



Facility Name & ID Number Manorcare of Libertyville

# 0049411 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	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	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	16,882	3,594	22,398	42,874	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,882	3,594	22,398	42,874	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.31%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/23/88

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/23/88 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 150 and days of care provided 17,264

Medicare Intermediary National Government 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 Libertyville # 0049411 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
	<b>A. General Services</b>										
1	Dietary	409,223	24,331	1,896	435,450	11,854	447,304		447,304		1
2	Food Purchase		296,764		296,764		296,764	(790)	295,974		2
3	Housekeeping	168,136	19,622	1,172	188,930		188,930		188,930		3
4	Laundry	36,049	22,026	3,625	61,700		61,700		61,700		4
5	Heat and Other Utilities			172,056	172,056	3,299	175,355		175,355		5
6	Maintenance	44,231	19,152	79,055	142,438		142,438		142,438		6
7	Other (specify):* <b>Medical Waste</b>			1,559	1,559		1,559		1,559		7
8	<b>TOTAL General Services</b>	657,639	381,895	259,363	1,298,897	15,153	1,314,050	(790)	1,313,260		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,600	21,600		21,600		21,600		9
10	Nursing and Medical Records	3,433,055	350,627	255,473	4,039,155	4,354	4,043,509		4,043,509		10
10a	Therapy	1,322,273	14,572	315,931	1,652,776		1,652,776		1,652,776		10a
11	Activities	87,894	3,164	4,632	95,690		95,690		95,690		11
12	Social Services	219,044		1,570	220,614		220,614		220,614		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	5,062,266	368,363	599,206	6,029,835	4,354	6,034,189		6,034,189		16
	<b>C. General Administration</b>										
17	Administrative	108,991		662,289	771,280	(243,425)	527,855		527,855		17
18	Directors Fees										18
19	Professional Services			32,255	32,255		32,255	(32,255)			19
20	Dues, Fees, Subscriptions & Promotions			112,326	112,326		112,326	(55,952)	56,374		20
21	Clerical & General Office Expenses	418,618	45,547	461,848	926,013		926,013	(399,980)	526,033		21
22	Employee Benefits & Payroll Taxes			1,355,499	1,355,499	98,419	1,453,918		1,453,918		22
23	Inservice Training & Education			4,392	4,392		4,392		4,392		23
24	Travel and Seminar			12,054	12,054		12,054		12,054		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			364,226	364,226		364,226		364,226		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	527,609	45,547	3,004,889	3,578,045	(145,006)	3,433,039	(488,187)	2,944,852		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,247,514	795,805	3,863,458	10,906,777	(125,499)	10,781,278	(488,977)	10,292,301		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 Libertyville #0049411 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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			425,494	425,494	26,315	451,809		451,809			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(8,926)	(8,926)	99,183	90,257		90,257			32
33	Real Estate Taxes			116,636	116,636		116,636		116,636			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			227,764	227,764		227,764		227,764			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			760,968	760,968	125,498	886,466		886,466			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		694,683		694,683		694,683		694,683			39
40	Barber and Beauty Shops		13	19,171	19,184		19,184		19,184			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee		82,125		82,125		82,125		82,125			42
43	Other (specify):* <b>IV, Xray, Lab</b>		141,784	107,972	249,756		249,756		249,756			43
44	<b>TOTAL Special Cost Centers</b>		918,605	127,143	1,045,748		1,045,748		1,045,748			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,247,514	1,714,410	4,751,569	12,713,493	(1)	12,713,492	(488,977)	12,224,515			45

**THE TOTAL FOR COLUMN 5 MUST BE ZERO, PLEASE CORRECT**

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



Manorcare of Libertyville

ID# 0049411

Report Period Beginning: 06/01/09

Ending: 05/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Vending Income	\$	(1,650)	21
2				
3				
4				
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49	<b>Total</b>		(1,650)	

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Libertyville# 0049411

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	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	(790)	0	0	0	0	0	0	0	0	0	0	(790)	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	<b>TOTAL General Services</b>	<b>(790)</b>	<b>0</b>	<b>(790)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(32,255)	0	0	0	0	0	0	0	0	0	0	(32,255)	19
20	Fees, Subscriptions & Promotions	(55,952)	0	0	0	0	0	0	0	0	0	0	(55,952)	20
21	Clerical & General Office Expenses	(399,980)	0	0	0	0	0	0	0	0	0	0	(399,980)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(488,187)</b>	<b>0</b>	<b>(488,187)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(488,977)</b>	<b>0</b>	<b>(488,977)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Libertyville# 0049411

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)	
	<b>D. Ownership</b>													
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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(488,977)	0	0	0	0	0	0	0	0	0	0	(488,977)	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						
2	V	Page						
3	V	8						
4	V							
5	V							
6	V	10a						
		Therapy Management	47,844	Heartland Rehab Services, LLC	100.00%	47,844		
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 710,133			\$ 710,133	\$ *	

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

Facility Name & ID Number Manorcare of Libertyville # 0049411 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									\$		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 Libertyville

# 0049411

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 Nurs. Fac.	\$ 2,826,629	\$ 1,585,087	11,985,079	\$ 11,854	1
2	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.			11,985,079	0	2
3	5	Utilities - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.			11,985,079	0	3
4	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	911,333		11,985,079	3,299	4
5	10	Nursing - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	632,689	715,152	11,985,079	2,653	5
6	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	469,810		11,985,079	1,701	6
7	17	General & Admin - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	35,518,981		11,985,079	148,962	7
8	17	General & Admin - Direct Centra	Accumulated Cost	691,284,298	359 Nurs. Fac.	1,045,204		11,985,079	18,121	8
9	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	69,554,530	79,745,671	11,985,079	251,781	9
10	22	Employee Benefits - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	6,239,311		11,985,079	26,167	10
11	22	Employee Benefits - Direct Centra	Accumulated Cost	691,284,298	359 Nurs. Fac.	2,434,366		11,985,079	42,206	11
12	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	8,300,418		11,985,079	30,047	12
13	30	De[reciation - Dorect	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	102,714		11,985,079	431	13
14	30	Depreciation - Direct Cent Div	Accumulated Cost	691,284,298	359 Nurs. Fac.	43,612		11,985,079	756	14
15	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	6,941,685		11,985,079	25,128	15
16										16
17	32	Interest				21,122,019			99,183	17
18		Non-Nursing Home Allocations				25,797,439				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 662,289	25

Facility Name & ID Number

Manorcare of Libertyville

# 0049411

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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Conv Sub Debentures	X	Various			\$ 3,895,128	\$ 3,895,128		0.0258	\$ 99,183	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8	Interest Income / Expense									(8,926)	8								
9	<b>TOTAL Facility Related</b>					\$ 3,895,128	\$ 3,895,128			\$ 90,257	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 3,895,128	\$ 3,895,128			\$ 90,257	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.		\$	<b>119,948</b>		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.)		\$	<b>122,307</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,359</b>		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>114,277</b>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$N/A For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>116,636</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<b>98,986</b>			8
	2006	<b>114,218</b>			9
	2007	<b>114,392</b>			10
	2008	<b>119,948</b>			11
	2009	<b>119,648</b>			12
<b>Line 2: \$122,307 = 2nd 1/2 2008 paid 9/25/09 \$59,973.78 + 1st 1/2 2009 paid 5/31/10 62,332.80</b>					
<b>Line 4: \$62,332.80 2nd half 2009 to be paid in Sep 2010 + \$51,944 estimate for Jan-May 2010</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2009	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

**NOTES:**

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



Facility Name & ID Number Manorcare of Libertyville

# 0049411

Report Period Beginning:

06/01/09

Ending:

05/31/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 36,902 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

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>1988</u>	<u>\$ 476,076</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 476,076</b>	<b>3</b>

Facility Name & ID Number Manorcare of Libertyville# 0049411

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	150			1988	\$ 4,592,131	\$ 117,249		\$ 117,249	\$	\$ 2,514,791	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>Building Improvements current year Depreciation</b>										9
10			1988		68,073	152,359		152,359		2,235,053	10
11			1989		52,434						11
12			1990		30,247						12
13			1991		67,316						13
14			1992		175,480						14
15		RETIREMENTS	1992		(10,437)						15
16			1993		55,746						16
17			1994		135,262						17
18			1995		66,532						18
19		FLOOR VINYL/TILE & INSTALLATION	1996		31,353						19
20		CAPITALIZED LABOR-NURSES STATION RENOV	1996		7,272						20
21		C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996		(7,272)						21
22		WALL VINYL/SIGNS	1996		5,576						22
23		CARPET	1996		4,210						23
24		INNER CAMERA MONITOR	1996		4,177						24
25		SIDING	1996		2,205						25
26		REPAIR LOOSE BRICKS	1996		2,183						26
27		NURSES STATION RENOVATION	1996		11,271						27
28		DOOR RELEASE	1996		2,071						28
29		REMODELING	1996		1,129						29
30		WATER HEATER	1996		5,313						30
31		CARPER/INSTALLATION	1996		2,991						31
32		FLOORING/TILE	1996		23,312						32
33		DOOR FRAME/GUARDS	1996		4,941						33
34		KITCHEN CEILING TILE	1996		3,638						34
35		WALLCOVERING	1996		4,964						35
36		ELECTRICAL/LIGHTING	1996		3,055						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 Libertyville# 0049411

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	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	CABINERY	1996	\$ 5,880	\$		\$	\$	37
38	REBUILD NURSES STATION	1996	8,500					38
39	INSTALL SWING DOORS	1996	8,826					39
40	INSTALL BALLUSTER POSTS	1996	2,500					40
41	FLOOR COVING	1996	7,791					41
42	BRICK PIER/CONCRETE SIDEWALK	1996	3,880					42
43	INSTALL BOULDER EDGE	1996	4,830					43
44	NURSES STATION RENOVATIONS	1996	1,506					44
45	WALL VINYL	1997	18,304					45
46	CARPETING	1997	1,624					46
47	DECORATING	1997	45,045					47
48	BRICK PIER	1997	1,500					48
49	EXTERIOR ENTRY DOORS	1997	3,317					49
50	PAINTING	1997	7,449					50
51	INSTALL CONDENSING COILS	1997	2,583					51
52	LANDSCAPE	1997	59,118					52
53	CURBING/ASPHALT	1997	30,000					53
54	ROOFING	1997	1,536					54
55	CORPORATE OVERHEAD-PARKING LOT	1997	10,516					55
56	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)					56
57	PARKING LOT WORK	1997	25,000					57
58	FACILITY PLAN ALLOC	1997	5,964					58
59	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)					59
60	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)					60
61	ELEVATOR REPAIRS	1997	5,018					61
62	SECURITY SYSTEM	1997	16,954					62
63	NEW EXHAUSTERS	1997	6,310					63
64	BUILD & INSTALL CABINETS	1997	6,512					64
65	CARPET	1997	5,148					65
66	LANDSCAPE	1997	25,279					66
67	CURB/ASPHALT	1997	45,210					67
68	INSTALL CEDAR FENCE	1997	2,750					68
69	DRUM SLUDGE REMOVAL	1997	2,563					69
70	TOTAL (lines 4 thru 69)		\$ 5,700,105	\$ 269,608		\$ 269,608	\$ 4,749,844	70

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

Facility Name & ID Number Manorcare of Libertyville# 0049411

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,700,105	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	1
2	INSTALL OIL TANK	1997	11,780						2
3	FLOORING/CEILING	1998	1,115						3
4	CARPETING	1998	2,574						4
5	ARCHITECT/PROFESSIONAL FEES-ADMIN OFFICE	1998	3,685						5
6	PAINTING/WALLPAPER	1998	10,125						6
7	RENOVATE ADMIN OFFICE	1998	2,533						7
8	ENERGY AUDITS	1998	1,875						8
9	GENERAL CONTRACTOR FEES-ADMIN OFFICE	1998	4,165						9
10	CORPORATE OVERHEAD-ADMIN OFFICE	1998	1,651						10
11	C/R 5/31/99 AUDIT ADJ - MONTHLY CAP BUDGET	1998	(1,651)						11
12	INSTALL FENCE/GAZEBO	1998	2,153						12
13	PAINTING/WALLCOVERING	1998	5,821						13
14	PLUMBING	1998	5,250						14
15	ELECTRICAL	1998	8,883						15
16	DEVELOPERS-ADMIN OFFICE	1998	5,555						16
17	SIGN	1998	11,862						17
18	ROOFING	1998	5,520						18
19	MASONARY	1998	4,766						19
20	CARPENTRY	1998	3,137						20
21	PAINTING/WALLCOVERING	1999	6,873						21
22	ELECTRICAL	1999	6,590						22
23	FLOORING/CEILING	1999	8,230						23
24	CARPENTRY	1999	12,373						24
25	MILLWORK	1999	540						25
26	FINISH STUDS	1999	20,000						26
27	PAVING	1999	35,325						27
28	CARPET FOR BUILDING	1999	11,611						28
29	WINDOW TREATMENTS	1999	10,291						29
30	KNOBLOCKS, CYPHER	1999	1,448						30
31	CARPET, CREDIT	1999	(13,990)						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,890,195	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	34

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

Facility Name & ID Number Manorcare of Libertyville# 0049411

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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,890,195	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	1
2	SALES TAX, CARPET	1999	71						2
3	CARPET	1999	148						3
4	DOOR FRAME FOR BOILER ROOM	1999	2,550						4
5	ELECTRICAL CIRCUITS, HEATER	1999	5,937						5
6	PTAC UNITS	1999	2,920						6
7	DOOR, HARDWARE, & STAIN	2000	1,025						7
8	ADDTL COST GARAGE	2000	1,671						8
9	SECURE CARE SYS 2ND FL STAIRWELL	2000	3,147						9
10	DOOR - SOUTH CORRIDOR EXIT	2000	2,440						10
11	PANIC DEVICE - EXTERIOR DOOR	2000	760						11
12	2 A/C UNITS	2000	1,156						12
13	GARAGE	2000	21,256						13
14	LANDSCAPING	2000	2,675						14
15	LANDSCAPING - ARBORIVITAE	2000	3,784						15
16	GARAGE	2000	19,209						16
17	GARAGE	2000	5,556						17
18	BOILER	2001	4,525						18
19	FIRE WALL IN ATTIC	2001	7,422						19
20	A/C UNIT	2001	597						20
21	4 A/C UNITS	2001	2,680						21
22	WORKCOUNTER & CABINETS	2001	2,219						22
23	GATES	2001	4,760						23
24	ELECTRICAL CIRCUITS	2001	1,279						24
25	ARCADIA CORRIDORS & LOUNGE (See Line 32)	2001	132,623						25
26	ARCADIA CORRIDORS & LOUNGE	2001	5,666						26
27	ARCADIA CORRIDORS & LOUNGE (See Line 32)	2001	124,865						27
28	ARCADIA CORRIDORS & LOUNGE	2001	20,483						28
29	ARCADIA CORRIDORS & LOUNGE	2001	181,656						29
30	CARPENTRY, DOORS, ELECT.	2001	52,344						30
31	VWC, CORNER GUARDS	2001	10,041						31
32	Per 7/06 Cap. Rate Audit Adjustments	2001	(122,832)						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,392,829	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	34

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

Facility Name & ID Number Manorcare of Libertyville# 0049411

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	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,392,829	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	1
2	Invoice #13216 Per 7/06 Cap Rate Audit Adj.	2002	21,952						2
3	Invoice #13233 Pre 7/16 Cap Rate Audit Adj.	2002	24,155						3
4	Per 7/06 Cap Rate Audit Adj. Move (See Lines 2 & 3)	2003	(46,107)						4
5									5
6	DINING ROOM & BREAKROOM	2003	21,720						6
7	RETROACTIVE ADDITION	2003	(588)						7
8	ARCH&ENGINEER COSTS, PLANS REVIEWS	2003	16,667						8
9	GENERAL OVERHEAD & INTEREST	2003	33,439						9
10	GENERAL OH & INT Pr 7/06 Cap Rate Audit Adj.	2003	(33,439)						10
11	CARPETING & PADS, WALLCOVERINGS	2003	74,310						11
12	CARPENTRY & MILLWORK	2003	5,750						12
13	HVAC & ELECTRICAL WORK	2003	30,572						13
14	HM DOORS & FRAMES	2003	3,662						14
15	WARDROBES	2004	11,000						15
16	FLOORING	2004	761						16
17	GENERAL OVERHEAD & INTEREST (See Line 18)	2004	32,935						17
18	Gen OH & Int Per 7/06 Cap Rate Audit Adj.	2004	(32,935)						18
19	SOWER ROOM RENOVATION	2004	3,000						19
20	Building décor/3 yrs Ta (See Line 21)	2004	21						20
21	Building décor/3 yrs Ta Per Cap Rate Audit Adjs.	2004	(21)						21
22	VWC	2004	252						22
23	SECOND FLOORING	2004	13,500						23
24	FRP FIRE WALL	2004	2,941						24
25	WINDOWS	2004	18,532						25
26	PAINTING EXTERIOR	2004	13,667						26
27	SHOWER ROOM RENOVATION	2004	3,800						27
28	ADD'L FLOORING	2004	1,238						28
29	SHOWER ROOM RENOVATION RE	2004	690						29
30	VWC	2004	83						30
31	INSTALL CARPET	2004	4,364						31
32	Per 7/06 Cap Rate Audit Adj.	2004	43,112						32
33	Per 7/06 Cap Rate Audit Adj.	2004	5,300						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,667,162	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	34

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

Facility Name &amp; ID Number Manorcare of Libertyville

# 0049411

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	<b>Totals from Page 12D, Carried Forward</b>		\$ 6,667,162	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	1
2	INSTALL VCT FLOORING	2005	3,436						2
3	Renov -Lobby Finishes	2005	1,680						3
4	Renov -Custom Casework (See Line 29)	2005	16,000						4
5	Renov -Carpeting & Pads & Guards & WC	2005	26,679						5
6	Renov -General Overhead & Interest (See Line 19)	2005	6,015						6
7	Stainles Steel Flashing	2005	20,000						7
8	Linen&Bathroom doors	2005	2,482						8
9	Renov -Roof Covering	2005	101,050						9
10	Renov -General Overhead (See Line 30)	2005	4,327						10
11	Renov -Interest on Construction (See Line 30)	2005	546						11
12	VWC	2005	4,168						12
13	Stainless steel flashing	2005	15,440						13
14	Bathroom Exhaust fans	2005	4,426						14
15	Carpet	2005	1,648						15
16	Renov -Drywall/Studs	2005	1,430						16
17	Renov -Resilient Flooring	2005	16,153						17
18	Renov -General Overhead & Interest (See Line 31)	2005	866						18
19	Adj. out OH & Int Per 7/06 Cap Rate Audit Adjs.	2005	(6,015)						19
20	To 2004 Per 7/06 Cap Rate Audit Adjs.	2005	(28,179)						20
21	Adj. out OH & Int Per 7/06 Cap Rate Audit Adjs.	2005	(5,670)						21
22	RENOVATION/ 440 018 04C (See Line 21)	2005	25,904						22
23	RENOVATION/ 440 018 04C (See Line 20)	2005	27,234						23
24	RENOVATION/ 440 018 04C (See Line 20)	2005	945						24
25	FLOORING	2005	1,636						25
26	INSTALL DOORS	2005	6,480						26
27	2 LIGHT FIXTURES	2005	1,650						27
28	INSTALL SMOKE WALL & SIDE	2005	10,129						28
29	Per 7/06 Cap Rate Audit Adjs.	2005	(5,000)						29
30	Per 7/06 Cap Rate Audit Adjs.	2005	(4,873)						30
31	Per 7/06 Cap Rate Audit Adjs.	2005	(866)						31
32	Per 7/06 Cap Rate Audit Adjs.	2005	(20,234)						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,896,649	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	34

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

Facility Name & ID Number Manorcare of Libertyville# 0049411

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	<b>Totals from Page 12E, Carried Forward</b>		\$ 6,896,649	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	1
2	<u>KVA TRANSFORMER</u>	2006	2,838						2
3	<u>21 doors</u>	2006	37,670						3
4	<u>sheet vinyl &amp; ceramic flo</u>	2006	4,074						4
5	<u>metals doors</u>	2006	3,317						5
6	<u>electrical</u>	2006	827						6
7	<u>DOORS ON KITCHEN</u>	2007	14,124						7
8	<u>DOORS ON 3RD &amp; 2ND FLOOR</u>	2007	5,940						8
9	<u>Renov - Carpentry</u>	2007	29,850						9
10	<u>Renov - Doors/Frames/Drywall/Studs/Plumbing</u>	2007	14,674						10
11	<u>Renov - Resilient Flooring</u>	2007	79,144						11
12	<u>Renov - Carpeting &amp; ads</u>	2007	19,746						12
13	<u>Renov - Fire Sprinkler</u>	2007	3,752						13
14	<u>Renov - Basic Electric</u>	2007	21,558						14
15	<u>Renov - Interest on Construction</u>	2007	1,493						15
16	<u>Renov - General Overhead</u>	2007	20,811						16
17	<u>Fire Rated Doors</u>	2007	22,384						17
18	<u>00000001811 Concrete Sidewalk</u>	2008	2,862						18
19	<u>00000001815 Seal Parking Lot</u>	2008	8,031						19
20	<u>00000001821 Asphalt</u>	2008	1,706						20
21	<u>00000001809 Fire Proofing</u>	2008	8,820						21
22	<u>00000001810 Kitchen Make Air</u>	2008	4,903						22
23	<u>00000001812 30 amp 277 volt Circuit</u>	2008	5,238						23
24	<u>00000001813 0208 Door Alarm System</u>	2008	1,382						24
25	<u>00000001834 Ceramic Tile in 4 Showers</u>	2008	22,440						25
26	<u>00000001835 Elevator Switches</u>	2008	4,757						26
27	<u>00000001839 Added Sprinklers</u>	2009	9,700						27
28	<u>00000001840 2208 Water Heaters</u>	2009	7,056						28
29	<u>00000001841 2208 Water Heaters</u>	2009	48,816						29
30	<u>00000001844 0908 Rms &amp; Bthrms Gen Overhead &amp; Interest</u>	2009	41,216						30
31	<u>00000001846 0908 Rms &amp; Bthrms Carpentry &amp; Milwork</u>	2009	137,855						31
32	<u>00000001847 0908 Rms &amp; Bthrms Ceiling tile, flooring VWC</u>	2009	26,975						32
33	<u>1847 0908 Rms &amp; Bathrms VWC</u>	2009	396						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,511,002	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 7,511,002	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	1
2	1864 Door	2009	2,076						2
3	1866 Adj Asset #1847 VWC	2009	(30)						3
4	1870 Steel Railing & Gate	2010	2,250						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	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,515,298	\$ 269,608		\$ 269,608	\$	\$ 4,749,844	34

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

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	\$ 1,953,694	\$ 155,886	\$ 155,886	\$		\$ 1,467,931	71
72	Current Year Purchases	101,098						72
73	Fully Depreciated Assets							73
74				26,315	26,315			74
75	TOTALS	\$ 2,054,792	\$ 155,886	\$ 182,201	\$ 26,315		\$ 1,467,931	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)	\$ 10,046,166	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 425,494	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 451,809	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,315	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,217,775	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	\$ 17,110	92
93			93
94			94
95		\$ 17,110	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: \$ 227,764 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. \_\_\_\_\_/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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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	6854	hrs	\$ 281,560	1,007	\$ 62,846	\$ 471	7,861	\$ 344,877	1	
2	Licensed Speech and Language Development Therapist	10a	2258	hrs	71,469	18	1,150		2,276	72,619	2	
3	Licensed Recreational Therapist			hrs		365	22,747		365	22,747	3	
4	Licensed Physical Therapist	10a	13518	hrs	550,730	2,502	156,114	14,101	16,020	720,945	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 prescrpts				694,683		694,683	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): <u>IV Therapy</u>	10a & 43,2					15,984	157,768		173,752	12	
13	Other (specify): <u>Xray/Lab</u>	43,3					107,972			107,972	13	
14	<b>TOTAL</b>				\$ 903,759	3,892	\$ 366,813	\$ 867,023	26,522	\$ 2,137,595	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 Libertyville# 0049411Report 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 31,349	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (663,640) )	1,697,747		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,589		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,733,685	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	476,076		13
14	Buildings, at Historical Cost	7,515,298		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,054,792		16
17	Accumulated Depreciation (book methods)	(6,217,775)		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>	17,110		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,845,501	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,579,186	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 175,683	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	471,337		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,277		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accounts Payable</u>	147,247		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 908,544	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,895,128		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	27,312		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,922,440	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,830,984	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 748,202	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,579,186	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(129,007)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(129,007)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,332,055</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,332,055</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	<b>(454,846)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(454,846)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>748,202</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,306,987	1
2	Discounts and Allowances for all Levels	(5,341,388)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 8,965,599</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,247,447	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 4,247,447</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,650	12
13	Barber and Beauty Care	22,158	13
14	Non-Patient Meals	790	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	733,912	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,145	19
20	Radiology and X-Ray	17,648	20
21	Other Medical Services	1,199	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 832,502</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 14,045,548</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,298,897	31
32	Health Care	6,029,835	32
33	General Administration	3,578,045	33
<b>B. Capital Expense</b>			
34	Ownership	760,968	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	963,623	35
36	Provider Participation Fee	82,125	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 12,713,493</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,332,055</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,332,055</b>	<b>43</b>

\* 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 Libertyville**

# **0049411**

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	1,956	2,102	\$ 100,527	\$ 47.82	1
2	Assistant Director of Nursing	4,965	5,336	197,750	37.06	2
3	Registered Nurses	41,288	44,372	1,447,363	32.62	3
4	Licensed Practical Nurses	18,961	20,377	502,357	24.65	4
5	CNAs & Orderlies	89,512	96,393	1,155,153	11.98	5
6	CNA Trainees					6
7	Licensed Therapist	22,268	23,896	969,837	40.59	7
8	Rehab/Therapy Aides	13,609	14,604	352,436	24.13	8
9	Activity Director					9
10	Activity Assistants	5,307	5,717	87,894	15.37	10
11	Social Service Workers	8,615	9,308	219,044	23.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,845	26,767	409,223	15.29	15
16	Dishwashers					16
17	Maintenance Workers	2,101	2,259	44,231	19.58	17
18	Housekeepers	12,462	13,426	168,136	12.52	18
19	Laundry	3,157	3,403	36,049	10.59	19
20	Administrator	2,250	2,250	108,991	48.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,577	20,999	418,618	19.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	2,004	2,159	29,905	13.85	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	272,877	293,368	\$ 6,247,514 *	\$ 21.30	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 21,600	9,3	36
37	Medical Records Consultant	Monthly 2,025	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 2,871	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)	\$ 26,496		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Pamela Lamb	Administrator	0	\$ 108,991	Workers' Compensation Insurance	\$ 384,064	IDPH License Fee	\$ 5,539	
				Unemployment Compensation Insurance	54,539	Advertising: Employee Recruitment	33,526	
				FICA Taxes	436,756	Health Care Worker Background Check	6,953	
				Employee Health Insurance	347,163	(Indicate # of checks performed <u>482</u> )		
				Employee Meals		Patient Background Checks	<u>257</u> 2,570	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,182	
						Association Dues	10,466	
						Advertising	51,090	
TOTAL (agree to Schedule V, line 17, col. 1)				401K	46,395	Less: Non-allowable Association Dues	(4,862)	
(List each licensed administrator separately.)			\$ 108,991	Appreciation & Other Employee Benefits	78,716	Less: Public Relations Expense	( )	
B. Administrative - Other				Tuition Program	978	Non-allowable advertising	(51,090)	
Description			Amount	Employee Uniforms	6,888	Yellow page advertising	( )	
Management Fees			\$ 662,289	Home Office Allocation	98,419			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 662,289	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,453,918	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Foote, Meyers & Flowers	Legal		\$ 30,990				Out-of-State Travel	\$
United Collection Bureau	Collection Services		1,265					
							In-State Travel	12,054
All the above adjusted off via page 5 line 22, therefore no invoices are attached								
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 32,255				TOTAL	\$ 12,054

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Manorcare of Libertyville# 0049411Report 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. HCFA \$5,604
- (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 \$4,862
- (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. \$ 80,518 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. \$ 82,125  
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. \$ 790
- (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.