

Facility Name & ID Number Manorcare at Skokie# 0040014 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>56</u>	Skilled (SNF)	<u>56</u>	<u>20,496</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>56</u>	TOTALS	<u>56</u>	<u>20,496</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>3,745</u>	<u>1,631</u>	<u>5,761</u>	<u>11,137</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>3,745</u>	<u>1,631</u>	<u>5,761</u>	<u>11,137</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.34%

D. How many bed-hold days during this year were paid by the Department?

N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/AF. Does the facility maintain a daily midnight census? 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 11/1/94

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

YES Date 11/1/94 NO

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

YES NO If YES, enter number of beds certified 56 and days of care provided 4,559Medicare Intermediary Highmark Medicare Servies

IV. ACCOUNTING BASIS

ACCRAUAL 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.

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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	198,286	12,496	359	211,141	1,298	212,439		212,439		1
2	Food Purchase		66,103		66,103		66,103	(659)	65,444		2
3	Housekeeping	65,270	6,548	1,050	72,868		72,868		72,868		3
4	Laundry	56,929	5,995		62,924		62,924		62,924		4
5	Heat and Other Utilities			105,584	105,584	2,979	108,563	(543)	108,020		5
6	Maintenance	40,519	8,480	100,345	149,344		149,344	(54,397)	94,947		6
7	Other (specify):*			1,213	1,213		1,213		1,213		7
8	TOTAL General Services	361,004	99,622	208,551	669,177	4,277	673,454	(55,599)	617,855		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	952,872	103,126	26,487	1,082,485	2,408	1,084,893	(2,470)	1,082,423		10
10a	Therapy	375,294	3,277	84,346	462,917		462,917		462,917		10a
11	Activities	24,387	1,647	1,380	27,414		27,414		27,414		11
12	Social Services	97,445		2,318	99,763		99,763		99,763		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,449,998	108,050	132,531	1,690,579	2,408	1,692,987	(2,470)	1,690,517		16
	C. General Administration										
17	Administrative	83,060		220,201	303,261	(46,312)	256,949		256,949		17
18	Directors Fees										18
19	Professional Services			3,647	3,647		3,647	(3,647)			19
20	Dues, Fees, Subscriptions & Promotions			47,974	47,974		47,974	(21,031)	26,943		20
21	Clerical & General Office Expenses	214,419	26,724	401,830	642,973		642,973	(84,704)	558,269		21
22	Employee Benefits & Payroll Taxes			385,247	385,247	30,452	415,699		415,699		22
23	Inservice Training & Education			1,001	1,001		1,001		1,001		23
24	Travel and Seminar			4,884	4,884		4,884		4,884		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			72,082	72,082		72,082		72,082		26
27	Other (specify):*										27
28	TOTAL General Administration	297,479	26,724	1,136,866	1,461,069	(15,860)	1,445,209	(109,382)	1,335,827		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,108,481	234,396	1,477,948	3,820,825	(9,175)	3,811,650	(167,451)	3,644,199		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 Skokie #0040014 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
	D. Ownership										
30	Depreciation			107,882	107,882	9,175	117,057	117,057			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(1,384)	(1,384)		(1,384)	(1,384)			32
33	Real Estate Taxes			116,893	116,893		116,893	10,242	127,135		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			67,500	67,500		67,500	67,500			35
36	Other (specify):*										36
37	TOTAL Ownership			290,891	290,891	9,175	300,066	10,242	310,308		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		186,568		186,568		186,568	186,568			39
40	Barber and Beauty Shops			4,030	4,030		4,030	4,030			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			30,660	30,660		30,660	30,660			42
43	Other (specify):*		27,407	48,239	75,646		75,646	75,646			43
44	TOTAL Special Cost Centers		213,975	82,929	296,904		296,904	296,904			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,108,481	448,371	1,851,768	4,408,620		4,408,620	(157,209)	4,251,411		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 Skokie

0040014

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	(659)	2		4
5	Telephone, TV & Radio in Resident Rooms	(543)	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				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)	(2,470)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(862)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,647)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(83,842)	21		24
25	Fund Raising, Advertising and Promotional	(19,341)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	10,242	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(56,087)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (157,209)		\$	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))	\$ (157,209)		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.		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						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 Skokie

ID# 0040014

Report Period Beginning: 6-01-07

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	FMV Limit - Impaired asset	\$ (54,397)	6	1
2	AR Sub Fee	(1,690)	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	Total	(56,087)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Skokie

0040014

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(659)	0	0	0	0	0	0	0	0	0	0	(659)	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	(543)	0	0	0	0	0	0	0	0	0	0	(543)	5
6	Maintenance	(54,397)	0	0	0	0	0	0	0	0	0	0	(54,397)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(55,599)	0	0	0	0	0	0	0	0	0	0	(55,599)	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	(2,470)	0	0	0	0	0	0	0	0	0	0	(2,470)	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	(2,470)	0	0	0	0	0	0	0	0	0	0	(2,470)	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	(3,647)	0	0	0	0	0	0	0	0	0	0	(3,647)	19
20	Fees, Subscriptions & Promotions	(21,031)	0	0	0	0	0	0	0	0	0	0	(21,031)	20
21	Clerical & General Office Expenses	(84,704)	0	0	0	0	0	0	0	0	0	0	(84,704)	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	(109,382)	0	0	0	0	0	0	0	0	0	0	(109,382)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(167,451)	0	0	0	0	0	0	0	0	0	0	(167,451)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Skokie

0040014

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	10,242	0	0	0	0	0	0	0	0	0	0	10,242	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	10,242	0	10,242	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)	(157,209)	0	(157,209)	45									

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	\$ 220,201	HCR Manorcare, Inc.	100.00%	\$ 220,201	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	20,713	Heartland Management Services	100.00%	20,713	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 240,914			\$ 240,914	\$ *

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

Facility Name & ID Number

Manorcare at Skokie

#

0040014

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.

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0040014

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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	357 Nurs. Fac.	\$ 59,848	\$ 3,863,990	\$ 82	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	357 Nurs. Fac.	1,061,370	577,717	3,863,990	1,216	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	357 Nurs. Fac.	497,772	3,863,990	684	3	
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	357 Nurs. Fac.	2,002,556	3,863,990	2,295	4	
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	357 Nurs. Fac.		3,863,990	0	5	
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	357 Nurs. Fac.	2,100,636	1,287,391	3,863,990	2,408	6
7	17	General & Admin - Direct	Accumulated Cost	2,813,673,080	357 Nurs. Fac.	41,222,846	32,327,667	3,863,990	56,611	7
8	17	General & Admin - Pooled	Accumulated Cost	3,371,307,314	357 Nurs. Fac.	102,324,370	42,519,840	3,863,990	117,278	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	357 Nurs. Fac.	7,830,100	3,863,990	10,753	9	
10	22	Employee Benefits - Pooled	Accumulated Cost	3,371,307,314	357 Nurs. Fac.	17,187,062	3,863,990	19,699	10	
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	357 Nurs. Fac.		3,863,990	0	11	
12	30	Depreciation - Pooled	Accumulated Cost	3,371,307,314	357 Nurs. Fac.	8,005,430	3,863,990	9,175	12	
13									13	
14	32	Interest							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	\$ 220,201	25	

Facility Name & ID Number

Manorcare at Skokie

0040014

Report Period Beginning:

6-01-07

Ending:

5-31-08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	N/A						\$	\$			\$						
2																	
3																	
4																	
5	Interest																
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$						

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 2007 report.		\$	<u>112,845</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>123,087</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>10,242</u>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>106,161</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	<u>10,732</u>	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 \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>127,135</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<u>114,116</u>	8	
	2004	<u>109,027</u>	9	
	2005	<u>112,845</u>	10	
	2006	<u>112,845</u>	11	
	2007	<u>106,161</u>	12	
				FOR BHF USE ONLY
	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 Skokie COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040014

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>10-10-103-029-0000</u>	<u>See Attached</u>	\$ <u>186.59</u>	\$ <u>186.59</u>
2. <u>10-10-103-024-0000</u>	<u>See Attached</u>	\$ <u>59,650.01</u>	\$ <u>59,650.01</u>
3. <u>10-10-103-029-0000</u>	<u>See Attached</u>	\$ <u>206.98</u>	\$ <u>206.98</u>
4. <u>10-10-103-024-0000</u>	<u>See Attached</u>	\$ <u>46,117.10</u>	\$ <u>46,117.10</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>106,160.68</u>	\$ <u>106,160.68</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 Skokie

0040014 Report Period Beginning:

6-01-07 Ending:

5-31-08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,033 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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

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

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

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

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

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>1994</u>	<u>\$ 300,000</u>	1
2					2
3	TOTALS			\$ 300,000	3

Facility Name & ID Number Manorcare at Skokie

0040014

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 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	56			1994	\$ 1,940,000	\$ 48,500		\$ 48,500		\$ 689,507	4
5											5
6											6
7											7
8											8
Improvement Type**											
9						51,021		51,021		887,737	9
10	Doors/Windows			1995	1,331,819						10
11	Electrical			1996	7,023						11
12	Professional Services			1996	4,374						12
13	Medical Gas System			1996	8,622						13
14	Replace Water Pump Unit			1996	3,449						14
15	Doors/Hardware			1996	3,634						15
16	Carpeting			1996	4,847						16
17	Medical Gas System			1996	2,342						17
18	Professional Fees			1996	19,419						18
19	Wallcovering			1996	6,529						19
20	Plumbing			1996	25,335						20
21	Remodel OT			1996	60,000						21
22	Remodel Washrooms			1996	1,464						22
23	Electrical			1996	20,681						23
24	HVAC/Ductwork			1996	7,291						24
25	Wall Repairs			1996	4,891						25
26	Doors			1996	1,692						26
27	Landscaping			1996	1,812						27
28	Phone System			1997	1,762						28
29	Wallcoverings			1997	2,458						29
30	HVAC			1997	1,502						30
31	Carpeting			1997	21,340						31
32	Install CATV Jacks			1997	5,314						32
33	Remodel Offices			1997	5,548						33
34	HVAC			1997	22,516						34
35				1997	8,508						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 Skokie

0040014

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	
37		\$	\$		\$	\$	\$	37
38	Repair Walls	1997	1,328					38
39	Install New Siding	1997	20,000					39
40	Install Shower Tile	1997	15,817					40
41	Install Ball Valve	1997	1,955					41
42	Kitchen Plumbing	1997	7,446					42
43	Remodeling Tub/Shower	1997	9,300					43
44	Nurse Call Service	1997	1,795					44
45	Lighting	1997	13,266					45
46	Flooring	1997	6,671					46
47	New Siding/Soffit	1997	14,600					47
48	Office Remodeling	1998	6,000					48
49	Toilet Access	1998	1,612					49
50	Soors/Windows	1998	14,763					50
51	Electrical	1998	4,289					51
52	Carpeting	1998	3,457					52
53	Roofing	1998	1,915					53
54	HVAC	1998	11,786					54
55	Painting/Wallcoverings	1998	5,240					55
56	Painting/Wallcovering	1998	2,266					56
57	Developers	1998	5,555					57
58	HVAC	1998	797					58
59	Sign	1998	11,862					59
60	Comm. Edison	1998	2,842					60
61	Painting/Wallcovering	1999	62					61
62	Paving	1998	18,870					62
63	General construction	1999	6,241					63
64	Vinyl Wall Border	1999	191					64
65	Suite Signs	1999	942					65
66	Wallcoverings	1999	3,101					66
67	Wall Borders	1999	1,339					67
68	Vinyl Wallcoverings	1999	512					68
69		1999	117					69
70	TOTAL (lines 4 thru 69)		\$ 3,720,109	\$ 99,521		\$ 99,521	\$ 1,577,244	70

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

Facility Name & ID Number Manorcare at Skokie

0040014

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 12A, Carried Forward		\$ 3,720,109	\$ 99,521		\$ 99,521	\$	\$ 1,577,244	1
2	Relaminate Nurse Station	1999	7,015						2
3	Carpet	1999	14,458						3
4	Mag Door Holders	1999	756						4
5	Carpeting	1999	557						5
6	Handrail	2000	5,480						6
7	Border	2000	650						7
8	Molding & Painting	2000	3,958						8
9	Freight Wallcovering	2000	117						9
10	Heating	2000	7,015						10
11	Heritage Corridors	2000	7,618						11
12	Door Frame Protection	2000	741						12
13	Door Hardware	2000	49						13
14	Solarium	2000	3,260						14
15	Vinal Wall Covering, Corner Guards, & Painting	2000	5,772						15
16	Carpet	2000	752						16
17	Freight Carpet	2000	68						17
18	Plumbing Public Restrooms	2000	989						18
19	Plumbing remaining balance	2000	989						19
20	Door Work/Heating	2000	832						20
21	Painting - Exterior Bldg	2000	3,690						21
22	Doors	2000	6,121						22
23	Exterior Renovation	2000	15,230						23
24	Concrete	2000	2,570						24
25	Carpeting & Sheet Vinyl	2000	28,655						25
26	Carpet - O/T Room	2000	3,239						26
27	Curbing	2002	3,760						27
28	Boulders	2002	1,000						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,845,451	\$ 99,521		\$ 99,521	\$	\$ 1,577,244	34

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

Facility Name & ID Number Manorcare at Skokie

0040014

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		\$ 3,845,451	\$ 99,521		\$ 99,521	\$	\$ 1,577,244	1
2	Int. On Constr & Gen. O/H	2006	1,822						2
3	HM Doors & Frames	2006	45,700						3
4	Fire Sprinkler Syster.	2006	17,458						4
5	Engineering	2006	2,450						5
6	Install Doors & Frames	2006	16,122						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
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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)		\$ 3,929,003	\$ 99,521		\$ 99,521	\$	\$ 1,577,244	34

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

Facility Name & ID Number Manorcare at Skokie

0040014

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	\$ 3,929,003	\$ 99,521		\$ 99,521	\$	\$ 1,577,244		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)	\$ 3,929,003	\$ 99,521		\$ 99,521	\$	\$ 1,577,244		34

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

Facility Name & ID Number Manorcare at Skokie # 0040014 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	\$ 1,363,543	\$ 8,361	\$ 8,361	\$		\$ 1,301,401	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74				9,175	9,175			74
75	TOTALS	\$ 1,363,543	\$ 8,361	\$ 17,536	\$ 9,175		\$ 1,301,401	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)	\$ 5,592,546	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,882	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,057	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,175	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,878,645	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Manorcare at Skokie

0040014

Report Period Beginning:

6-01-07

Ending: 5-31-08

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.	_____ /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: \$ 67,500 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	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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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.

Facility Name & ID Number Manorcare at Skokie# 0040014 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	5079 hrs	\$ 185,893	848	\$ 21,201	\$ 45	5,927	\$ 207,139	1
2	Licensed Speech and Language Development Therapist	10a	794 hrs	35,725	109	2,736	242	903	38,703	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4058 hrs	153,676	2,416	60,409	2,990	6,474	217,075	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				186,568		186,568	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 & Lab</u>	5,43,3				48,239			48,239	13
14	TOTAL			\$ 375,294	3,373	\$ 132,585	\$ 189,845	13,304	\$ 697,724	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 Skokie# 0040014Report Period Beginning: 6-01-07

Ending:

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (51,685)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (271,588))	748,090		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,712		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 698,117	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	300,000		13
14	Buildings, at Historical Cost	3,929,002		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,363,543		16
17	Accumulated Depreciation (book methods)	(2,878,644)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,713,901	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,412,018	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 15,314	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	164,333		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,161		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	60,822		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 346,630	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 346,630	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,065,388	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,412,018	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,272,091	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,272,091	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,030,148)	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)	\$ (1,030,148)	17
	B. Transfers (Itemize):		
18	Changes in Intercompany	823,445	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 823,445	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,065,388	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Skokie# 0040014Report 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,201,951	1
2	Discounts and Allowances for all Levels	(106,690)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,095,261	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,054,022	6
7	Oxygen	11,256	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,065,278	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	659	12
13	Barber and Beauty Care	4,449	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	75	16
17	Sale of Drugs	212,821	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 218,004	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	Purchase Discounts	(71)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (71)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,378,472	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	669,177	31
32	Health Care	1,690,579	32
33	General Administration	1,461,069	33
B. Capital Expense			
34	Ownership	290,891	34
C. Ancillary Expense			
35	Special Cost Centers	296,904	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)*	\$ 4,408,620	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,030,148)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,030,148)	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 Skokie

0040014

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	1,913	2,044	\$ 77,456	\$ 37.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,060	17,156	471,582	27.49	3
4	Licensed Practical Nurses	4,141	4,423	98,815	22.34	4
5	CNAs & Orderlies	28,044	29,959	356,721	11.91	5
6	CNA Trainees					6
7	Licensed Therapist	6,267	6,931	270,798	39.07	7
8	Rehab/Therapy Aides	1,146	1,267	28,871	22.79	8
9	Activity Director					9
10	Activity Assistants	1,669	1,791	24,387	13.62	10
11	Social Service Workers	3,617	3,888	97,445	25.06	11
12	Dietician	14,236	15,119	198,286	13.12	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,868	2,017	40,519	20.09	17
18	Housekeepers	4,605	4,977	65,270	13.11	18
19	Laundry	4,612	4,962	56,929	11.47	19
20	Administrator	2,080	2,080	83,060	39.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,730	13,974	214,419	15.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,805	1,941	23,923	12.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,793	112,529	\$ 2,108,481 *	\$ 18.74	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 18,000	5,9,3	36
37	Medical Records Consultant	Monthly 4,428	5,10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Month 2,482	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	Medical Services	Monthly 121	5,10,3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 25,031		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 \$1249.37
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes \$3366.63 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. \$ 19,487 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. \$ 30,660
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? N/A Indicate the amount. \$ 0
- (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.