



Facility Name & ID Number Manorcare at Elgin

# 0027466 Report Period Beginning: 6-01-07 Ending: 5-31-08

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>88</u>	Skilled (SNF)	<u>88</u>	<u>32,208</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>88</u>	TOTALS	<u>88</u>	<u>32,208</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>14,446</u>	<u>3,603</u>	<u>8,454</u>	<u>26,503</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>14,446</u>	<u>3,603</u>	<u>8,454</u>	<u>26,503</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.29%

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/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/81 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 88 and days of care provided 5,944

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12-31-08 Fiscal Year: 05-31-08

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

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 6-01-07 Ending: 5-31-08

**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	235,852	12,103	1,450	249,405	2,023	251,428		251,428		1
2	Food Purchase		160,316		160,316		160,316	(442)	159,874		2
3	Housekeeping	109,456	17,172	5,347	131,975		131,975		131,975		3
4	Laundry	24,740	12,961	2,770	40,471		40,471		40,471		4
5	Heat and Other Utilities			158,254	158,254	4,640	162,894	(2,722)	160,172		5
6	Maintenance	45,217	19,510	64,116	128,843		128,843		128,843		6
7	Other (specify):*			636	636		636		636		7
8	<b>TOTAL General Services</b>	415,265	222,062	232,573	869,900	6,663	876,563	(3,164)	873,399		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	2,006,182	167,499	38,507	2,212,188	3,750	2,215,938	(21,884)	2,194,054		10
10a	Therapy	339,515	7,777	307,637	654,929		654,929		654,929		10a
11	Activities	55,278	3,039	995	59,312		59,312		59,312		11
12	Social Services	108,390		602	108,992		108,992		108,992		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,509,365	178,315	362,741	3,050,421	3,750	3,054,171	(21,884)	3,032,287		16
	<b>C. General Administration</b>										
17	Administrative	88,537		371,830	460,367	(100,990)	359,377		359,377		17
18	Directors Fees										18
19	Professional Services			11,053	11,053		11,053	(11,053)			19
20	Dues, Fees, Subscriptions & Promotions			56,865	56,865		56,865	(25,764)	31,101		20
21	Clerical & General Office Expenses	224,880	32,117	385,809	642,806		642,806	(232,814)	409,992		21
22	Employee Benefits & Payroll Taxes			589,111	589,111	47,430	636,541		636,541		22
23	Inservice Training & Education			10,208	10,208		10,208		10,208		23
24	Travel and Seminar			2,245	2,245		2,245		2,245		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			118,563	118,563		118,563		118,563		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	313,417	32,117	1,545,684	1,891,218	(53,560)	1,837,658	(269,631)	1,568,027		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,238,047	432,494	2,140,998	5,811,539	(43,147)	5,768,392	(294,679)	5,473,713		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 Elgin #0027466 Report Period Beginning: 6-01-07 Ending: 5-31-08

## 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			270,248	270,248	14,291	284,539		284,539			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					28,856	28,856		28,856			32
33	Real Estate Taxes			34,490	34,490		34,490	140	34,630			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,302	27,302		27,302		27,302			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			332,040	332,040	43,147	375,187	140	375,327			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			6,645	6,645		6,645		6,645			38
39	Ancillary Service Centers			249,803	249,803		249,803		249,803			39
40	Barber and Beauty Shops			5,828	5,828		5,828		5,828			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*			49,115	79,430	30,315	79,430		79,430			43
44	<b>TOTAL Special Cost Centers</b>		298,918	90,968	389,886		389,886		389,886			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,238,047	731,412	2,564,006	6,533,465		6,533,465	(294,539)	6,238,926			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 Elgin

# 0027466

Report Period Beginning: 6-01-07

Ending: 5-31-08

**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	(442)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,722)	5		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	(40)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(20,819)	10		16
17	Non-Care Related Fees	83	21		17
18	Fines and Penalties	(26)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,053)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(232,831)	21		24
25	Fund Raising, Advertising and Promotional	(20,220)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	140	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,609)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (294,539)		\$	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>	\$ (294,539)		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.

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

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Elgin

ID# 0027466  
 Report Period Beginning: 6-01-07  
 Ending: 5-31-08

Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Purchase Svc - Phys Care	\$ (1,065)	10	1
2	AR Sub Fee	(5,544)	20	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>	(6,609)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

## 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	(442)	0	0	0	0	0	0	0	0	0	0	(442)	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	(2,722)	0	0	0	0	0	0	0	0	0	0	(2,722)	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>(3,164)</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>(3,164)</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	(21,884)	0	0	0	0	0	0	0	0	0	0	(21,884)	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	<b>TOTAL Health Care and Programs</b>	<b>(21,884)</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>(21,884)</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	(11,053)	0	0	0	0	0	0	0	0	0	0	(11,053)	19
20	Fees, Subscriptions & Promotions	(25,764)	0	0	0	0	0	0	0	0	0	0	(25,764)	20
21	Clerical & General Office Expenses	(232,814)	0	0	0	0	0	0	0	0	0	0	(232,814)	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>(269,631)</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>(269,631)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(294,679)</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>(294,679)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin

# 0027466 Report Period Beginning:

6-01-07 Ending:

Summary B

5-31-08

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	140	0	0	0	0	0	0	0	0	0	0	140	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>140</b>	<b>0</b>	<b>140</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>(294,539)</b>	<b>0</b>	<b>(294,539)</b>	<b>45</b>									

Facility Name & ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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, OH			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	See Home Office Allocation	\$ 371,829	HCR Manorcare, Inc.	100.00%	\$ 371,829	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	25,530	Heartland Management Services	100.00%	25,530	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 397,359			\$ 397,359	\$ *

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

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 6-01-07 Ending: 5-31-08

## 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 Elgin

# 0027466 Report Period Beginning: 6-01-07

Ending: 5-31-08

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, OH 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	2,813,673,080		\$ 59,848	\$ 6,018,336	\$ 128	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314		1,061,370	577,717	6,018,336	1,895	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080		497,772	6,018,336	1,065	3	
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314		2,002,556	6,018,336	3,575	4	
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080			6,018,336	0	5	
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314		2,100,636	1,287,391	6,018,336	3,750	6
7	17	General & Admin - Direct	Accumulated Cost	2,813,673,080		41,222,846	32,327,667	6,018,336	88,174	7
8	17	General & Admin - Pooled	Accumulated Cost	3,371,307,314		102,324,370	42,519,840	6,018,336	182,666	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080		7,830,100	6,018,336	16,748	9	
10	22	Employee Benefits - Pooled	Accumulated Cost	3,371,307,314		17,187,062	6,018,336	30,682	10	
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080			6,018,336	0	11	
12	30	Depreciation - Pooled	Accumulated Cost	3,371,307,314		8,005,430	6,018,336	14,291	12	
13									13	
14	32	Interest						28,856	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 182,291,990	\$ 76,712,615	\$ 371,830	25	

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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			\$ 935,949	\$ 935,949		4.9100	\$ 28,856	1				
2												2				
3												3				
4												4				
5	Interest											5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 935,949	\$ 935,949			\$ 28,856	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>						\$ 935,949	\$ 935,949			\$ 28,856	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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 31,311	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.)		\$ 33,078	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,767	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 32,307	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ 555	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 34,630	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	54,266	8
	2004	42,326	9
	2005	34,285	10
	2006	33,849	11
	2007	32,307	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Manorcare at Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0027466

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 2007 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 2007.

(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>06-14-476-028</u>	<u>See Attached</u>	\$ <u>16,153.72</u>	\$ <u>16,153.72</u>
2. <u>06-14-476-028</u>	<u>See Attached</u>	\$ <u>16,153.72</u>	\$ <u>16,153.72</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>32,307.44</u>	\$ <u>32,307.44</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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 Elgin

# 0027466 Report Period Beginning:

6-01-07 Ending:

5-31-08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,117 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant 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).

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1967</u>	<u>\$ 107,499</u>	1
2			<u>2003</u>	<u>21,361</u>	2
3	<b>TOTALS</b>			<b>\$ 128,860</b>	3

**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	73		1967	1965	\$ 562,637	\$ 53,076		\$ 53,076		\$ 903,579	4
5	7			1991	325,282						5
6	8			2003	686,404						6
7											7
8											8
<b>Improvement Type**</b>											
9	<b>Current Year Depreciation</b>					131,554		131,554		1,736,095	9
10				1987	11,654						10
11				1988	164,890						11
12				1989	26,729						12
13				1990	64,209						13
14				1991	99,431						14
15				1992	69,948						15
16				1993	62,901						16
17				1994	59,739						17
18				1995	141,422						18
19				1996	111,267						19
20				1997	103,146						20
21				1998	338,111						21
22				1999	37,350						22
23				2000	98,791						23
24				2001	70,110						24
25				2002	75,611						25
26		WINDOW TREATMENTS		2003	2,265						26
27		COVE BASE		2003	3,086						27
28		RISER PIPE REPLACEMENT		2003	94,382						28
29		15 DOORS for resident rooma (1 of 3 pymts.)		2003	10,500						29
30		PAINTING, BORDER, VCT FLO		2003	1,010						30
31		VWC		2003	771						31
32		VWC		2003	545						32
33		VWC		2003	152						33
34		PAINTING AND BORDER		2003	463						34
35		PAINTING AND BORDER		2003	5,887						35
36				2003	399						36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	15 DOORS for resident rooma (2 of 3 pymts.)	2003	\$ 7,790	\$		\$	\$	\$	37
38	LAUNDRY ROOM DOORS	2003	4,266						38
39	NEW ADDITION - Updated for audit	2003	127,111						39
40	NEW ADDITION - Carpet & wallcovering	2003	9,623						40
41	NEW ADDITION - Millwork	2003	2,359						41
42	VWC, FLOORING, PAINTING	2003	15,124						42
43	VINYL CEILING & PAINTING	2003	6,274						43
44	ADJUST ASSETS 1583 & 1598 CARPET - per audit S/B 2002	2003							44
45	PAINTING AND BORDER	2003	5,887						45
46	15 DOORS for resident rooma (3 of 3 pymts.)	2003	2,312						46
47	TRIM HANDLE (COURTYARD DOOR)	2003	428						47
48	DOORS	2003	2,650						48
49	NEW ADDITION - Soil & concrete testing	2003	5,445						49
50	NEW ADDITION - Site preparation Per audit include w/Bldg.	2003							50
51	OUTSIDE LIGHT	2003	1,782						51
52	EXTERIOR DOORS (1 of 3 pymts)	2003	3,000						52
53	EXTERIOR DOORS (2 of 3 pymts)	2004	2,000						53
54	EXTERIOR DOORS (3 of 3 pymts)	2004	680						54
55	DOORS AND KICKPLATES	2004	30,571						55
56	WALLCOVERING	2004	869						56
57	FLUORESCENT LIGHT FIXTURES	2005	21,157						57
58	DOORS AND KICKPLATES	2005	1,190						58
59	ARCH & ENGINEERING COST	2005	5,718						59
60	O/H & INTEREST Nonallowable per audit	2005							60
61	FLOORING 465 003-05C	2005	2,540						61
62	WALL COVERING 465 003-05C	2005	1,106						62
63	CARPENTRY WORK 465 003-05C	2005	10,452						63
64	WINDOWS 465 003-05C	2005	36,400						64
65	GENERATOR EMERGENCY LIGHT	2005	1,964						65
66	RESURFACE ASPHALT PARKING LOT	2005	23,537						66
67	CONSTRUCT STONE WALL & GRADE AREAS	2006	1,110						67
68	DOORS (2) HOLLOW METAL	2006	5,272						68
69	VINYL FLOORING	2006	3,845						69
70	TOTAL (lines 4 thru 69)		\$ 3,571,554	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	70

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

Facility Name & ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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>		\$ 3,571,554	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	1
2	Overhead & Interest on Renov.	2006	3,122						2
3	Renov. - Concrete Work - Landings, Ramps, & Handrail	2006	24,850						3
4	Renov. - Doors & Frames	2006	35,440						4
5	Renov. - Electrical Work	2006	1,347						5
6	Door at 1st floor Stairwell	2006	1,400						6
7	Flooring	2006	5,090						7
8	Door and Frame	2006	4,235						8
9	Panic hardware on new doors per Life Saftey Survey	2007	3,220						9
10	FENCE	2007	5,600						10
11	PAVING	2007	3,240						11
12	DRAINAGE IN PARKING LOT	2007	39,440						12
13	CARPET	2007	4,315						13
14	SECOND FLOOR DINING RM DO	2007	5,654						14
15	carpet	2007	1,659						15
16	FLOORING ON FIRST FLOOR	2007	7,830						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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	34

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

Facility Name & ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

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	\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674		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
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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)	\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674		34

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

Facility Name & ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

**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	\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	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
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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)	\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	34	

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

Facility Name & ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	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
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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)	\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	34

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

Facility Name & ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

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	\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674		34

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

Facility Name & ID Number Manorcare at Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

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 12F, Carried Forward		\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,717,996	\$ 184,630		\$ 184,630	\$	\$ 2,639,674	34

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

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 6-01-07 Ending: 5-31-08

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	\$ 1,209,534	\$	\$	\$		\$	71
72	Current Year Purchases	92,046	85,619	85,619			864,219	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			14,291	14,291			74
75	TOTALS	\$ 1,301,580	\$ 85,619	\$ 99,910	\$ 14,291		\$ 864,219	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)	\$ 5,148,436	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 270,249	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 284,540	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,291	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,503,893	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	<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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 27,302 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	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.

Facility Name & ID Number Manorcare at Elgin# 0027466 Report Period Beginning:6-01-07 Ending:5-31-08

## 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	2952 hrs	\$ 129,520	4,873	\$ 121,825	\$ 1,473	7,825	\$ 252,818	1
2	Licensed Speech and Language Development Therapist	10a	1143 hrs	36,154	896	22,391	218	2,039	58,763	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4168 hrs	173,841	6,537	163,421	6,086	10,705	343,348	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	5,39,2	# of prescrpts				249,803		249,803	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>P/S X-Ray &amp; Lab</u>	5,43,3				30,315			30,315	13
14	TOTAL			\$ 339,515	12,306	\$ 337,952	\$ 257,580	20,569	\$ 935,047	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 Elgin# 0027466Report Period Beginning: 6-01-07Ending: 5-31-08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 5-31-08

(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	\$ (3,131)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (391,752) )	1,065,643		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,690		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,065,202	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	128,860		13
14	Buildings, at Historical Cost	3,717,995		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,301,580		16
17	Accumulated Depreciation (book methods)	(3,503,893)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,644,542	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,709,744	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 46,727	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	227,678		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,307		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36		92,722		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 399,434	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	2,079		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,079	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 401,513	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,308,231	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,709,744	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,409,924	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,409,924	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(762,552)	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)	\$ (762,552)	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	660,859	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 660,859	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,308,231	24 *

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

Facility Name & ID Number Manorcare at Elgin# 0027466Report Period Beginning: 6-01-07Ending: 5-31-08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,756,040	1
2	Discounts and Allowances for all Levels	(1,337,775)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,418,265	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,026,138	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,026,138	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	354	12
13	Barber and Beauty Care	5,615	13
14	Non-Patient Meals	88	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	302,055	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,569	19
20	Radiology and X-Ray		20
21	Other Medical Services	(211)	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 326,470	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28		40	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 40	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,770,913	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	869,900	31
32	Health Care	3,050,421	32
33	General Administration	1,891,218	33
<b>B. Capital Expense</b>			
34	Ownership	332,040	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	389,886	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>	\$ 6,533,465	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(762,552)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (762,552)	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 Elgin

# 0027466

Report Period Beginning:

6-01-07

Ending:

5-31-08

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,031	2,205	\$ 78,774	\$ 35.73	1
2	Assistant Director of Nursing	2,814	3,056	94,806	31.02	2
3	Registered Nurses	21,768	23,640	709,592	30.02	3
4	Licensed Practical Nurses	13,256	14,396	348,662	24.22	4
5	CNAs & Orderlies	56,042	60,918	810,731	13.31	5
6	CNA Trainees					6
7	Licensed Therapist	3,038	3,328	223,618	67.19	7
8	Rehab/Therapy Aides	6,519	7,141	73,419	10.28	8
9	Activity Director					9
10	Activity Assistants	5,730	6,238	55,278	8.86	10
11	Social Service Workers	4,004	4,359	108,390	24.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,227	20,931	235,852	11.27	15
16	Dishwashers					16
17	Maintenance Workers	2,042	2,222	45,217	20.35	17
18	Housekeepers	9,266	10,088	109,456	10.85	18
19	Laundry	2,509	2,730	24,740	9.06	19
20	Administrator	2,080	2,080	88,537	42.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,950	14,503	224,880	15.51	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	360	393	6,095	15.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,636	178,228	\$ 3,238,047 *	\$ 18.17	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	15,000	5,9,3	36
37	Medical Records Consultant	Monthly	1,080	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	3,971	5,10,3	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) <u>PS Phys</u>	Monthly	1,065	5,10,3	46
47	<u>Medical Services</u>	Monthly	6,729	5,10,3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,845		49

**C. CONTRACT NURSES**

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





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA \$1963.30
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes \$5519.70 If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 46,135 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. \$ 48,180  
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. \$ 88
- (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.