sprinkler system in canopy area	2004	3,550						10
11	Enterance/Porch - replace post & resurface floor	2005	5,940						11
12	Carpet & Cove Base	2005	3,250						12
13	Locksets, Simplex keyless	2005	3,109						13
14	HVAC System & electrical	2005	447,358						14
15	O/H & Interest - non-allowable per audit \$209,630								15
16	Wallcovering & Paint	2005	7,000						16
17	20 Amp Disconnect 200 for Chiller	2005	753						17
18	New sidewalks	2005	7,150						18
19	Ceramic Tile Walls/Floors Arcadia Shower	2006	4,100						19
20	Man door replacement	2006	1,141						20
21	Upgrade Kitchen Hood to UL300 fire system	2006	768						21
22	Privacy Fence	2006	820						22
23									23
24	Wallcovering & Rubber Cove Base	2006	7,155						24
25	Upgrade 3 Doors	2006	12,750						25
26	Upgrade Kitchen Walls	2006	3,150						26
27	New Plumbing in Hallway	2006	4,140						27
28	Show Room Renovation and Electric in Therapy Area	2006	21,850						28
29	Cabinets/Work Station in Dining Room	2006	4,260						29
30	Fire Rated Doors (3)	2007	9,995						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,431,183	\$ 141,008		\$ 141,008	\$	\$ 2,531,475	34

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

Facility Name & ID Number Manorcare at Kankakee # 0027490 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	\$ 1,080,248	\$ 79,209	\$ 79,209	\$		\$ 763,580	71
72	Current Year Purchases	53,372						72
73	Fully Depreciated Assets							73
74	Home Office Depr.			10,499	10,499			74
75	TOTALS	\$ 1,133,620	\$ 79,209	\$ 89,708	\$ 10,499		\$ 763,580	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)	\$ 4,593,880	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 220,217	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 230,716	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,499	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,295,055	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	<b>TOTAL</b>				\$ _____			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: \$ 10,663 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	<b>TOTAL</b>		\$ _____	\$ _____	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)	
<b>TOTAL TRAINED</b>	

- (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	174 hrs	\$ 6,874	1,666	\$ 100,983	\$ 1,130	1,840	\$ 108,987	1
2	Licensed Speech and Language Development Therapist	10a	339 hrs	13,354	1,484	89,911	20	1,823	103,285	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	869 hrs	34,286	1,654	100,216	4,625	2,523	139,127	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				269,303		269,303	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				21,358			21,358	13
14	TOTAL			\$ 54,514	4,804	\$ 312,468	\$ 275,078	6,186	\$ 642,060	14

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

Facility Name & ID Number Manorcare at Kankakee# 0027490Report Period Beginning: 06/01/06

Ending:

05/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (2,528)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>142,285</u> )	1,441,431		3
4	Supply Inventory (priced at <u>03/31/07</u> )	35,989		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,049		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,476,941	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	29,077		13
14	Buildings, at Historical Cost	3,431,183		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,133,620		16
17	Accumulated Depreciation (book methods)	(3,295,055)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,298,825	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,775,766	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 33,560	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	243,662		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,317		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Payable</u>	126,183		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 466,722	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 466,722	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,309,044	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,775,766	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,267,408	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,267,408	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	861,727	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)	\$ 861,727	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	(820,091)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (820,091)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,309,044	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Kankakee# 0027490Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,050,485	1
2	Discounts and Allowances for all Levels	(381,349)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,669,136	3
<b>B. Ancillary Revenue</b>			
4	Day Care	9,503	4
5	Other Care for Outpatients		5
6	Therapy	1,039,224	6
7	Oxygen	41,369	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,090,096	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,029	12
13	Barber and Beauty Care	7,953	13
14	Non-Patient Meals	70	14
15	Telephone, Television and Radio	6,128	15
16	Rental of Facility Space		16
17	Sale of Drugs	293,895	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,775	19
20	Radiology and X-Ray	2,380	20
21	Other Medical Services	3,266	21
22	Laundry	4,795	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 334,291	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	660	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 660	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc. Income	314	28
28a	Late Charges	2	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 316	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,094,499	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	788,624	31
32	Health Care	2,485,287	32
33	General Administration	1,303,990	33
<b>B. Capital Expense</b>			
34	Ownership	275,178	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	321,110	35
36	Provider Participation Fee	58,583	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,232,772	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	861,727	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 861,727	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 Kankakee

# 0027490

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	2,114	2,292	\$ 74,849	\$ 32.66	1
2	Assistant Director of Nursing	3,588	3,890	101,816	26.17	2
3	Registered Nurses	7,243	7,854	194,562	24.77	3
4	Licensed Practical Nurses	27,033	29,313	571,841	19.51	4
5	CNAs & Orderlies	66,995	72,803	787,164	10.81	5
6	CNA Trainees					6
7	Licensed Therapist	1,382	1,543	60,839	39.43	7
8	Rehab/Therapy Aides	1,360	1,517	47,918	31.59	8
9	Activity Director	4,411	4,801	47,972	9.99	9
10	Activity Assistants					10
11	Social Service Workers	3,944	4,293	86,263	20.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,555	19,138	183,305	9.58	15
16	Dishwashers					16
17	Maintenance Workers	1,878	2,046	36,295	17.74	17
18	Housekeepers	9,913	10,788	87,371	8.10	18
19	Laundry	3,913	4,258	40,775	9.58	19
20	Administrator	2,080	2,080	75,683	36.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,383	9,583	139,359	14.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,823	1,985	22,598	11.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,615	178,184	\$ 2,558,610 *	\$ 14.36	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	8,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,849	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)		\$ 11,249		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





**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 \$6945
- (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 \$2094
- (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. \$ 48,680 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. \$ 58,583  
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. \$ 70
- (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.