

Facility Name & ID Number Manorcare of Elk Grove Village

0049387 Report Period Beginning: 06/01/08 Ending: 05/31/09

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	190	Skilled (SNF)	190	69,350	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	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	18,968	10,564	34,489	64,021	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,968	10,564	34,489	64,021	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.32%

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)
None

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 07/30/90

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 190 and days of care provided 28,746

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 Fiscal Year: 05/31

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

Facility Name & ID Number Manorcare of Elk Grove Village # 0049387 Report Period Beginning: 06/01/08 Ending: 05/31/09

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	540,277	34,497	32,878	607,652	5,652	613,304		613,304		1
2	Food Purchase		377,877		377,877		377,877	(2,039)	375,838		2
3	Housekeeping	262,321	37,864	1,067	301,252		301,252		301,252		3
4	Laundry	81,624	31,534	3,678	116,836		116,836	(4,113)	112,723		4
5	Heat and Other Utilities			328,659	328,659	10,715	339,374		339,374		5
6	Maintenance	88,865	34,745	144,457	268,067		268,067		268,067		6
7	Other (specify):* Medical Waste			2,862	2,862		2,862		2,862		7
8	TOTAL General Services	973,087	516,517	513,601	2,003,205	16,367	2,019,572	(6,152)	2,013,420		8
	B. Health Care and Programs										
9	Medical Director			25,000	25,000		25,000		25,000		9
10	Nursing and Medical Records	5,525,422	505,989	314,931	6,346,342	9,062	6,355,404		6,355,404		10
10a	Therapy	1,604,831	50,903	782,694	2,438,428		2,438,428		2,438,428		10a
11	Activities	176,263	10,707	4,426	191,396		191,396	(150)	191,246		11
12	Social Services	272,614		4,773	277,387		277,387		277,387		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,579,130	567,599	1,131,824	9,278,553	9,062	9,287,615	(150)	9,287,465		16
	C. General Administration										
17	Administrative	186,881		806,029	992,910	(161,886)	831,024		831,024		17
18	Directors Fees										18
19	Professional Services			11,442	11,442	(848)	10,594	(10,594)			19
20	Dues, Fees, Subscriptions & Promotions			118,204	118,204		118,204	(43,268)	74,936		20
21	Clerical & General Office Expenses	558,079	82,777	608,264	1,249,120	848	1,249,968	(490,748)	759,220		21
22	Employee Benefits & Payroll Taxes			1,481,416	1,481,416	95,007	1,576,423		1,576,423		22
23	Inservice Training & Education			1,498	1,498		1,498		1,498		23
24	Travel and Seminar			20,880	20,880		20,880		20,880		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			294,916	294,916		294,916		294,916		26
27	Other (specify):*										27
28	TOTAL General Administration	744,960	82,777	3,342,649	4,170,386	(66,879)	4,103,507	(544,610)	3,558,897		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,297,177	1,166,893	4,988,074	15,452,144	(41,450)	15,410,694	(550,912)	14,859,782		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 of Elk Grove Village

#0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			518,741	518,741	29,249	547,990		547,990			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(743)	(743)	12,201	11,458		11,458			32
33	Real Estate Taxes			359,284	359,284		359,284		359,284			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			146,789	146,789		146,789		146,789			35
36	Other (specify):*											36
37	TOTAL Ownership			1,024,071	1,024,071	41,450	1,065,521		1,065,521			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,084,629		1,084,629		1,084,629		1,084,629			39
40	Barber and Beauty Shops			27,584	27,584		27,584		27,584			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,310	104,310		104,310		104,310			42
43	Other (specify):* IV X-Ray & Lab		234,850	199,158	434,008		434,008		434,008			43
44	TOTAL Special Cost Centers		1,319,479	331,052	1,650,531		1,650,531		1,650,531			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,297,177	2,486,372	6,343,197	18,126,746		18,126,746	(550,912)	17,575,834			45

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

Manorcare of Elk Grove Village

ID# 0049387

Report Period Beginning: 06/01/08

Ending: 05/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (680)	21	1
2	Misc. Income	(111)	21	2
3	Activity Income	(150)	11	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	(941)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Elk Grove Village# 0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,039)	0	0	0	0	0	0	0	0	0	0	(2,039)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,113)	0	0	0	0	0	0	0	0	0	0	(4,113)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,152)	0	(6,152)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(150)	0	0	0	0	0	0	0	0	0	0	(150)	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	(150)	0	(150)	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	(10,594)	0	0	0	0	0	0	0	0	0	0	(10,594)	19
20	Fees, Subscriptions & Promotions	(43,268)	0	0	0	0	0	0	0	0	0	0	(43,268)	20
21	Clerical & General Office Expenses	(490,748)	0	0	0	0	0	0	0	0	0	0	(490,748)	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	(544,610)	0	(544,610)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(550,912)	0	(550,912)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Elk Grove Village# 0049387

Report Period Beginning:

06/01/08 Ending:05/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(550,912)	0	0	0	0	0	0	0	0	0	0	(550,912)	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
HCR Manor Care, Inc.	100	Health Care & Retirement Corporation of America (see H.O. Cost Report)				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	\$ 802,140	HCR Manor Care, Inc.	100.00%	\$ 802,140	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	81,936	Heartland Rehab Services, LLC	100.00%	81,936		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 884,076			\$ 884,076	\$ *	14

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

Facility Name & ID Number Manorcare of Elk Grove Village # 0049387 Report Period Beginning: 06/01/08 Ending: 05/31/09

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 of Elk Grove Village

0049387

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

Name of Related Organization HCR Manor Care, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604-2617
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

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	2,759,273,494	369 Nurs. Fac.	\$ 1,686	\$ 16,705,252	\$ 10	1	
2	1	Dietary - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,103,816	559,529	16,705,252	5,642	2
3	5	Utilities - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	287,502		16,705,252	1,741	3
4	5	Utilities - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,755,769		16,705,252	8,974	4
5	10	Nursing - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.			16,705,252	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,773,058	1,106,606	16,705,252	9,062	6
7	17	General & Admin - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	30,646,209		16,705,252	185,539	7
8	17	General & Admin - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	88,964,011	51,489,483	16,705,252	454,715	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	6,188,752		16,705,252	37,468	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	11,257,416		16,705,252	57,539	10
11	30	Depreciation - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.			16,705,252	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	5,722,441		16,705,252	29,249	12
13										13
14	32	Interest				10,928,075			12,201	14
15		Non-Nursing Home Allocations				28,224,463				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 186,853,198	\$ 53,155,618	\$	802,140	25

Facility Name & ID Number

Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Conv. Sub Debentures		X	Facility				\$ 241,832	\$ 241,832		5.0452	\$ 12,201	1							
2													2							
3													3							
4													4							
5													5							
Working Capital																				
6													6							
7													7							
8	Interest Income Other											(743)	8							
9	TOTAL Facility Related						\$ 241,832	\$ 241,832				\$ 11,458	9							
B. Non-Facility Related*																				
10													10							
11													11							
12													12							
13													13							
14	TOTAL Non-Facility Related						\$	\$				\$	14							
15	TOTALS (line 9+line14)						\$ 241,832	\$ 241,832				\$ 11,458	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.)

Facility Name & ID Number Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,632 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1990</u>	<u>\$ 853,628</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 853,628	3

Facility Name & ID Number Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120			1990	\$ 5,025,494	\$ 188,398		\$ 188,398		\$ 3,059,334	4
5	60			1996	1,726,800						5
6	10			2000	1,063,936						6
7	5/31/03 Audit Adjustment			2000	(277,211)						7
8											8
	Improvement Type**										
9	Current Year Depreciation					112,460		112,460		1,524,421	9
10				1990	12,954						10
11				1991	41,034						11
12				1992	89,111						12
13				1993	29,775						13
14				1994	18,939						14
15				1995	182,383						15
16				1996	485,188						16
17				1997	111,890						17
18				1998	127,587						18
19				1999	60,314						19
20				2000	68,449						20
21				2001	5,850						21
22				2002	53,586						22
23		HOLLOW METAL DOOR		2003	975						23
24		ARCH & ENGINEERING COSTS		2003	975						24
25		BORDER		2003	162						25
26		VWC		2003	1,710						26
27		VWC		2003	219						27
28		ARCHITECTURAL ENGINEERING		2003	258						28
29		VWC		2003	427						29
30		NEW BATHROOM FLOORING & TILE		2003	22,640						30
31		ARCHITECT & ENGINEERING		2003	258						31
32		FLOORING		2003	4,599						32
33		VWC, BORDER, AND PAINTING		2003	3,317						33
34		ADDITIONAL COST FOR FLOORING		2003	2,820						34
35		ARCHITECT AND ENGINEERING COSTS		2003	2,064						35
36		WINDOW TREATMENT		2003	3,629						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 of Elk Grove Village

0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

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	BORDER	2003	\$ 54	\$		\$	\$	\$	37
38	ARCHITECT AND ENGINEERING COSTS	2003	455						38
39	ELECTRICAL WORK	2003	5,182						39
40	VCT FLOORING	2003	7,005						40
41	BASE AND FLOOR TILE	2003	4,118						41
42	CARPET	2004	609						42
43	INSTALL CARPET	2004	550						43
44	PAVING	2003	67,500						44
45	CONCRETE WALK	2003	3,822						45
46	PAVING	2004	7,500						46
47	Renov. - General Construction Overhead & Interest	2004	19,622						47
48	Renov. - Carpeting	2004	595						48
49	Renov. - Painting	2004	14,000						49
50	Renov. - Wallcovering & Corner Guards	2004	37,811						50
51	Renov. - Carpentry	2004	8,201						51
52	Renov. - Plumbing	2004	2,880						52
53	Renov. - Electrical	2004	2,931						53
54	Carpet	2004	1,324						54
55	Ceramic Cove Base	2004	3,360						55
56	Renov. - Wood Doors & Hardware for Lobby	2004	8,597						56
57	Renov. - Electrical	2004	2,484						57
58	Electric Door Strike at Service Door	2004	1,509						58
59	CARPETING & DELIVERY OF CARPETTING	2005	2,435						59
60	REBUILD SHOWER STALLS (5)	2006	14,000						60
61	VWC, BASE, & CEILING TILES IN BREAK ROOM	2006	2,470						61
62									62
63	Ceramic Tile - Wall/Floor	2006	3,300						63
64	Wallcovering	2006	3,605						64
65	Plumbing Work on Sprinkler System	2006	4,727						65
66	Architecture/Engineering for Parking Lot	2007	9,285						66
67	Drywall Work	2007	8,378						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,118,441	\$ 300,858		\$ 300,858	\$	\$ 4,583,755	70

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

Facility Name & ID Number Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

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		\$ 9,118,441	\$ 300,858		\$ 300,858	\$	\$ 4,583,755	1
2	DOOR HOLDER & CLOSER	2007	1,556						2
3	DOOR HOLDER & CLOSER	2007	1,869						3
4	Renov. - Carpeting & Pad	2007	1,742						4
5	Renov. - Wallcovering	2007	84,542						5
6	Renov. - Carpentry - Subtractor	2007	38,200						6
7	Renov. - Basic Electrical	2007	7,626						7
8	Renov. - HM Doors & Frames	2007	10,505						8
9	Renov. - Generator, Permit	2007	3,096						9
10	Renov. - Basic Electrical	2007	9,357						10
11	Renov. - Generator, Engineering	2007	13,539						11
12	Renov. - Parking Lot Expansion & Landscaping	2007	83,045						12
13	BLACKTOP PATCHING	2007	12,078						13
14									14
15	Roofing	2008	7,221						15
16	Roofing - additional	2008	802						16
17	Generator - Installation & Materials	2008	36,317						17
18	Generator - Equipment	2008	10,814						18
19	Generator - Installation & Materials	2008	62,613						19
20	Renov. - CORRIDOR DOORS (35)	2008	50,575						20
21	CO2 Detectors & Control Panel	2008	11,781						21
22	Generator - Equipment	2008	63,883						22
23	Storm Drain Enhancements	2008	4,100						23
24	Sealcoating & Restriping	2008	13,362						24
25	Renov. - Internet Café Construction	2009	88,371						25
26	Double Egress Kitchen Doors	2009	6,076						26
27	Renov. - Carpentry	2009	76,000						27
28	Renov. - Millwork (Hand Rails)	2009	14,910						28
29	Renov. - Electrical (Light Fixtures)	2009	5,990						29
30	Renov. - Carpet	2009	6,195						30
31	Renov. - Wallcovering, Corner Guards	2009	8,076						31
32	Generator - Installation & Materials	2009	11,108						32
33	Renov. - Carpentry	2009	45,000						33
34	TOTAL (lines 1 thru 33)		\$ 9,908,790	\$ 300,858		\$ 300,858	\$	\$ 4,583,755	34

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

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		\$ 9,908,790	\$ 300,858		\$ 300,858	\$	\$ 4,583,755	1
2	2009	16,827						2
3	2009	9,331						3
4	2009	9,237						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		\$ 9,944,185	\$ 300,858		\$ 300,858	\$	\$ 4,583,755	34

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

Facility Name & ID Number Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

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	\$ 2,729,445	\$ 217,883	\$ 217,883	\$		\$ 2,086,343	71
72	Current Year Purchases	250,855						72
73	Fully Depreciated Assets							73
74				29,249	29,249			74
75	TOTALS	\$ 2,980,300	\$ 217,883	\$ 247,132	\$ 29,249		\$ 2,086,343	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)	\$ 13,778,113	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 518,741	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 547,990	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,249	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,670,098	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	Various	\$ 383,648	92
93			93
94			94
95		\$ 383,648	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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: \$ 146,789 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	5547	hrs	\$ 226,696	7,923	\$ 461,140	\$ 1,409	13,470	\$ 689,245	1
2	Licensed Speech and Language Development Therapist	10a	2713	hrs	110,917	540	31,419	83	3,253	142,419	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	15911	hrs	650,258	2,888	168,071	49,411	18,799	867,740	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescripts				1,084,629		1,084,629	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>	43, 2						234,850		234,850	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					199,158			199,158	13
14	TOTAL				\$ 987,871	11,351	\$ 859,788	\$ 1,370,382	35,522	\$ 3,218,041	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 of Elk Grove Village# 0049387Report Period Beginning: 06/01/08Ending: 05/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 317,257	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>750,998</u>)	2,747,895		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,812		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,070,964	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	853,628		13
14	Buildings, at Historical Cost	9,944,185		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,980,300		16
17	Accumulated Depreciation (book methods)	(6,670,098)		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): <u>CIP</u>	383,648		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,491,663	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,562,627	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 344,413	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	729,938		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	366,835		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payable</u>	259,864		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,701,050	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	136,662		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 136,662	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,837,712	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,724,915	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,562,627	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,654,756	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,654,756	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,542,766	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)	\$ 3,542,766	17
	B. Transfers (Itemize):		
18		(2,472,607)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,472,607)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,724,915	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Elk Grove Village

0049387

Report Period Beginning: 06/01/08

Ending: 05/31/09

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	\$ 18,461,824	1
2	Discounts and Allowances for all Levels	(3,932,497)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,529,327	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,782,793	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,782,793	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	680	12
13	Barber and Beauty Care	35,033	13
14	Non-Patient Meals	2,039	14
15	Telephone, Television and Radio	18	15
16	Rental of Facility Space	(1,992)	16
17	Sale of Drugs	1,179,344	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	115,675	19
20	Radiology and X-Ray	4,349	20
21	Other Medical Services	18,011	21
22	Laundry	4,113	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,357,270	23
D. Non-Operating Revenue			
24	Contributions	11	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discounts	111	28
28a	Late Charges		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 111	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,669,512	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,003,205	31
32	Health Care	9,278,553	32
33	General Administration	4,170,386	33
B. Capital Expense			
34	Ownership	1,024,071	34
C. Ancillary Expense			
35	Special Cost Centers	1,546,221	35
36	Provider Participation Fee	104,310	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,126,746	40
41	Income before Income Taxes (line 30 minus line 40)**	3,542,766	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,542,766	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 of Elk Grove Village**

0049387

Report Period Beginning:

06/01/08

Ending:

05/31/09

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	1,607	1,727	\$ 72,647	\$ 42.07	1
2	Assistant Director of Nursing	6,079	6,532	232,665	35.62	2
3	Registered Nurses	80,065	86,041	2,880,616	33.48	3
4	Licensed Practical Nurses	16,096	17,297	446,035	25.79	4
5	CNAs & Orderlies	133,382	143,662	1,842,816	12.83	5
6	CNA Trainees					6
7	Licensed Therapist	24,171	25,870	1,057,305	40.87	7
8	Rehab/Therapy Aides	22,980	24,595	547,526	22.26	8
9	Activity Director	12,166	13,085	176,263	13.47	9
10	Activity Assistants					10
11	Social Service Workers	10,758	11,566	272,614	23.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,754	40,642	540,277	13.29	15
16	Dishwashers					16
17	Maintenance Workers	3,851	4,134	88,865	21.50	17
18	Housekeepers	20,129	21,647	262,321	12.12	18
19	Laundry	7,217	7,761	81,624	10.52	19
20	Administrator	2,080	2,080	128,922	61.98	20
21	Assistant Administrator	1,410	1,410	57,959	41.11	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,560	29,996	558,079	18.61	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	2,942	3,162	50,643	16.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	410,247	441,207	\$ 9,297,177 *	\$ 21.07	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	25,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,677	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,677		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,605	\$ 96,949	10, 3	50
51	Licensed Practical Nurses	283	12,846	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,888	\$ 109,795		53

Facility Name & ID Number Manorcare of Elk Grove Village# 0049387Report Period Beginning: 06/01/08Ending: 05/31/09**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 \$13958
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$8668
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 139,975 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. \$ 104,310
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. \$ 2,039
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.