

		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:** 0032904

**Facility Name:** Manorcare at Libertyville

**Address:** 1500 South Milwaukee Avenue Libertyville 60048  
 Number City Zip Code

**County:** Lake

**Telephone Number:** (708) 816-3200 Fax # (708) 816-8981

**HFS ID Number:** 520886946009

**Date of Initial License for Current Owners:** 02/02/88

**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 6/1/2006 to 5/31/2007 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 Lazarus</u>	
	(Title) <u>Vice President - Reimbursement</u>	
<b>Paid Preparer</b>	(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 Libertyville# 0032904 Report Period Beginning: 6/1/2006 Ending: 5/31/2007

## 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>150</u>	Skilled (SNF)	<u>150</u>	<u>54,750</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>150</u>	TOTALS	<u>150</u>	<u>54,750</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>18,864</u>	<u>3,327</u>	<u>19,951</u>	<u>42,142</u>	8
9	SNF/PED					9
10	ICF	<u>972</u>			<u>972</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,836</u>	<u>3,327</u>	<u>19,951</u>	<u>43,114</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 78.75%

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)

N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES  NO 

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

YES  NO 

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

Date started 2/23/88

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

YES  Date 2/23/88 NO 

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

YES  NO  If YES, enter number  
of beds certified 150 and days of care provided 16,988Medicare 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: 5/31/07

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

Facility Name & ID Number      Manorcare at Libertyville      #      0032904      Report Period Beginning:      6/1/2006      Ending:      5/31/2007

**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	369,674	20,053	916	390,643	3,482	394,125		394,125			1
2	Food Purchase		253,312		253,312		253,312	(2,453)	250,859			2
3	Housekeeping	143,295	20,347	372	164,014		164,014		164,014			3
4	Laundry	43,544	27,679	970	72,193		72,193		72,193			4
5	Heat and Other Utilities			169,745	169,745	8,162	177,907		177,907			5
6	Maintenance	41,721	26,679	132,238	200,638		200,638		200,638			6
7	Other (specify):* <b>Med Waste Utilities</b>			2,404	2,404		2,404		2,404			7
8	<b>TOTAL General Services</b>	<b>598,234</b>	<b>348,070</b>	<b>306,645</b>	<b>1,252,949</b>	<b>11,644</b>	<b>1,264,593</b>	<b>(2,453)</b>	<b>1,262,140</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,944,805	313,263	239,508	3,497,576	5,516	3,503,092	(32,356)	3,470,736			10
10a	Therapy	366,402	13,049	1,080,408	1,459,859		1,459,859	(1,880)	1,457,979			10a
11	Activities	102,536	3,481	2,926	108,943		108,943		108,943			11
12	Social Services	143,973		911	144,884		144,884		144,884			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>3,557,716</b>	<b>329,793</b>	<b>1,345,353</b>	<b>5,232,862</b>	<b>5,516</b>	<b>5,238,378</b>	<b>(34,236)</b>	<b>5,204,142</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	96,535		652,999	749,534	(257,063)	492,471		492,471			17
18	Directors Fees											18
19	Professional Services			19,768	19,768	(249)	19,519	(19,519)				19
20	Dues, Fees, Subscriptions & Promotions			119,274	119,274		119,274	(19,923)	99,351			20
21	Clerical & General Office Expenses	338,242	60,148	77,737	476,127	249	476,376	(6,758)	469,618			21
22	Employee Benefits & Payroll Taxes			791,978	791,978	60,183	852,161		852,161			22
23	Inservice Training & Education			981	981		981		981			23
24	Travel and Seminar			8,219	8,219		8,219		8,219			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			142,392	142,392		142,392		142,392			26
27	Other (specify):* <b>Vend Mach Admin</b>			35	35		35		35			27
28	<b>TOTAL General Administration</b>	<b>434,777</b>	<b>60,148</b>	<b>1,813,383</b>	<b>2,308,308</b>	<b>(196,880)</b>	<b>2,111,428</b>	<b>(46,200)</b>	<b>2,065,228</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,590,727</b>	<b>738,011</b>	<b>3,465,381</b>	<b>8,794,119</b>	<b>(179,720)</b>	<b>8,614,399</b>	<b>(82,889)</b>	<b>8,531,510</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 Libertyville #0032904 Report Period Beginning: 6/1/2006 Ending: 5/31/2007

## 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			433,232	433,232	20,557	453,789		453,789			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,692	40,692	159,163	199,855		199,855			32
33	Real Estate Taxes			106,602	106,602		106,602	24,102	130,704			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			161,988	161,988		161,988		161,988			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			742,514	742,514	179,720	922,234	24,102	946,336			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			637,882	637,882		637,882		637,882			39
40	Barber and Beauty Shops			21,347	21,347		21,347		21,347			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* <b>IV Drugs &amp; PS X-Ray</b>		109,234	77,101	186,335		186,335		186,335			43
44	<b>TOTAL Special Cost Centers</b>		109,234	818,455	927,689		927,689		927,689			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,590,727	847,245	5,026,350	10,464,322		10,464,322	(58,787)	10,405,535			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 Libertyville

# 0032904

Report Period Beginning: 6/1/2006

Ending: 5/31/2007

**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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,453)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	2,783	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(32,356)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,900)	21		18
19	Entertainment				19
20	Contributions	(320)	21		20
21	Owner or Key-Man Insurance	(19,519)	19		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,321)	21		24
25	Fund Raising, Advertising and Promotional	(19,923)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	24,102	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>PGA</u>	(1,880)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (58,787)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (58,787)		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		52

Manorcare at Libertyville

ID# 0032904

Report Period Beginning: 6/1/2006

Ending: 5/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Purch. Svs. Psychology	\$ (1,880)	10a	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,880)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Manorcare at Libertyville

# 0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

## 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	(2,453)	0	0	0	0	0	0	0	0	0	0	(2,453)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	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>(2,453)</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>(2,453)</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	(32,356)	0	0	0	0	0	0	0	0	0	0	(32,356)	10
10a	Therapy	(1,880)	0	0	0	0	0	0	0	0	0	0	(1,880)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(34,236)</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>(34,236)</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	(19,519)	0	0	0	0	0	0	0	0	0	0	(19,519)	19
20	Fees, Subscriptions & Promotions	(19,923)	0	0	0	0	0	0	0	0	0	0	(19,923)	20
21	Clerical & General Office Expenses	(6,758)	0	0	0	0	0	0	0	0	0	0	(6,758)	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>(46,200)</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>(46,200)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(82,889)</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>(82,889)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Libertyville

# 0032904

Report Period Beginning:

6/1/2006 Ending:

Summary B

5/31/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	24,102	0	0	0	0	0	0	0	0	0	0	24,102	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>24,102</b>	<b>0</b>	<b>24,102</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>(58,787)</b>	<b>0</b>	<b>(58,787)</b>	<b>45</b>									

Facility Name & ID Number Manorcare at Libertyville

# 0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corp. of America (SEE H.O. COST REPORT)	Toledo, Ohio			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Home Office Allocation	\$ 652,999	HCR ManorCare, Inc.	100.00%	\$ 652,999	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	40,805	Heartland Management Services - Administrative Fees	100.00%	40,805		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 693,804			\$ 693,804	\$ *	14

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

Facility Name &amp; ID Number

Manorcare at Libertyville

#

0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

## 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 Libertyville

# 0032904

Report Period Beginning:

6/1/2006

Ending: 5/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization HCR ManorCare, Inc.  
 Street Address 333 North Summit Street  
 City / State / Zip Code Toledo, Ohio 43604  
 Phone Number ( 419) - 252-5500  
 Fax Number ( 419) - 252-5495

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	\$	\$	9,733,005	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	1,156,548	625,878	9,733,005	3,482	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	500,452		9,733,005	1,870	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	2,089,736		9,733,005	6,292	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.			9,733,005	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	1,831,963	1,296,078	9,733,005	5,516	6
7	17	General & Administrative - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	41,206,110	32,327,667	9,733,005	153,958	7
8	17	General & Administrative - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	80,368,229	42,462,992	9,733,005	241,978	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	8,458,198		9,733,005	31,602	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	9,492,678		9,733,005	28,581	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.			9,733,005	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	6,827,559		9,733,005	20,557	12
13										13
14	32	Interest				4,662,634			159,163	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 156,594,107	\$ 76,712,615		\$ 652,999	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Conv. Sub. Debentures		X	Facility			\$ 3,244,133	\$ 3,244,133		\$ 159,163	1									
2	National Bank, Trustee						650,995	650,995		40,692	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6											6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$ 3,895,128	\$ 3,895,128		\$ 199,855	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>						\$ 3,895,128	\$ 3,895,128		\$ 199,855	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 Libertyville COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0032904

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>11-28-401-003</u>	<u>See Attached</u>	\$ <u>57,109.24</u>	\$ <u>57,109.24</u>
2. <u>11-28-401-003</u>	<u>See Attached</u>	\$ <u>57,109.25</u>	\$ <u>57,109.25</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>114,218.49</u>	\$ <u>114,218.49</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 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 Libertyville

# 0032904 Report Period Beginning:

6/1/2006 Ending:

5/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 36,902 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 3

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

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

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

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

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

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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>1988</u>	<u>\$ 476,076</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 476,076</b>	3

Facility Name &amp; ID Number Manorcare at Libertyville

# 0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

**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	150			1988	\$ 4,592,131	\$ 117,249		\$ 117,249	\$	\$ 2,163,045	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Building Improvements Current Year Depreciation				175,047		175,047		1,760,474	9
10				1988	68,073						10
11				1989	52,434						11
12				1990	30,247						12
13				1991	67,316						13
14				1992	175,480						14
15		RETIREMENTS		1992	(10,437)						15
16				1993	55,746						16
17				1994	135,262						17
18				1995	66,532						18
19		FLOOR VINYL/TILE & INSTALLATION		1996	31,353						19
20		CAPITALIZED LABOR-NURSES STATION RENOV		1996	7,272						20
21		C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR		1996	(7,272)						21
22		WALLVINYL/SIGNS		1996	5,576						22
23		CARPET		1996	4,210						23
24		INNER CAMERA MONITOR		1996	4,177						24
25		SIDING		1996	2,205						25
26		REPAIR LOOSE BRICKS		1996	2,183						26
27		NURSES STATION RENOVATION		1996	11,271						27
28		DOOR RELEASE		1996	2,071						28
29		REMODELING		1996	1,129						29
30		WATER HEATER		1996	5,313						30
31		CARPET/INSTALLATION		1996	2,991						31
32		FLOORING/TILE		1996	23,312						32
33		DOOR FRAME/GUARDS		1996	4,941						33
34		KITCHEN CELING TILE		1996	3,638						34
35		WALLCOVERINGS		1996	4,964						35
36		ELECTRICAL/LIGHTING		1996	3,055						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 Libertyville# 0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CABINERY	1996	\$ 5,880	\$		\$	\$	\$	37
38	REBUILD NURSES STATION	1996	8,500						38
39	INSTALL SWING DOORS	1996	8,826						39
40	INSTALL BALLUSTER POSTS	1996	2,500						40
41	FLOOR COVING	1996	7,791						41
42	BRICK PIER/CONCRETE SIDEWALK	1996	3,880						42
43	INSTALL BOULDER EDGE	1996	4,830						43
44	NURSES STATION RENOVATIONS	1996	1,506						44
45	WALL VINYL	1997	18,304						45
46	CARPETING	1997	1,624						46
47	DECORATING	1997	45,045						47
48	BRICK PIER	1997	1,500						48
49	EXTERIOR ENTRY DOORS	1997	3,317						49
50	PAINTING	1997	7,449						50
51	INSTALL CONDENSING COILS	1997	2,583						51
52	LANDSCAPE	1997	59,118						52
53	CURBING/ASPHALT	1997	30,000						53
54	ROOFING	1997	1,536						54
55	CORPORATE OVERHEAD-PARKING LOT	1997	10,516						55
56	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)						56
57	PARKING LOT WORK	1997	25,000						57
58	FACILITY PLAN ALLOC	1997	5,964						58
59	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)						59
60	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)						60
61	ELEVATOR REPAIRS	1997	5,018						61
62	SECURITY SYSTEM	1997	16,954						62
63	NEW EXHAUSTERS	1997	6,310						63
64	BUILD & INSTALL CABINETS	1997	6,512						64
65	CARPET	1997	5,148						65
66	LANDSCAPE	1997	25,279						66
67	CURB/ASPHALT	1997	45,210						67
68	INSTALL CEDAR FENCE	1997	2,750						68
69	DRUM SLUDGE REMOVAL	1997	2,563						69
70	TOTAL (lines 4 thru 69)		\$ 5,700,105	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	70

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

Facility Name &amp; ID Number    Manorcare at Libertyville

#    0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

**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>		\$ 5,700,105	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	1
2	INSTALL OIL TANK	1997	11,780						2
3	FLOORING/CEILING	1998	1,115						3
4	CARPETING	1998	2,574						4
5	ARCHITECT/PROFESSIONAL FEES-ADMIN OFFICE	1998	3,685						5
6	PAINTING/WALLPAPER	1998	10,125						6
7	RENOVATE ADMIN OFFICE	1998	2,533						7
8	ENERGY AUDITS	1998	1,875						8
9	GENERAL CONTRACTOR FEES-ADMIN OFFICE	1998	4,165						9
10	CORPORATE OVERHEAD-ADMIN OFFICE	1998	1,651						10
11	C/R 5/31/99 AUDIT ADJ - MONTHLY CAP BUDGET	1998	(1,651)						11
12	INSTALL FENCE/GAZEBO	1998	2,153						12
13	PAINTING/WALLCOVERING	1998	5,821						13
14	PLUMBING	1998	5,250						14
15	ELECTRICAL	1998	8,883						15
16	DEVELOPERS-ADMIN OFFICE	1998	5,555						16
17	SIGN	1998	11,862						17
18	ROOFING	1998	5,520						18
19	MASONARY	1998	4,766						19
20	CARPENTRY	1998	3,137						20
21	PAINTING/WALLCOVERING	1999	6,873						21
22	ELECTRICAL	1999	6,590						22
23	FLOORING/CEILING	1999	8,230						23
24	CARPENTRY	1999	12,373						24
25	MILLWORK	1999	540						25
26	FINISH STUDS	1999	20,000						26
27	PAVING	1999	35,325						27
28	CARPET FOR BUILDING	1999	11,611						28
29	WINDOW TREATMENTS	1999	10,291						29
30	KNOBLOCKS, CYPHER	1999	1,448						30
31	CARPET, CREDIT	1999	(13,990)						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,890,195	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	34

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

Facility Name &amp; ID Number    Manorcare at Libertyville

#    0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

**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>		\$ 5,890,195	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	1
2	SALES TAX, CARPET	1999	71						2
3	CARPET	1999	148						3
4	DOOR FRAME FOR BOILER ROOM	1999	2,550						4
5	ELECTRICAL CIRCUITS, HEATER	1999	5,937						5
6	PTAC UNITS	1999	2,920						6
7	DOOR, HARDWARE, & STAIN	2000	1,025						7
8	ADDTL COST GARAGE	2000	1,671						8
9	SECURE CARE SYS 2ND FL STAIRWELL	2000	3,147						9
10	DOOR - SOUTH CORRIDOR EXIT	2000	2,440						10
11	PANIC DEVICE - EXTERIOR DOOR	2000	760						11
12	2 A/C UNITS	2000	1,156						12
13	GARAGE	2000	21,256						13
14	LANDSCAPING	2000	2,675						14
15	LANDSCAPING - ARBORIVITAE	2000	3,784						15
16	GARAGE	2000	19,209						16
17	GARAGE	2000	5,556						17
18	BOILER	2001	4,525						18
19	FIRE WALL IN ATTIC	2001	7,422						19
20	A/C UNIT	2001	597						20
21	4 A/C UNITS	2001	2,680						21
22	WORKCOUNTER & CABINETS	2001	2,219						22
23	GATES	2001	4,760						23
24	ELECTRICAL CIRCUITS	2001	1,279						24
25	ARCADIA CORRIDORS & LOUNGE (See Line 32)	2001	132,623						25
26	ARCADIA CORRIDORS & LOUNGE	2001	5,666						26
27	ARCADIA CORRIDORS & LOUNGE (See Line 32)	2001	124,865						27
28	ARCADIA CORRIDORS & LOUNGE	2001	20,483						28
29	ARCADIA CORRIDORS & LOUNGE	2001	181,656						29
30	CARPENTRY, DOORS, ELECT.	2001	52,344						30
31	VWC, CORNER GUARDS	2001	10,041						31
32	Per 7/06 Cap. Rate Audit Adjustments	2001	(122,832)						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,392,829	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	34

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

Facility Name &amp; ID Number    Manorcare at Libertyville

#    0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

**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 12C, Carried Forward</b>		\$ 6,392,829	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	1
2	Invoice #13216 Per 7/06 Cap Rate Audit Adj.	2002	21,952						2
3	Invoice #13233 Pre 7/16 Cap Rate Audit Adj.	2002	24,155						3
4	Per 7/06 Cap Rate Audit Adj. Move (See Lines 2 & 3)	2003	(46,107)						4
5									5
6	DINING ROOM & BREAKROOM	2003	21,720						6
7	RETROACTIVE ADDITION	2003	(588)						7
8	ARCH&ENGINEER COSTS, PLANS REVIEWS	2003	16,667						8
9	GENERAL OVERHEAD & INTEREST	2003	33,439						9
10	GENERAL OH & INT Pr 7/06 Cap Rate Audit Adj.	2003	(33,439)						10
11	CARPETING & PADS, WALLCOVERINGS	2003	74,310						11
12	CARPENTRY & MILL WORK	2003	5,750						12
13	HVAC & ELECTRICAL WORK	2003	30,572						13
14	HM DOORS & FRAMES	2003	3,662						14
15	WARDROBES	2004	11,000						15
16	FLOORING	2004	761						16
17	GENERAL OVERHEAD & INTEREST (See Line 18)	2004	32,935						17
18	Gen OH & Int Per 7/06 Cap Rate Audit Adj.	2004	(32,935)						18
19	SOWER ROOM RENOVATION	2004	3,000						19
20	Building décor/3 yrs Ta (See Line 21)	2004	21						20
21	Building décor/3 yrs Ta Per Cap Rate Audit Adj.	2004	(21)						21
22	VWC	2004	252						22
23	SECOND FLOORING	2004	13,500						23
24	FRP FIRE WALL	2004	2,941						24
25	WINDOWS	2004	18,532						25
26	PAINTING EXTERIOR	2004	13,667						26
27	SHOWER ROOM RENOVATION	2004	3,800						27
28	ADD'L FLOORING	2004	1,238						28
29	SHOWER ROOM RENOVATION RE	2004	690						29
30	VWC	2004	83						30
31	INSTALL CARPET	2004	4,364						31
32	Per 7/06 Cap Rate Audit Adj.	2004	43,112						32
33	Per 7/06 Cap Rate Audit Adj.	2004	5,300						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,667,162	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	34

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

Facility Name &amp; ID Number    Manorcare at Libertyville

#    0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

**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 12D, Carried Forward</b>		\$ 6,667,162	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	1
2	<b>INSTALL VCT FLOORING</b>	2005	3,436						2
3	<b>Renov -Lobby Finishes</b>	2005	1,680						3
4	<b>Renov -Custom Casework</b> (See Line 29)	2005	16,000						4
5	<b>Renov -Carpeting &amp; Pads &amp; Guards &amp; WC</b>	2005	26,679						5
6	<b>Renov -General Overhead &amp; Interest</b> (See Line 19)	2005	6,015						6
7	<b>Stainles Steel Flashing</b>	2005	20,000						7
8	<b>Linen&amp;Bathroom doors</b>	2005	2,482						8
9	<b>Renov -Roof Covering</b>	2005	101,050						9
10	<b>Renov -General Overhead</b> (See Line 30)	2005	4,327						10
11	<b>Renov -Interest on Construction</b> (See Line 30)	2005	546						11
12	<b>VWC</b>	2005	4,168						12
13	<b>Stainless steel flashing</b>	2005	15,440						13
14	<b>Bathroom Exhaust fans</b>	2005	4,426						14
15	<b>Carpet</b>	2005	1,648						15
16	<b>Renov -Drywall/Studs</b>	2005	1,430						16
17	<b>Renov -Resilient Flooring</b>	2005	16,153						17
18	<b>Renov -General Overhead &amp; Interest</b> (See Line 31)	2005	866						18
19	<b>Adj. out OH &amp; Int Per 7/06 Cap Rate Audit Adjs.</b>	2005	(6,015)						19
20	<b>To 2004 Per 7/06 Cap Rate Audit Adjs.</b>	2005	(28,179)						20
21	<b>Adj. out OH &amp; Int Per 7/06 Cap Rate Audit Adjs.</b>	2005	(5,670)						21
22	<b>RENOVATION/ 440 018 04C</b> (See Line 21)	2005	25,904						22
23	<b>RENOVATION/ 440 018 04C</b> (See Line 20)	2005	27,234						23
24	<b>RENOVATION/ 440 018 04C</b> (See Line 20)	2005	945						24
25	<b>FLOORING</b>	2005	1,636						25
26	<b>INSTALL DOORS</b>	2005	6,480						26
27	<b>2 LIGHT FIXTURES</b>	2005	1,650						27
28	<b>INSTALL SMOKE WALL &amp; SIDE</b>	2005	10,129						28
29	<b>Per 7/06 Cap Rate Audit Adjs.</b>	2005	(5,000)						29
30	<b>Per 7/06 Cap Rate Audit Adjs.</b>	2005	(4,873)						30
31	<b>Per 7/06 Cap Rate Audit Adjs.</b>	2005	(866)						31
32	<b>Per 7/06 Cap Rate Audit Adjs.</b>	2005	(20,234)						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,896,649	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	34

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

Facility Name & ID Number Manorcare at Libertyville

# 0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,896,649	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	1
2	KVA TRANSFORMER	2006	2,838						2
3	21 doors	2006	37,670						3
4	sheet vinyl & ceramic flo	2006	4,074						4
5	metls doors	2006	3,317						5
6	electrical	2006	827						6
7	DOORS ON KITCHEN	2007	14,124						7
8	DOORS ON 3RD & 2ND FLOOR	2007	5,940						8
9	Renov - Carpentry	2007	29,850						9
10	Renov - Doors/Frames/Drywall/Studs/Plumbing	2007	14,974						10
11	Renov - Resilient Flooring	2007	79,144						11
12	Renov - Carpeting & ads	2007	19,746						12
13	Renov - Fire Sprinkler	2007	3,752						13
14	Renov - Basic Electric	2007	21,558						14
15	Renov - Interest on Construction	2007	1,493						15
16	Renov - General Overhead	2007	20,811						16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,156,766	\$ 292,296		\$ 292,296	\$	\$ 3,923,519	34

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

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	\$ 1,636,013	\$ 140,936	\$ 140,936	\$		\$ 1,029,568	71
72	Current Year Purchases	120,414						72
73	Fully Depreciated Assets							73
74				20,557	20,557			74
75	TOTALS	\$ 1,756,427	\$ 140,936	\$ 161,493	\$ 20,557		\$ 1,029,568	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)	\$ 9,389,269	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 433,232	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 453,789	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,557	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,953,087	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Manorcare at Libertyville

# 0032904

Report Period Beginning: 6/1/2006

Ending: 5/31/2007

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<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: \$ 161,988      Description: O2 Centrators, Wheelchairs, Gerichairs, Elect. Beds., Etc.

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<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	2734 hrs	\$ 105,369	14,961	\$ 374,012	\$ 1,253	17,695	\$ 480,634	1
2	Licensed Speech and Language Development Therapist	10a	693 hrs	26,692	2,006	50,161	402	2,699	77,255	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	6080 hrs	234,341	26,174	654,355	11,394	32,254	900,090	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				637,882		637,882	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	10a	hrs		75	1,880		75	1,880	10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39,3								13
14	<b>TOTAL</b>			\$ 366,402	43,216	\$ 1,080,408	\$ 650,931	52,723	\$ 2,097,741	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 Libertyville# 0032904Report Period Beginning: 6/1/2006

Ending:

5/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 5/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 20,100	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (104,977) )	1,667,353		3
4	Supply Inventory (priced at )	49,506		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,706		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,741,665	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	476,076		13
14	Buildings, at Historical Cost	7,156,466		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,756,427		16
17	Accumulated Depreciation (book methods)	(4,953,087)		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</b> (sum of lines 11 thru 23)	\$ 4,435,882	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,177,547	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 35,136	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	314,993		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,602		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 Expenses</u>	310,867		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 767,598	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	650,995		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</b> (sum of lines 39 thru 44)	\$ 650,995	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,418,593	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 4,758,954	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,177,547	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,063,045	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,063,045	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	395,868	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)	\$ 395,868	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	(699,959)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (699,959)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,758,954	24 *

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

Facility Name & ID Number Manorcare at Libertyville# 0032904Report Period Beginning: 6/1/2006Ending: 5/31/2007**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	\$ 9,474,388	1
2	Discounts and Allowances for all Levels	(2,511,153)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,963,235	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,178,955	6
7	Oxygen	3,776	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,182,731	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	1,497	12
13	Barber and Beauty Care	24,777	13
14	Non-Patient Meals	956	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	618,123	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,577	19
20	Radiology and X-Ray	17,980	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 713,910	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	320	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 320	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Purch. Disc. Other Inc.</b>	(6)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (6)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,860,190	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,252,949	31
32	Health Care	5,232,862	32
33	General Administration	2,308,308	33
<b>B. Capital Expense</b>			
34	Ownership	742,514	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	927,689	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,464,322	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	395,868	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 395,868	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 Libertyville

# 0032904

Report Period Beginning:

6/1/2006

Ending:

5/31/2007

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,965	2,108	\$ 76,014	\$ 36.06	1
2	Assistant Director of Nursing	2,450	2,628	87,172	33.17	2
3	Registered Nurses	36,910	39,597	1,235,275	31.20	3
4	Licensed Practical Nurses	14,910	15,997	378,138	23.64	4
5	CNAs & Orderlies	92,372	99,095	1,142,835	11.53	5
6	CNA Trainees					6
7	Licensed Therapist	8,197	8,777	338,222	38.54	7
8	Rehab/Therapy Aides	1,794	1,926	28,180	14.63	8
9	Activity Director					9
10	Activity Assistants	6,603	7,088	102,536	14.47	10
11	Social Service Workers	5,541	5,944	143,973	24.22	11
12	Dietician					12
13	Food Service Supervisor	25,406	27,265	369,674	13.56	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,231	2,362	41,721	17.66	17
18	Housekeepers	13,078	14,038	143,295	10.21	18
19	Laundry	4,380	4,700	43,544	9.26	19
20	Administrator	2,335	2,080	96,535	46.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,535	18,969	338,242	17.83	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	1,920	2,060	25,371	12.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	237,627	254,634	\$ 4,590,727 *	\$ 18.03	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	21,600	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,056	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,656		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,210	\$ 162,544	5,10,3	50
51	Licensed Practical Nurses	734	17,355	5,10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,944	\$ 179,899		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 \$4,925
- (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? \$8,787
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 76,406 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. \$ 82,125  
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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ (956)
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.