

Facility Name & ID Number Manorcare of Elgin

0049692 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	88	Skilled (SNF)	88	32,120	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	88	TOTALS	88	32,120	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	18,378	1,336	7,562	27,276	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,378	1,336	7,562	27,276	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.92%

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 11/01/81

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 88 and days of care provided 4,939

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name & ID Number Manorcare of Elgin # 0049692 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	270,039	19,727	1,630	291,396	6,167	297,563		297,563		1
2	Food Purchase		194,427		194,427		194,427	(74)	194,353		2
3	Housekeeping	124,295	14,773	83	139,151		139,151		139,151		3
4	Laundry	37,972	15,754	985	54,711		54,711		54,711		4
5	Heat and Other Utilities			142,708	142,708	1,716	144,424		144,424		5
6	Maintenance	45,249	16,999	136,221	198,469		198,469		198,469		6
7	Other (specify):*			321	321		321		321		7
8	TOTAL General Services	477,555	261,680	281,948	1,021,183	7,883	1,029,066	(74)	1,028,992		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	2,066,234	193,487	28,761	2,288,482	2,265	2,290,747		2,290,747		10
10a	Therapy	493,091	2,543	104,391	600,025		600,025		600,025		10a
11	Activities	64,621	3,428	3,264	71,313		71,313		71,313		11
12	Social Services	92,570		871	93,441		93,441		93,441		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,716,516	199,458	151,687	3,067,661	2,265	3,069,926		3,069,926		16
	C. General Administration										
17	Administrative	88,658		316,782	405,440	(98,872)	306,568		306,568		17
18	Directors Fees										18
19	Professional Services			7,353	7,353		7,353	(7,353)			19
20	Dues, Fees, Subscriptions & Promotions			44,206	44,206		44,206	(29,585)	14,621		20
21	Clerical & General Office Expenses	263,642	33,952	42,639	340,233		340,233	18,582	358,815		21
22	Employee Benefits & Payroll Taxes			593,695	593,695	51,202	644,897		644,897		22
23	Inservice Training & Education			2,465	2,465		2,465		2,465		23
24	Travel and Seminar			2,935	2,935		2,935		2,935		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			206,294	206,294		206,294		206,294		26
27	Other (specify):*										27
28	TOTAL General Administration	352,300	33,952	1,216,369	1,602,621	(47,670)	1,554,951	(18,356)	1,536,595		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,546,371	495,090	1,650,004	5,691,465	(37,522)	5,653,943	(18,430)	5,635,513		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 Elgin

#0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			230,191	230,191	13,690	243,881		243,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(5,573)	(5,573)	23,832	18,259		18,259			32
33	Real Estate Taxes			32,674	32,674		32,674		32,674			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			51,953	51,953		51,953		51,953			35
36	Other (specify):*											36
37	TOTAL Ownership			309,245	309,245	37,522	346,767		346,767			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			222,989	222,989		222,989		222,989			39
40	Barber and Beauty Shops			5,632	5,632		5,632		5,632			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*		71,131	42,391	113,522		113,522		113,522			43
44	TOTAL Special Cost Centers		71,131	319,192	390,323		390,323		390,323			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,546,371	566,221	2,278,441	6,391,033		6,391,033	(18,430)	6,372,603			45

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

Manorcare of Elgin

ID# 0049692

Report Period Beginning: 06/01/09

Ending: 05/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	None	\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Elgin# 0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	(74)	0	0	0	0	0	0	0	0	0	0	(74)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(74)	0	0	0	0	0	0	0	0	0	0	(74)	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	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(7,353)	0	0	0	0	0	0	0	0	0	0	(7,353)	19
20	Fees, Subscriptions & Promotions	(29,585)	0	0	0	0	0	0	0	0	0	0	(29,585)	20
21	Clerical & General Office Expenses	18,582	0	0	0	0	0	0	0	0	0	0	18,582	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	(18,356)	0	0	0	0	0	0	0	0	0	0	(18,356)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(18,430)	0	0	0	0	0	0	0	0	0	0	(18,430)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Elgin# 0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

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)	(18,430)	0	0	0	0	0	0	0	0	0	0	(18,430)	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)	Toledo			

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	\$ 316,782	HCR Manor Care, Inc.	100.00%	\$ 316,782	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	18,134	Heartland Rehab Services, LLC	100.00%	18,134		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 334,916			\$ 334,916	\$ *	14

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

Facility Name & ID Number Manorcare of Elgin # 0049692 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 Elgin

0049692

Report Period Beginning:

06/01/09

Ending: 05/31/10

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	2,857,768,524	359 NFs	\$ 2,826,629	\$ 1,585,087	6,235,112	\$ 6,167	1
2	5	Utilities Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	911,333		6,235,112	1,716	2
3	10	Nursing - Direct	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	6,235,112	1,380	3
4	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	469,810		6,235,112	885	4
5	17	General & Admin - Direct	Accumulated Cost	2,857,768,524	359 NFs	35,518,981		6,235,112	77,496	5
6	17	General & Admin Direct Cen	Accumulated Cost	691,284,298	95NFs	1,045,204		6,235,112	9,427	6
7	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	69,554,530	79,745,671	6,235,112	130,986	7
8	22	Employee Benefits - Direct	Accumulated Cost	2,857,768,524	359 NFs	6,239,311		6,235,112	13,613	8
9	22	Employee Benefits - Direct Cen	Accumulated Cost	691,284,298	95 NFs	2,434,366		6,235,112	21,957	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,908	732 NFs, HHs, & Re	8,300,418		6,235,112	15,632	10
11	30	Depreciation - Direct	Accumulated Cost	2,857,768,524	359 NFs	102,714		6,235,112	224	11
12	30	Depreciation - Direct Cen	Accumulated Cost	691,284,298	95 NFs	43,612		6,235,112	393	12
13	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	6,941,685		6,235,112	13,074	13
14										14
15	32	Interest				21,122,019			23,832	15
16		Non-Nursing Home Allocation				25,797,439				16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 316,782	25

Facility Name & ID Number

Manorcare of Elgin

0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

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				\$ 935,949	\$ 935,949		0.0258	\$ 23,832	1							
2													2							
3													3							
4													4							
5													5							
Working Capital																				
6													6							
7													7							
8	Interest Income Other											(5,573)	8							
9	TOTAL Facility Related						\$ 935,949	\$ 935,949				\$ 18,259	9							
B. Non-Facility Related*																				
10													10							
11													11							
12													12							
13													13							
14	TOTAL Non-Facility Related						\$	\$				\$	14							
15	TOTALS (line 9+line14)						\$ 935,949	\$ 935,949				\$ 18,259	15							

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report.		\$	32,691	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	33,646	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	955	3	
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	31,719	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.)		\$		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.		\$	32,674	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<u>34,285</u>	8		
	2006	<u>33,849</u>	9		
	2007	<u>32,307</u>	10		
	2008	<u>32,691</u>	11		
	2009	<u>34,602</u>	12		
Line 2: 33646.76 = 16,345.69 2nd 1/2 2008 paid 9/09 + 1st half 2009 17,301.07 paid 5/10					
Line 4: 31,783.63 = 17,301.07 2nd 1/2 2009 + 14,417.56 estimate for Jan-May 2010					
				FOR BHF USE ONLY	
				13	13
				14	14
				15	15
				16	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.

Facility Name & ID Number Manorcare of Elgin

0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,117 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Manorcare of Elgin

0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	73		1967	1965	\$ 562,637	\$ 51,130		\$ 51,130		\$ 1,005,839	4
5	7			1991	325,282						5
6	8			2003	686,404						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					85,157		85,157		1,917,316	9
10				1987	11,654						10
11				1988	164,890						11
12				1989	26,729						12
13				1990	64,209						13
14				1991	99,431						14
15				1992	69,948						15
16				1993	62,901						16
17				1994	59,739						17
18				1995	141,422						18
19				1996	111,267						19
20				1997	103,146						20
21				1998	338,111						21
22				1999	37,350						22
23				2000	98,791						23
24				2001	70,110						24
25				2002	75,611						25
26		WINDOW TREATMENTS		2003	2,265						26
27		COVE BASE		2003	3,086						27
28		RISER PIPE REPLACEMENT		2003	94,382						28
29		15 DOORS for resident rooma (1 of 3 pymts.)		2003	10,500						29
30		PAINTING, BORDER, VCT FLO		2003	1,010						30
31		VWC		2003	771						31
32		VWC		2003	545						32
33		VWC		2003	152						33
34		PAINTING AND BORDER		2003	463						34
35		PAINTING AND BORDER		2003	5,887						35
36				2003	399						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Elgin

0049692

Report Period Beginning:

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Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	15 DOORS for resident rooma (2 of 3 pymts.)	2003	\$ 7,790	\$		\$	\$	\$	37
38	LAUNDRY ROOM DOORS	2003	4,266						38
39	NEW ADDITION - Updated for audit	2003	127,111						39
40	NEW ADDITION - Carpet & wallcovering	2003	9,623						40
41	NEW ADDITION - Millwork	2003	2,359						41
42	VWC, FLOORING, PAINTING	2003	15,124						42
43	VINYL CEILING & PAINTING	2003	6,274						43
44	ADJUST ASSETS 1583 & 1598 CARPET - per audit S/B 2002	2003							44
45	PAINTING AND BORDER	2003	5,887						45
46	15 DOORS for resident rooma (3 of 3 pymts.)	2003	2,312						46
47	TRIM HANDLE (COURTYARD DOOR)	2003	428						47
48	DOORS	2003	2,650						48
49	NEW ADDITION - Soil & concrete testing	2003	5,445						49
50	NEW ADDITION - Site preperation Per audit include w/Bldg.	2003							50
51	OUTSIDE LIGHT	2003	1,782						51
52	EXTERIOR DOORS (1 of 3 pymts)	2003	3,000						52
53	EXTERIOR DOORS (2 of 3 pymts)	2004	2,000						53
54	EXTERIOR DOORS (3 of 3 pymts)	2004	680						54
55	DOORS AND KICKPLATES	2004	30,571						55
56	WALLCOVERING	2004	869						56
57	FLUORESCENT LIGHT FIXTURES	2005	21,157						57
58	DOORS AND KICKPLATES	2005	1,190						58
59	ARCH & ENGINEERING COST	2005	5,718						59
60	O/H & INTEREST Nonallowable per audit	2005							60
61	FLOORING 465 003-05C	2005	2,540						61
62	WALL COVERING 465 003-05C	2005	1,106						62
63	CARPENTRY WORK 465 003-05C	2005	10,452						63
64	WINDOWS 465 003-05C	2005	36,400						64
65	GENERATOR EMERGENCY LIGHT	2005	1,964						65
66	RESURFACE ASPHALT PARKING LOT	2005	23,537						66
67	CONSTRUCT STONE WALL & GRADE AREAS	2006	1,110						67
68	DOORS (2) HOLLOW METAL	2006	5,272						68
69	VINYL FLOORING	2006	3,845						69
70	TOTAL (lines 4 thru 69)		\$ 3,571,554	\$ 136,287		\$ 136,287	\$	\$ 2,923,155	70

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

Facility Name & ID Number Manorcare of Elgin

0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

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		\$ 3,571,554	\$ 136,287		\$ 136,287	\$	\$ 2,923,155	1
2	Overhead & Interest on Renov.	2006	3,122						2
3	Renov. - Concrete Work - Landings, Ramps, & Handrail	2006	24,850						3
4	Renov. - Doors & Frames	2006	35,440						4
5	Renov. - Electrical Work	2006	1,347						5
6	Door at 1st floor Stairwell	2006	1,400						6
7	Flooring	2006	5,090						7
8	Door and Frame	2006	4,235						8
9	Panic hardware on new doors per Life Saftey Survey	2007	3,220						9
10	FENCE	2007	5,600						10
11	PAVING	2007	3,240						11
12	DRAINAGE IN PARKING LOT	2007	39,440						12
13	CARPET	2007	4,315						13
14	SECOND FLOOR DINING RM DO	2007	5,654						14
15	carpet	2007	1,659						15
16	FLOORING ON FIRST FLOOR	2007	7,830						16
17	00000001843 DOORS	2008	5,980						17
18	00000001845 WATER SOFTNER	2008	23,985						18
19	00000001848 CARPET	2008	1,438						19
20	00000001849 CARPET	2008	1,200						20
21	00000001853 1008 ROOF REPLACEMENT	2008	2,708						21
22	00000001854 1008 ROOF REPLACEMENT	2008	33,377						22
23	00000001856 DRYWALL AND PAINT	2008	2,969						23
24	00000001864 DRYWALL AND APINT	2008	6,004						24
25	00000001866 PAINT KITCHEN	2008	4,980						25
26	00000001869 ELECTRICAL UPGRADE FOR APPLIANCE	2008	1,360						26
27	00000001871 GAS AIR UNIT	2008	11,700						27
28	00000001874 2 doors restrictors	2008	3,950						28
29	00000001875 EPDM ROOF PATCHES	2008	3,500						29
30	00000001879 1508 ELEVATOR UPGRADE	2008	1,052						30
31	00000001880 1508 ELEVATOR UPGRADE	2008	30,800						31
32	00000001885 2 ELGIN WINDOWS	2008	2,551						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,855,550	\$ 136,287		\$ 136,287	\$	\$ 2,923,155	34

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

Facility Name & ID Number Manorcare of Elgin

0049692

Report Period Beginning:

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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		\$ 3,855,550	\$ 136,287		\$ 136,287	\$	\$ 2,923,155	1
2	000000001861 patio sidewalk	2008	1,740						2
3	000000001862 upgrade delivery entrance	2008	2,160						3
4	000000001870 100 FT FENCE	2008	5,475						4
5	000000001876 ELGIN ENTR SIDEWALK	2008	1,485						5
6	000000001883 CONCRETE SIDEWALK	2008	1,740						6
7	000000001884 PAVING / SEALCOATING	2008	2,160						7
8	1893 HM door	2009	5,725						8
9	1895 WEG cooling tower moter	2009	3,830						9
10	1898 Painting of Basement	2009	2,063						10
11	1899 Painting of Basement	2009	6,585						11
12	1900 Dishwasher area flooring	2009	5,344						12
13	1901 Carpeting & Installation	2009	11,349						13
14	1903 0409 Lobby, Corridor, Admin floor tile	2009	4,085						14
15	1907 0409 Lobby, Corridor front door	2009	6,142						15
16	1902 0409 Lobby, Corridor, Admin floor tile	2009	11,814						16
17	1909 1309 Replace underground Electrical Service	2010	38,471						17
18	1910 0310 2nd floor Nurse station	2010	1,075						18
19	1912 0310 2nd floor Nurse Station, Elect, Walls,Cabin,floor	2010	37,488						19
20	1896 Southside paving of parking lot	2009	10,830						20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,015,111	\$ 136,287		\$ 136,287	\$	\$ 2,923,155	34

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

Facility Name & ID Number Manorcare of Elgin

0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	\$ 1,400,137	\$	\$	\$		\$	71
72	Current Year Purchases	13,507	93,904	93,904			1,053,845	72
73	Fully Depreciated Assets							73
74	Home Office			13,690	13,690			74
75	TOTALS	\$ 1,413,644	\$ 93,904	\$ 107,594	\$ 13,690		\$ 1,053,845	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)	\$ 5,557,615	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 230,191	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 243,881	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,690	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,977,000	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			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: \$ 51,953 Description: _____
(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

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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	1716	hrs	\$ 68,557	1	\$ 11	\$ 400	1,717	\$ 68,968	1
2	Licensed Speech and Language Development Therapist	10a	1701	hrs	54,458	159	11,251		1,860	65,709	2
3	Licensed Recreational Therapist			hrs		738	52,277		738	52,277	3
4	Licensed Physical Therapist	10a	3412	hrs	148,611	68	4,817	2,143	3,480	155,571	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescripts				222,989		222,989	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>							71,131		71,131	12
13	Other (specify): <u>X-Ray & Lab</u>						42,391			42,391	13
14	TOTAL				\$ 271,626	966	\$ 110,747	\$ 296,663	7,795	\$ 679,036	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 Elgin# 0049692Report Period Beginning: 06/01/09Ending: 05/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/10

(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	\$ 3,771	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>(468,125)</u>)	497,984		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,692		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 504,447	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	128,860		13
14	Buildings, at Historical Cost	4,015,108		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,413,644		16
17	Accumulated Depreciation (book methods)	(3,977,000)		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)	\$ 1,580,612	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,085,059	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 122,967	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,944		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,719		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	13,054		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 439,684	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	935,949		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	5,011		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 940,960	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,380,644	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 704,415	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,085,059	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,359,173	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,359,173	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(544,646)	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)	\$ (544,646)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(110,112)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (110,112)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 704,415	24 *

* This must agree with page 17, line 47.

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	\$ 5,833,499	1
2	Discounts and Allowances for all Levels	(1,554,482)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,279,017	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,289,070	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,289,070	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	36	12
13	Barber and Beauty Care	5,759	13
14	Non-Patient Meals	74	14
15	Telephone, Television and Radio	11	15
16	Rental of Facility Space		16
17	Sale of Drugs	235,583	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,814	19
20	Radiology and X-Ray		20
21	Other Medical Services	34,023	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 278,300	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			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,846,387	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,021,183	31
32	Health Care	3,067,661	32
33	General Administration	1,602,621	33
B. Capital Expense			
34	Ownership	309,245	34
C. Ancillary Expense			
35	Special Cost Centers	342,143	35
36	Provider Participation Fee	48,180	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,391,033	40
41	Income before Income Taxes (line 30 minus line 40)**	(544,646)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (544,646)	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 Elgin**

0049692

Report Period Beginning:

06/01/09

Ending:

05/31/10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,014	2,186	\$ 84,724	\$ 38.76	1
2	Assistant Director of Nursing	3,346	3,631	119,878	33.02	2
3	Registered Nurses	21,659	23,509	743,332	31.62	3
4	Licensed Practical Nurses	12,674	13,757	351,824	25.57	4
5	CNAs & Orderlies	51,247	55,690	752,045	13.50	5
6	CNA Trainees					6
7	Licensed Therapist	6,883	7,520	296,754	39.46	7
8	Rehab/Therapy Aides	6,858	7,493	196,337	26.20	8
9	Activity Director					9
10	Activity Assistants	5,474	5,947	64,621	10.87	10
11	Social Service Workers	3,722	4,044	92,570	22.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,368	23,052	270,039	11.71	15
16	Dishwashers					16
17	Maintenance Workers	1,957	2,125	45,249	21.29	17
18	Housekeepers	9,670	10,504	124,295	11.83	18
19	Laundry	3,433	3,728	37,972	10.19	19
20	Administrator	1,872	2,080	88,658	42.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,894	16,171	263,642	16.30	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	795	864	14,431	16.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	167,866	182,301	\$ 3,546,371 *	\$ 19.45	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 14,400	9,3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,684	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)	\$ 16,084		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

Facility Name & ID Number Manorcare of Elgin# 0049692Report Period Beginning: 06/01/09Ending: 05/31/10**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 \$3288
- (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 \$3570
- (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. \$ 49,599 Line 10,2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,180
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 74
- (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.