

		FOR BHF USE					

LL1

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: 0020297

Facility Name: Manorcare at Rolling Meadows

Address: 4225 Kirchoff Road Rolling Meadows 6008
 Number City Zip Code

County: Cook

Telephone Number: (847) 397-2400 **Fax #** (847)397-2414

HFS ID Number: 521077856001

Date of Initial License for Current Owners: 7/1/77

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) - 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Barry Lazarus</u>	
	(Title) <u>Vice President - Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Manorcare at Rolling Meadows# 0020297 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>155</u>	Skilled (SNF)	<u>155</u>	<u>56,575</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>155</u>	TOTALS	<u>155</u>	<u>56,575</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>19,734</u>	<u>11,433</u>	<u>14,426</u>	<u>45,593</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>19,734</u>	<u>11,433</u>	<u>14,426</u>	<u>45,593</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.59%

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)

NoF. 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 7/1/77

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 155 and days of care provided 10,875Medicare 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.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	347,516	27,824	1,173	376,513	2,980	379,493		379,493		1
2	Food Purchase		249,309		249,309		249,309	(2,951)	246,358		2
3	Housekeeping	177,764	28,138	426	206,328		206,328		206,328		3
4	Laundry	33,335	13,263	20,032	66,630		66,630	(212)	66,418		4
5	Heat and Other Utilities			214,879	214,879	6,985	221,864		221,864		5
6	Maintenance	52,059	25,178	81,871	159,108		159,108		159,108		6
7	Other (specify):* Med Waste			1,200	1,200		1,200		1,200		7
8	TOTAL General Services	610,674	343,712	319,581	1,273,967	9,965	1,283,932	(3,163)	1,280,769		8
	B. Health Care and Programs										
9	Medical Director			30,800	30,800		30,800		30,800		9
10	Nursing and Medical Records	3,162,560	221,691	69,606	3,453,857	24,374	3,478,231	(17,697)	3,460,534		10
10a	Therapy	191,034	4,230	644,131	839,395		839,395		839,395		10a
11	Activities	149,351	5,371	3,135	157,857	1,852	159,709		159,709		11
12	Social Services	117,768	11	165	117,944		117,944		117,944		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,620,713	231,303	747,837	4,599,853	26,226	4,626,079	(17,697)	4,608,382		16
	C. General Administration										
17	Administrative	91,633		422,674	514,307	(83,792)	430,515		430,515		17
18	Directors Fees										18
19	Professional Services			45,237	45,237	(22,289)	22,948	(22,432)	516		19
20	Dues, Fees, Subscriptions & Promotions			85,210	85,210		85,210	(30,303)	54,907		20
21	Clerical & General Office Expenses	309,840	62,953	173,226	546,019	784	546,803	(133,141)	413,662		21
22	Employee Benefits & Payroll Taxes			794,685	794,685	51,511	846,196		846,196		22
23	Inservice Training & Education			1,409	1,409		1,409		1,409		23
24	Travel and Seminar			6,712	6,712		6,712		6,712		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			140,967	140,967		140,967		140,967		26
27	Other (specify):*										27
28	TOTAL General Administration	401,473	62,953	1,670,120	2,134,546	(53,786)	2,080,760	(185,876)	1,894,884		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,632,860	637,968	2,737,538	8,008,366	(17,595)	7,990,771	(206,736)	7,784,035		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Rolling Meadows #0020297 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
	D. Ownership										
30	Depreciation			274,621	274,621	17,595	292,216		292,216		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							(39)	(39)		32
33	Real Estate Taxes			389,448	389,448		389,448	(83,449)	305,999		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			81,834	81,834		81,834		81,834		35
36	Other (specify):*										36
37	TOTAL Ownership			745,903	745,903	17,595	763,498	(83,488)	680,010		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			409,634	409,634		409,634		409,634		39
40	Barber and Beauty Shops			15,531	15,531		15,531		15,531		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			84,863	84,863		84,863		84,863		42
43	Other (specify):* IV Drugs EKG X-Ray & Lab		41,317	41,490	82,807		82,807		82,807		43
44	TOTAL Special Cost Centers		41,317	551,518	592,835		592,835		592,835		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,632,860	679,285	4,034,959	9,347,104		9,347,104	(290,224)	9,056,880		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 Rolling Meadows

0020297

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	(2,951)	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	(212)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(39)	32		10
11	Discounts, Allowances, Rebates & Refunds	(17)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,805)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(17,697)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,550)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(22,432)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,769)	21		24
25	Fund Raising, Advertising and Promotional	(30,303)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(83,449)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (290,224)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (290,224)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Rolling Meadows

ID# 0020297

Report Period Beginning: 6/1/2006

Ending: 5/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Rolling Meadows

0020297

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,951)	0	0	0	0	0	0	0	0	0	0	(2,951)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(212)	0	0	0	0	0	0	0	0	0	0	(212)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,163)	0	0	0	0	0	0	0	0	0	0	(3,163)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(17,697)	0	0	0	0	0	0	0	0	0	0	(17,697)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(17,697)	0	0	0	0	0	0	0	0	0	0	(17,697)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(22,432)	0	0	0	0	0	0	0	0	0	0	(22,432)	19
20	Fees, Subscriptions & Promotions	(30,303)	0	0	0	0	0	0	0	0	0	0	(30,303)	20
21	Clerical & General Office Expenses	(133,141)	0	0	0	0	0	0	0	0	0	0	(133,141)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(185,876)	0	0	0	0	0	0	0	0	0	0	(185,876)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(206,736)	0	0	0	0	0	0	0	0	0	0	(206,736)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Rolling Meadows

0020297

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

	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	(39)	0	0	0	0	0	0	0	0	0	0	(39)	32
33	Real Estate Taxes	(83,449)	0	0	0	0	0	0	0	0	0	0	(83,449)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(83,488)	0	(83,488)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(290,224)	0	(290,224)	45									

Facility Name & ID Number Manorcare at Rolling Meadows

0020297

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	\$ 422,674	HCR ManorCare, Inc.	100.00%	\$ 422,674	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	21,685	Heartland Management Services - Administrative Fees	100.00%	21,685	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 444,359			\$ 444,359	\$ *

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

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 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 Rolling Meadows

0020297

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	\$	\$	8,330,460	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,156,548	625,878	8,330,460	2,980	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	500,452		8,330,460	1,600	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	2,089,736		8,330,460	5,385	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			8,330,460	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	1,831,963	1,296,078	8,330,460	4,721	6
7	17	General & Administrative - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	41,206,110	32,327,667	8,330,460	131,772	7
8	17	General & Administrative - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	80,368,229	42,462,992	8,330,460	207,109	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac	8,458,198		8,330,460	27,048	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	9,492,678		8,330,460	24,463	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs Fac			8,330,460	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs Fac	6,827,559		8,330,460	17,596	12
13										13
14		Interest				4,662,634				14
15		Non Nursing Home Allocation				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		\$ 422,674	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			
A. Directly Facility Related																				
Long-Term																				
1	N/A									1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related									9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related									14										
15	TOTALS (line 9+line14)									15										

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	462,987	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	383,646	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(79,341)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	389,448	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	4,306	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>12,523</u> For <u>2004</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(8,415)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	305,999	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	389,104	8
	2003	365,145	9
	2004	366,240	10
	2005	377,844	11
	2006	377,844	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Rolling Meadows COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020297

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>02-26-400-25-0000</u>	<u>See Attached</u>	\$ <u>188,922.02</u>	\$ <u>188,922.02</u>
2. <u>02-26-400-25-0000</u>	<u>See Attached</u>	\$ <u>188,922.02</u>	\$ <u>188,922.02</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>377,844.04</u>	\$ <u>377,844.04</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 Rolling Meadows

0020297 Report Period Beginning:

6/1/2006 Ending:

5/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,523 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1977</u>	<u>\$ 155,000</u>	1
2					2
3	TOTALS			\$ 155,000	3

Facility Name & ID Number Manorcare at Rolling Meadows# 0020297

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	155			1977	\$ 1,350,315	\$ 51,357		\$ 51,357	\$	\$ 1,333,115	4
5				1990	765,804						5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					132,566		132,566		1,841,322	9
10				1987	72,739						10
11	RETIREMENTS			1987	(44,531)						11
12				1988	33,303						12
13				1989	74,517						13
14				1990	157,389						14
15				1991	127,927						15
16				1992	107,998						16
17	RETIREMENTS			1992	(36,743)						17
18				1993	73,889						18
19				1994	71,280						19
20				1995	236,489						20
21	CR 5/31/99 AUDIT ADJ-CORPORATE O/H			1995	(791)						21
22	HVAC/DUCTWORK			1996	3,845						22
23	PLUMBING			1996	2,184						23
24	CORPORATE OVERHEAD-ARCADIA/DINING			1996	7,272						24
25	REMODEL ARCADIA/DINING/BEDROOM			1996	95,560						25
26	PROFESSIONAL FEES-ARCADIA/DINING			1996	1,737						26
27	CORNER GUARDS			1996	1,340						27
28	WOODEN DOORS			1996	11,077						28
29	WALLCOVERINGS			1996	5,279						29
30	ELECTRICAL/LIGHTING			1996	7,005						30
31	CARPETING			1996	3,300						31
32	REBUILD GENERATOR			1996	1,927						32
33	REPLACE SMOKE DETECTOR			1996	2,156						33
34	CR 5/31/99 AUDIT ADJ-CORPORATE O/H			1996	(7,272)						34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Rolling Meadows

0020297

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	
37	INSTALL HANDRAILS	1997	\$ 8,660	\$		\$	\$	\$	37
38	WALL GUARDS	1997	2,756						38
39	REPLACE CEILING TILES	1997	12,173						39
40	REMOVE & INSTALL FIRE DOORS	1997	2,012						40
41	INSTALL CLOSET DOORS	1997	10,821						41
42	WALLCOVERINGS	1997	4,812						42
43	DECORATING	1997	10,594						43
44	CARPETING	1997	2,343						44
45	FLOORING	1997	11,254						45
46	REPAIR ELEVATOR	1997	3,430						46
47	ROOFING	1997	1,679						47
48	REMODELING-ARCADIA	1997	8,663						48
49	CONNECT WATER AND GAS LINES	1997	1,705						49
50	CORPORATE OVERHEAD-ARCADIA/DINING	1997	10,515						50
51	FACILITY PLAN ALLOC,-ARCADIA/DINING	1997	5,964						51
52	REPLACE CLOSET DOORS	1997	12,000						52
53	PROFESSIONAL FEES-ARCADIA/DINING	1997	1,396						53
54	CEILING TILES	1997	10,349						54
55	INSTALL CIRCULATING PUMPS	1997	2,250						55
56	BOILER WORK	1997	5,613						56
57	WALLPAPER	1997	482						57
58	STORAGE SHED	1997	789						58
59	REMODELING	1997	(8,489)						59
60	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1997	(10,515)						60
61	C/R 5/31/99 AUDIT ADJ. - FACILITY PLAN ALLOC	1997	(5,964)						61
62	ROOF WORK	1998	53,389						62
63	DOORS/WINDOWS	1998	10,090						63
64	PLUMBING	1998	3,838						64
65	RENOVATE PT & OT ROOMS	1998	4,500						65
66	DOOR & WINDOW CASINGS	1998	4,500						66
67	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,416						67
68	INSTALL STEEL DOORS	1998	4,224						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,315,244	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	70

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

Facility Name & ID Number Manorcare at Rolling Meadows# 0020297

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 12A, Carried Forward		\$ 3,315,244	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	1
2	ELECTRICAL	1998	754						2
3	PAINTING/WALLCOVERING	1998	36,239						3
4	PLUMBING	1998	13,534						4
5	ELECTRICAL	1998	10,004						5
6	DEVELOPERS-PT & OT ROOMS	1998	11,097						6
7	FLOORING/CEILING	1998	985						7
8	HVAC	1998	37,124						8
9	DOOR/WINDOW	1998	8,160						9
10	SIGN	1998	11,862						10
11	ROOFING	1998	92,520						11
12	MASONARY	1998	1,499						12
13	CARPENTRY	1998	1,475						13
14	FINISH STUDS	1998	26,279						14
15	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,601						15
16	CONCRETE SIDEWALK	1998	1,482						16
17	FLOORING/CEILING	1999	1,340						17
18	CARPENTRY	1999	19,278						18
19	FINISH STUDS	1999	25,000						19
20	PAINTING/WALLCOVERING	1999	750						20
21	WINDOW TREATMENTS	1999	525						21
22	ROOF WORK	1999	6,098						22
23	C/R 5/31/03 AUDIT ADJ #1-ROOF WORK	1999	(6,098)						23
24	ROOFING CONTRACT	1999	876						24
25	C/R 5/31/03 AUDIT ADJ #2-ROOFING CONTRACT	1999	(876)						25
26	DRAIN/FLASH SCUPPERS/OVERFLOW	1999	1,782						26
27	ROOFING CONTRACT	1999	6,098						27
28	C/R 5/31/03 AUDIT ADJ #3-ROOFING CONTRACT	1999	(6,098)						28
29	BUILDING IMPROVEMENTS-NURSES STATIONS	1999	4,554						29
30	BUILDING IMPROVEMENTS-NURSES STATIONS	1999	22,150						30
31	INSTALL CLOSETS	1999	2,895						31
32	25 EXIT SIGNS FOR BU	1999	4,810						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,655,943	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	34

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

Facility Name & ID Number Manorcare at Rolling Meadows# 0020297

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 12B, Carried Forward		\$ 3,655,943	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	1
2	VINYL WALLCOVERING	1999	336						2
3	WALLCOVERING	1999	226						3
4	RENOVATE NURSING STATIONS	1999	11,478						4
5	WALLCOVERING	1999	2,245						5
6	DAMPER MOTOR	1999	2,693						6
7	CHART RACK	2000	1,450						7
8	ELECTRICAL FOR A/C UNITS	2000	1,214						8
9	WALLCOVERING	2000	294						9
10	ELECTRICAL FOR A/C UNITS	2000	1,151						10
11	WORK STATIONS BOOKKEEPING & PAYROLL	2000	5,975						11
12	WORK STATIONS	2000	728						12
13	EXTERIOR LIGHTING	2000	19,956						13
14	CEILING TILE, PAINTING, CARPET	2000	900						14
15	FENCING	2000	17,820						15
16	FENCING	2000	1,980						16
17	CONCRETE, MASONRY, CARPENTRY	2000	49,335						17
18	CARPET	2000	35,925						18
19	C/R 5/31/03 AUDIT ADJ #4-CARPET	2000	(14,231)						19
20	WALLCOVERING	2000	52,636						20
21	C/R 5/31/03 AUDIT ADJ #5-WALLCOVERING	2000	(466)						21
22	ELECTRICAL	2000	34,947						22
23	C/R 5/31/03 AUDIT ADJ #6-ELECTRICAL	2000	(9,885)						23
24	INTEREST - CONST & GENERAL O/H ARCADIA	2000	74,862						24
25	C/R 5/31/03 AUDIT ADJ #15-CONST & GEN O/H	2000	(74,862)						25
26	ARCADIA RENOVATION	2000	12,075						26
27	C/R 5/31/03 AUDIT ADJ #10-ARCADIA RENOV	2000	(12,075)						27
28	ARCADIA RENO - DRAPES	2001	2,843						28
29	C/R 5/31/03 AUDIT ADJ #11-ARCADIA DRAPES	2001	(184)						29
30	ARCADIA RENO - CARPENTRY	2001	6,748						30
31	C/R 5/31/03 AUDIT ADJ #12-CARPENTRY	2001	(2,200)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,879,857	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	34

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

Facility Name & ID Number Manorcare at Rolling Meadows

0020297

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 12C, Carried Forward		\$ 3,879,857	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	1
2	ARCAIDA RENO - CONTRACTOR	2001	50,636						2
3	C/R 5/31/03 AUDIT ADJ #13-CONTRACTOR	2001	(25,985)						3
4	ARCADIA RENO - ELECTRICAL	2001	3,560						4
5	BORDER	2001	170						5
6	KITCHEN WALLS AND FLOOR	2002	2,566						6
7	KITCHEN WALLS AND FLOOR	2002	14,796						7
8	DOORS	2002	6,445						8
9	DOORS	2002	1,868						9
10	DOORS	2002	7,740						10
11	PAINTING	2002	204						11
12	CEILING TILE	2002	517						12
13	DUCT WORK AND DAMPERS	2002	8,301						13
14	DOORS AND DRYWALL	2002	9,694						14
15	GENERAL CONSTRUCTION	2002	4,640						15
16	OVERHEAD AND INTEREST	2002	15,405						16
17	CARPENTRY	2002	85,703						17
18	C/R 5/31/03 AUDIT ADJ #7-CARPENTRY	2002	(650)						18
19	VINYL WALL COVERING	2002	10,495						19
20	C/R 5/31/03 AUDIT ADJ #8-VINYL WALL COVERING	2002	(979)						20
21	HVAC, ELECTRIC	2002	12,530						21
22	C/R 5/31/03 AUDIT ADJ #9-RECLASS HVAC, ELECTRIC	2002	(4,808)						22
23	PARKING LOT UPGRADE	2002	17,482						23
24	PARKING LOT UPGRADE	2003	1,943						24
25	METAL DOOR	2003	1,968						25
26	WALLCOVERINGS	2003	563						26
27	CARPET	2003	335						27
28	FLOORING & CARPENTRY	2003	100,275						28
29	CARPENTRY	2003	27,714						29
30	DOORS AND FRAMES	2003	24,849						30
31	SPRINKLER SYSTEM	2003	9,660						31
32	DOORS	2004	4,464						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,271,957	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	34

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

Facility Name & ID Number Manorcare at Rolling Meadows

0020297

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 12D, Carried Forward		\$ 4,271,957	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	1
2	HERITAGE WING ROOF	2004	10,976						2
3	HERITAGE WING	2004	10,976						3
4	VWC	2004	291						4
5	VWC	2004	203						5
6	CARPET	2004	659						6
7	FREIGHT ON CARPET	2004	37						7
8	CARPET & BASE	2004	674						8
9	FREIGHT ON CARPET	2004	109						9
10	CARPET	2004	5,250						10
11	COVE BASE	2004	3,545						11
12	INSTALL CARPET	2004	4,222						12
13	INSTALL CARPET	2004	(4,222)						13
14	VWC	2005	697						14
15	PHONE LINES	2005	1,700						15
16	CABINETS	2005	6,000						16
17	MED ROOM RENOVATION	2005	2,850						17
18	door	2005	1,107						18
19	CEILING TILE	2006	10,305						19
20	vwc	2006	9,776						20
21	Renov - Doors/Frames/Drywall/ Stud/Plumbing	2006	32,276						21
22	Renov - Wall covering	2006	3,128						22
23	Renov - Interest & Gen Overhead	2006	6,615						23
24	2 Elevator door operators	2006	4,400						24
25	flooring and painting in	2006	19,120						25
26	Renov - Basic Electrical	2006	28,016						26
27	Renov - Arch & Engineering	2006	197,182						27
28	Renov - Interest & Gen Overhead	2006	62,439						28
29	ceiling & painting in lau	2006	3,245						29
30	INSTALL GENERATOR- Basic Electrical	2007	24,160						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,717,692	\$ 183,923		\$ 183,923	\$	\$ 3,174,437	34

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

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 6/1/2006 Ending: 5/31/2007

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	\$ 1,403,726	\$ 90,698	\$ 90,698	\$		\$ 1,067,162	71
72	Current Year Purchases	131,072						72
73	Fully Depreciated Assets							73
74				17,595	17,595			74
75	TOTALS	\$ 1,534,798	\$ 90,698	\$ 108,293	\$ 17,595		\$ 1,067,162	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)	\$ 6,407,490	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 274,621	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 292,216	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,595	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,241,599	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:	<u>N/A</u>			\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /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: \$ 81,834 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			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	976 hrs	\$ 32,259	9,622	\$ 240,561	\$ 1,072	10,598	\$ 273,892	1
2	Licensed Speech and Language Development Therapist	10a	355 hrs	11,718	2,353	58,826		2,708	70,544	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4449 hrs	147,057	13,790	344,744	3,158	18,239	494,959	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 prescripts				409,634		409,634	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39,3								13
14	TOTAL			\$ 191,034	25,765	\$ 644,131	\$ 413,864	31,545	\$ 1,249,029	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 Rolling Meadows# 0020297Report 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 49,545	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (249,925))	1,283,392		3
4	Supply Inventory (priced at)	53,247		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,969		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,389,153	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	155,000		13
14	Buildings, at Historical Cost	4,717,162		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,535,328		16
17	Accumulated Depreciation (book methods)	(4,241,599)		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):	72,740		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,238,631	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,627,784	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 40,452	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	431,697		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	389,448		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	274,275		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,135,872	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	67,711		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 67,711	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,203,583	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,424,201	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,627,784	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,491,934	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,491,934	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	596,581	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)	\$ 596,581	17
	B. Transfers (Itemize):		
18		(664,314)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (664,314)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,424,201	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Rolling Meadows# 0020297Report 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,076,649	1
2	Discounts and Allowances for all Levels	(1,602,037)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,474,612	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,943,884	6
7	Oxygen	30,250	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,974,134	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,025	12
13	Barber and Beauty Care	17,882	13
14	Non-Patient Meals	1,926	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	454,451	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,785	19
20	Radiology and X-Ray	3,630	20
21	Other Medical Services		21
22	Laundry	212	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 496,911	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc., Purch Disc, & Rev. Sus. & Late Chgs.	(1,972)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,972)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,943,685	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,273,967	31
32	Health Care	4,599,853	32
33	General Administration	2,134,546	33
B. Capital Expense			
34	Ownership	745,903	34
C. Ancillary Expense			
35	Special Cost Centers	592,835	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,347,104	40
41	Income before Income Taxes (line 30 minus line 40)**	596,581	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 596,581	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 Rolling Meadows

0020297

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
2	Assistant Director of Nursing	3,858	4,198	133,882	31.89	2
3	Registered Nurses	34,995	38,072	1,135,179	29.82	3
4	Licensed Practical Nurses	18,278	19,885	508,499	25.57	4
5	CNAs & Orderlies	93,296	101,654	1,341,569	13.20	5
6	CNA Trainees					6
7	Licensed Therapist	4,744	5,165	170,739	33.06	7
8	Rehab/Therapy Aides	1,151	1,253	20,295	16.20	8
9	Activity Director					9
10	Activity Assistants	11,251	12,202	149,351	12.24	10
11	Social Service Workers	6,040	6,606	117,768	17.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,550	28,950	347,516	12.00	15
16	Dishwashers					16
17	Maintenance Workers	3,229	3,551	52,059	14.66	17
18	Housekeepers	16,965	18,464	177,764	9.63	18
19	Laundry	3,559	3,869	33,335	8.62	19
20	Administrator	2,080	2,307	91,633	39.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,029	13,551	251,492	18.56	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	8,108	8,420	101,779	12.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	246,133	268,147	\$ 4,632,860 *	\$ 17.28	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	30,800	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,440	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)		\$ 38,240		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	473	\$ 14,097	5,10,3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	473	\$ 14,097		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 \$10,437
- (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? \$10,183
- (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. \$ 60,824 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. \$ 84,863
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (1,926)
- (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.