

Facility Name & ID Number Manorcare of Northbrook

0049676 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	158	Skilled (SNF)	158	57,670	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	158	TOTALS	158	57,670	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	21,892	7,940	17,842	47,674	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,892	7,940	17,842	47,674	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.67%

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 03/22/1999

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/22/1999 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 158 and days of care provided 12,679

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 Northbrook # 0049676 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	445,235	48,705	22,745	516,685	11,374	528,059		528,059		1
2	Food Purchase		314,223		314,223		314,223	(3,253)	310,970		2
3	Housekeeping	231,058	35,841	3,679	270,578		270,578		270,578		3
4	Laundry	98,197	20,891	1,148	120,236		120,236	883	121,119		4
5	Heat and Other Utilities			197,540	197,540	3,165	200,705		200,705		5
6	Maintenance	58,403	22,901	73,295	154,599		154,599		154,599		6
7	Other (specify):*			1,598	1,598		1,598		1,598		7
8	TOTAL General Services	832,893	442,561	300,005	1,575,459	14,539	1,589,998	(2,370)	1,587,628		8
	B. Health Care and Programs										
9	Medical Director			73,437	73,437		73,437		73,437		9
10	Nursing and Medical Records	3,670,242	378,428	111,821	4,160,491	4,177	4,164,668		4,164,668		10
10a	Therapy	817,876	8,701	302,415	1,128,992		1,128,992		1,128,992		10a
11	Activities	175,796	9,489	4,219	189,504		189,504		189,504		11
12	Social Services	200,366		798	201,164		201,164		201,164		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,864,280	396,618	492,690	5,753,588	4,177	5,757,765		5,757,765		16
	C. General Administration										
17	Administrative	95,067		540,286	635,353	(138,396)	496,957		496,957		17
18	Directors Fees										18
19	Professional Services			63,193	63,193	(3,135)	60,058	(60,058)			19
20	Dues, Fees, Subscriptions & Promotions			115,545	115,545		115,545	(65,450)	50,095		20
21	Clerical & General Office Expenses	470,440	63,096	328,629	862,165	3,135	865,300	(194,948)	670,352		21
22	Employee Benefits & Payroll Taxes			1,015,222	1,015,222	94,431	1,109,653		1,109,653		22
23	Inservice Training & Education			7,285	7,285		7,285		7,285		23
24	Travel and Seminar			15,539	15,539		15,539		15,539		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			380,991	380,991		380,991		380,991		26
27	Other (specify):*			(1)	(1)		(1)		(1)		27
28	TOTAL General Administration	565,507	63,096	2,466,689	3,095,292	(43,965)	3,051,327	(320,456)	2,730,871		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,262,680	902,275	3,259,384	10,424,339	(25,249)	10,399,090	(322,826)	10,076,264		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.

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			434,833	434,833	25,249	460,082		460,082			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			186,561	186,561		186,561		186,561			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			173,316	173,316		173,316		173,316			35
36	Other (specify):*											36
37	TOTAL Ownership			794,710	794,710	25,249	819,959		819,959			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		600,292		600,292		600,292		600,292			39
40	Barber and Beauty Shops		387	19,982	20,369		20,369		20,369			40
41	Coffee and Gift Shops	31,369			31,369		31,369		31,369			41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):*		132,926	83,779	216,705		216,705		216,705			43
44	TOTAL Special Cost Centers	31,369	733,605	190,266	955,240		955,240		955,240			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,294,049	1,635,880	4,244,360	12,174,289		12,174,289	(322,826)	11,851,463			45

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

Manorcare of Northbrook

ID# 0049676

Report Period Beginning: 06/01/09

Ending: 05/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (77)	21	1
2	Misc income	(160)	21	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	(237)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Northbrook# 0049676

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	(3,253)	0	0	0	0	0	0	0	0	0	0	(3,253)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	883	0	0	0	0	0	0	0	0	0	0	883	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	(2,370)	0	(2,370)	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	(60,058)	0	0	0	0	0	0	0	0	0	0	(60,058)	19
20	Fees, Subscriptions & Promotions	(65,450)	0	0	0	0	0	0	0	0	0	0	(65,450)	20
21	Clerical & General Office Expenses	(194,948)	0	0	0	0	0	0	0	0	0	0	(194,948)	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	(320,456)	0	(320,456)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(322,826)	0	(322,826)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Northbrook# 0049676

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)	(322,826)	0	0	0	0	0	0	0	0	0	0	(322,826)	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						
		Tharapy Management	31,484	Heartland Rehab Services, LLC	100.00%	31,484		
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 571,770			\$ 571,770	\$ *	

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

Facility Name & ID Number

Manorcare of Northbrook

#

0049676

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 Northbrook

0049676

Report Period Beginning:

06/01/09

Ending: 05/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization HCR Manor Care, Inc.
 Street Address 333 North Summit St
 City / State / Zip Code Toledo, OH 43604-2617
 Phone Number (419-252-5000
 Fax Number (419-254-5495

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.

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	11,499,398	\$ 11,374	1
2	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 Nurs. Fac	911,333		11,499,398	3,165	2
3	10	Nursing - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	632,689	715,152	11,499,398	2,546	3
4	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 Nurs. Fac	469,810		11,499,398	1,632	4
5	17	General & Admin - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	35,518,981		11,499,398	142,925	5
6	17	General & Admin Dir Cent Dev	Accumulated Cost	691,284,298	95 Nurs. Fac	1,045,204		11,499,398	17,387	6
7	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	732 Nurs. Fac	69,554,530	79,745,671	11,499,398	241,578	7
8	22	Employee Benefits - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	6,239,311		11,499,398	25,106	8
9	22	Employee Benefits - Dir Cen Div	Accumulated Cost	691,284,298	95 Nurs. Fac.	2,434,366		11,499,398	40,495	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 Nurs. Fac	8,300,418		11,499,398	28,829	10
11	30	Depreciation - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	102,714		11,499,398	414	11
12	30	Depreciation - Direct Cen Div	Accumulated Cost	691,284,298	95 Nurs. Fac	43,612		11,499,398	725	12
13	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 Nurs. Fac	6,941,685		11,499,398	24,110	13
14										14
15		Directly Assigned Interest				21,122,019				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		\$ 540,286	25

Facility Name & ID Number

Manorcare of Northbrook

0049676

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		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	N/A						\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$			\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.		\$	276,365		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.)		\$	308,236		2
3. Under or (over) accrual (line 2 minus line 1).		\$	31,871		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	154,692		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.		\$	186,563		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	186,042			8
	2006	294,514			9
	2007	278,852			10
	2008	288,812			11
	2009	221,321			12
Line 2: \$308,236 = 2nd 1/2 2008 paid 12/09 \$149,388.90 + 1st 1/2 2009 paid 3/10 158,846.76					
Line 4: \$62,474.63 2nd half 2009 to be paid in Dec 2010 + \$92,217.24 estimate for Jan-May 2010					
Line 12: 158,846.76 1st half 2009, 62,474.63 2nd half 2009					
				FOR BHF USE ONLY	
	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 Northbrook

0049676 Report Period Beginning:

06/01/09 Ending:

05/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,393 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>1999</u>	<u>\$ 1,885,717</u>	<u>1</u>
2			<u>2003</u>	<u>32,884</u>	<u>2</u>
3	TOTALS			\$ 1,918,601	3

Facility Name & ID Number Manorcare of Northbrook

0049676

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	148			1999	\$ 8,207,461	\$ 229,500		\$ 229,500	\$	\$ 2,201,771	4
5	CR 5/31/01 Audit Adj			1999	494,486						5
6	10			2003	478,057						6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)			1999	531	41,383		41,383		593,618	9
10				1999	(531)						10
11	CR 5/31/01 AUDIT ADJ			1999	1,470						11
12				1999	(1,470)						12
13	CR 5/31/01 AUDIT ADJ			1999	73						13
14				1999	(73)						14
15	CR 5/31/01 AUDIT ADJ			1999	449						15
16				1999	(449)						16
17	CR 5/31/01 AUDIT ADJ			2000	14,841						17
18	SECURE CARE SYSTEM			2000	1,134						18
19	MAGNETIC DOOR HOLDER			2000	2,473						19
20	ACCESS DOORS - FIRE DAMPERS			2000	14,790						20
21	ENGINEER COST V#3413 RESIDENT'S ROOMS			2000	1,398						21
22	WALLCOVERING-2ND FL RESIDENTS R			2000	205						22
23	ADDT'L CONSTRUCTION COST-RESIDENTS ROOMS			2000	1,374						23
24	CIRCUITRY SECURE CARE SYSTEM			2000	1,036,860						24
25	SITEWORK			2000	(1,036,860)						25
26	CR 5/31/01 AUDIT ADJ			2000	965						26
27	FENCE			2001	977						27
28	BLOCKING AND PULLY SYSTEM			2001	1,298						28
29	ELECTRICAL ON GENERATOR			2001	103						29
30	FREIGHT ON CARPET			2001	484						30
31	CARPET			2001	626						31
32	CARPET			2003	395,966						32
33	GEN OVERHEAD,ARCHITECT,ENGINEER COSTS			2003	2,646						33
34	MILLWORK			2003	3,248						34
35	CARPET										35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Northbrook

0049676

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	CARPET	2003	\$ 840	\$		\$	\$	37
38	CARPET	2003	188					38
39	CARPET, BADE AND TILE	2003	2,275					39
40	FREIGHT ON CARPET	2003	60					40
41	FREIGHT ON CARPET	2003	69					41
42	CARPET	2003	835					42
43	ARCHITECT COSTS	2003	848					43
44	ENGINEERING & ARCHITECT COST	2003	1,680					44
45	ENGINEERING & ARCHITECT COST	2003	738					45
46	CERMAIC TILE	2003	2,450					46
47	FREIGHT ON CARPET	2003	69					47
48	VINYL WALL COVERING	2003	148					48
49	CARPET	2003	620					49
50	VINYL WALL COVERING	2003	201					50
51	ENGINEERING COSTS	2003	3,647					51
52	SITE PREPARATION COSTS	2003	71,550					52
53	ADDTL CIVIL ENGINEERING COST	2004	1,800					53
54	ADDTL ARCHITECTURAL COST	2004	30					54
55	CERAMIC TILE	2004	1,093					55
56	CARPET	2004	707					56
57	ENGINEERING COSTS	2004	125					57
58	FREIGHT ON VINYL	2004	62					58
59	INSTALLATION OF COUNTERTOPS AND CONCRETE	2004	12,653					59
60	COMPLETION OF BORDER AND WALL COVERINGS	2004	7,980					60
61	VINYL WALL COVERING	2004	989					61
62	VINYL WALL COVERING	2004	77					62
63	VINYL WALL COVERING	2004	407					63
64	VINYL WALL COVERING	2004	672					64
65	VINYL WALL COVERING	2004	801					65
66	DRYWALL INSTALLATION FOR LAUNDRY ROOM	2004	1,382					66
67	VINYL WALL COVERING	2004	660					67
68	WINDOW TREATMENTS	2004	2,097					68
69	COMPLETE ADDITIONAL WALL VINYL PATCH	2004	450					69
70	TOTAL (lines 4 thru 69)		\$ 9,740,735	\$ 270,883		\$ 270,883	\$ 2,795,389	70

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

Facility Name & ID Number Manorcare of Northbrook

0049676

Report Period Beginning:

06/01/09

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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		\$ 9,740,735	\$ 270,883		\$ 270,883	\$	\$ 2,795,389	1
2	CARPET	2005	4,450						2
3	VINYL SHEET FOR NURSE STATION	2005	14,330						3
4	DOOR HINGES	2005	1,975						4
5	WALLCOVERING	2006	1,650						5
6	PAINTING & CORNER GUARDS	2003	15,000						6
7	WALLCOVERING	2006	345						7
8	STEEL SERVICE DOOR	2006	9,608						8
9	WALLCOVERING	2006	385						9
10	PAINT/CORNER GUARDS	2006	12,466						10
11	PAINT-DINING ROOM AND BAT	2007	1,875						11
12	DOORS ON ELECTRICAL ROOM	2007	736						12
13	LEGAL FEES V21550	2007	1725						13
14	ELECTRICAL for Steamer	2007	1286						14
15	CARPENTRY FOR PANTRY	2008	9979						15
16	00000000305 T&P VALVES	2008	1,600						16
17	00000000307 0408 WATER HEATERS	2008	1,772						17
18	00000000308 0408 WATER HEATERS	2008	39,500						18
19	00000000309 21 CO2 DETECTORS	2008	5,983						19
20	00000000310 CARPET-2nd Floor Corridor	2008	2,323						20
21	00000000311 FRIEGHT FOR CARPET	2008	443						21
22	00000000317 KITCHEN TILES AND DURAROCK	2008	14,683						22
23	00000000318 2ND FLOOR CARPET	2008	2,873						23
24	00000000326 4 HM DOORS AT ARCADIA & 2ND FLR UTLY I	2009	5,450						24
25	00000000312 PAVING	2008	7,582						25
26	0909 TILE & WALLCOVERING	2009	1,023						26
27	0909 STAINLESS STEEL IN KITCHEN	2009	47,220						27
28	3 SETS OF HM DOORS	2009	12,630						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,959,630	\$ 270,883		\$ 270,883	\$	\$ 2,795,389	34

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

Facility Name & ID Number Manorcare of Northbrook

0049676

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	\$ 1,577,295	\$ 163,950	\$ 163,950	\$		\$ 1,378,211	71
72	Current Year Purchases	101,029						72
73	Fully Depreciated Assets							73
74	HOME OFFICE			25,249	25,249			74
75	TOTALS	\$ 1,678,324	\$ 163,950	\$ 189,199	\$ 25,249		\$ 1,378,211	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,556,555	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 434,833	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 460,082	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,249	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,173,600	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: \$ 173,316 Description: 02 Concentrators, Wheelchairs, Gerichairs, Clect. Bed

(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 checked="" type="checkbox"/> YES <input 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 checked="" 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	\$	\$ 5,092	\$	\$ 5,092
2	Books and Supplies		50		50
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	\$	\$ 5,142	\$	\$ 5,142
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,142		

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	6795	hrs	\$ 241,773	2,321	\$ 148,983	\$ 1,181	9,116	\$ 391,937	1
2	Licensed Speech and Language Development Therapist	10a	3603	hrs	113,105	3	221	10	3,606	113,336	2
3	Licensed Recreational Therapist			hrs		1,119	71,836		1,119	71,836	3
4	Licensed Physical Therapist		6182	hrs	234,917	768	49,328	7,510	6,950	291,755	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				599,336		599,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): _____										12
13	Other (specify): <u>X-Ray & Lab</u>	43,2					83,779			83,779	13
14	TOTAL				\$ 589,795	4,211	\$ 354,147	\$ 608,037	20,791	\$ 1,551,979	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 Northbrook# 0049676Report 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	\$ 26,490	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>(567,198)</u>)	1,340,212		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,833		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,371,535	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,918,601		13
14	Buildings, at Historical Cost	9,959,631		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,678,324		16
17	Accumulated Depreciation (book methods)	(4,173,600)		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)	\$ 9,382,956	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,754,491	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 225,047	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	465,721		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	154,692		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accounts Payable</u>	104,704		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 950,164	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	17,310		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17,310	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 967,474	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,787,017	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,754,491	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,756,051	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,756,051	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	892,945	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)	\$ 892,945	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(1,861,979)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,861,979)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,787,017	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Northbrook# 0049676Report Period Beginning: 06/01/09Ending: 05/31/10

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	\$ 13,216,295	1
2	Discounts and Allowances for all Levels	(3,437,516)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,778,779	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,517,539	6
7	Oxygen	6,848	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,524,387	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	77	12
13	Barber and Beauty Care	25,460	13
14	Non-Patient Meals	3,253	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	618,570	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,751	19
20	Radiology and X-Ray	11,386	20
21	Other Medical Services	63,294	21
22	Laundry	(883)	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 763,908	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	<u>Misc Income</u>	160	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 160	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,067,234	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,575,459	31
32	Health Care	5,753,588	32
33	General Administration	3,095,292	33
B. Capital Expense			
34	Ownership	794,710	34
C. Ancillary Expense			
35	Special Cost Centers	868,735	35
36	Provider Participation Fee	86,505	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,174,289	40
41	Income before Income Taxes (line 30 minus line 40)**	892,945	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 892,945	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 Northbrook**

0049676

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	2,066	2,229	\$ 92,538	\$ 41.52	1
2	Assistant Director of Nursing	3,920	4,228	145,794	34.48	2
3	Registered Nurses	47,873	51,646	1,658,469	32.11	3
4	Licensed Practical Nurses	13,469	14,531	339,779	23.38	4
5	CNAs & Orderlies	104,290	112,702	1,396,712	12.39	5
6	CNA Trainees					6
7	Licensed Therapist	16,284	17,603	637,575	36.22	7
8	Rehab/Therapy Aides	7,402	8,001	180,301	22.53	8
9	Activity Director					9
10	Activity Assistants	13,962	15,087	175,796	11.65	10
11	Social Service Workers	7,234	7,815	200,366	25.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,627	31,809	445,235	14.00	15
16	Dishwashers					16
17	Maintenance Workers	2,073	2,247	58,403	25.99	17
18	Housekeepers	17,979	19,479	231,058	11.86	18
19	Laundry	9,651	10,432	98,197	9.41	19
20	Administrator	1,912	2,080	95,067	45.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,689	22,549	470,440	20.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,289	2,474	36,950	14.94	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,939	2,095	31,369	14.97	33
34	TOTAL (lines 1 - 33)	302,659	327,007	\$ 6,294,049 *	\$ 19.25	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	73,437	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,024	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)		\$ 76,461		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	752	\$ 51,146	10,3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	752	\$ 51,146		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	
Lynette Rugg	Administrator	0	\$ 95,067	Workers' Compensation Insurance	\$ 52,432	IDPH License Fee	\$ 1,837	
				Unemployment Compensation Insurance	62,448	Advertising: Employee Recruitment	31,138	
				FICA Taxes	451,151	Health Care Worker Background Check	4,508	
				Employee Health Insurance	396,628	(Indicate # of checks performed <u>245</u>)		
				Employee Meals		Patient Background Checks	359	
				Illinois Municipal Retirement Fund (IMRF)*		Dues/Subs	3,120	
				401 K	35,642	Association Dues	12,130	
				Other Emp Benefits	2,767	Advertising	59,222	
				Tuition Program - Wages	4,025			
				SMSP Company Match	3,268	Less: Non-allowable Association Dues	(6,228)	
				Employee Uniforms	6,861	Less: Public Relations Expense	()	
				Home Office Allocation	94,431	Non-allowable advertising	(59,222)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,067	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,109,653		\$ 50,095		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees			\$ 540,286	N/A		\$	Out-of-State Travel	\$
							In-State Travel	15,539
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 540,286				Seminar Expense	
							Entertainment Expense	()
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount	\$			\$ 15,539	
Foote Meyers	Legal		\$ 5,886					
Littler Mendelson	Legal		32,014					
Collection Fees/UCB	Collections		22,158					
All the above adjusted off via page 5 line 22, therefore no invoices are attached!								
Joint Commission	Accreditation		3,135					
Reclass on V								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 63,193					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare of Northbrook# 0049676Report 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 \$5,902
- (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) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 97,655 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. \$ 86,505
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. \$ 3,253
- (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.