

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387 Report Period Beginning: 06/01/13 Ending: 05/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	190	Skilled (SNF)	190	69,350	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	22,265	5,785	34,713	62,763	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,265	5,785	34,713	62,763	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.50%

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

1 (Do not include bed-hold days in Section B.)

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

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/30/90

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

YES Date 04/07/11 NO

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

YES NO If YES, enter number of beds certified 190 and days of care provided 27,251

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL 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.

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	207,000	62,512	440,664	710,176		710,176	710,176		1	
2	Food Purchase		444,644		444,644		444,644	(2,593)	442,051	2	
3	Housekeeping	258,095	35,841	1,114	295,050		295,050	295,050		3	
4	Laundry	70,949	35,577	48	106,574		106,574	106,574		4	
5	Heat and Other Utilities			337,427	337,427	3,830	341,257	341,257		5	
6	Maintenance	112,538	18,488	221,223	352,249		352,249	352,249		6	
7	Other (specify):* Med Waste			5,866	5,866		5,866	5,866		7	
8	TOTAL General Services	648,582	597,062	1,006,342	2,251,986	3,830	2,255,816	(2,593)	2,253,223	8	
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000	30,000		9	
10	Nursing and Medical Records	5,969,144	527,710	174,601	6,671,455	16,694	6,688,149	6,688,149		10	
10a	Therapy	2,565,249	19,542	191,833	2,776,624		2,776,624	2,776,624		10a	
11	Activities	167,317	6,109	7,998	181,424		181,424	181,424		11	
12	Social Services	356,745		1,665	358,410		358,410	358,410		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	9,058,455	553,361	406,097	10,017,913	16,694	10,034,607	10,034,607		16	
	C. General Administration										
17	Administrative	208,275		851,396	1,059,671	(290,303)	769,368	769,368		17	
18	Directors Fees									18	
19	Professional Services			51,702	51,702	(2,090)	49,612	(49,612)		19	
20	Dues, Fees, Subscriptions & Promotions			133,052	133,052		133,052	(70,968)	62,084	20	
21	Clerical & General Office Expenses	763,857	129,278	581,195	1,474,330	2,090	1,476,420	(383,675)	1,092,745	21	
22	Employee Benefits & Payroll Taxes			1,474,602	1,474,602	84,191	1,558,793	1,558,793		22	
23	Inservice Training & Education			4,181	4,181		4,181	4,181		23	
24	Travel and Seminar			2,340	2,340		2,340	2,340		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			638,435	638,435		638,435	638,435		26	
27	Other (specify):*							(279)	(279)	27	
28	TOTAL General Administration	972,132	129,278	3,736,903	4,838,313	(206,112)	4,632,201	(504,534)	4,127,667	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,679,169	1,279,701	5,149,342	17,108,212	(185,588)	16,922,624	(507,127)	16,415,497	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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			690,683	690,683	28,336	719,019		719,019			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,460,077	2,460,077	157,252	2,617,329	(2,538,028)	79,301			32
33	Real Estate Taxes			830,247	830,247		830,247		830,247			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			42,996	42,996		42,996		42,996			35
36	Other (specify):*											36
37	TOTAL Ownership			4,024,003	4,024,003	185,588	4,209,591	(2,538,028)	1,671,563			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,052,457		1,052,457		1,052,457		1,052,457			39
40	Barber and Beauty Shops			22,000	22,000		22,000		22,000			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			320,482	320,482		320,482		320,482			42
43	Other (specify):* IV Ther/ Xray /Lab		219,129	99,164	318,293		318,293		318,293			43
44	TOTAL Special Cost Centers		1,271,586	441,646	1,713,232		1,713,232		1,713,232			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,679,169	2,551,287	9,614,991	22,845,447		22,845,447	(3,045,155)	19,800,292			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,593)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(203)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(279)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(9,900)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(34,610)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(372,689)	21		24
25	Fund Raising, Advertising and Promotional	(70,968)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,553,913)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,045,155)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (3,045,155)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

Manorcare of Elk Grove Vlg

ID# 0049387

Report Period Beginning: 06/01/13

Ending: 05/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	HCP Lease Interest	\$ (2,538,028)	32	1
2	Vending Income	(883)	21	2
3	Accounting / Collection Fees	(15,002)	19	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
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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	(2,553,913)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

06/01/13

Ending:

05/31/14

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,593)	0	0	0	0	0	0	0	0	0	0	(2,593)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,593)	0	(2,593)	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	(49,612)	0	0	0	0	0	0	0	0	0	0	(49,612)	19
20	Fees, Subscriptions & Promotions	(70,968)	0	0	0	0	0	0	0	0	0	0	(70,968)	20
21	Clerical & General Office Expenses	(383,675)	0	0	0	0	0	0	0	0	0	0	(383,675)	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):*	(279)	0	0	0	0	0	0	0	0	0	0	(279)	27
28	TOTAL General Administration	(504,534)	0	(504,534)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(507,127)	0	(507,127)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

06/01/13 Ending:

05/31/14

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	(2,538,028)	0	0	0	0	0	0	0	0	0	0	(2,538,028)	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	(2,538,028)	0	0	0	0	0	0	0	0	0	0	(2,538,028)	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)	(3,045,155)	0	0	0	0	0	0	0	0	0	0	(3,045,155)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Health Care	Toledo	Nursing Staff
		See Pg 6 Supp for list of related nursing homes in Illinois				

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Home Office Allocation	\$ 851,396	HCR Manor Care Services, LLC	100.00%	\$ 851,396	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	10,679,169	Heartland Employment Services, LLC	100.00%	10,679,169		4
5	V	10a Therapy Management	20,308	Heartland Rehabilitation Services, LLC	100.00%	20,308		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 11,550,873			\$ 11,550,873	\$ *	14

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

Facility Name & ID Number

Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

06/01/13

Ending:

05/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Decatur				2
3			Heartland of Decatur IL, LLC	Galesburg				3
4			Heartland of Galesburg IL, LLC	Henry				4
5			Heartland of Henry IL, LLC	Macomb				5
6			Heartland of Macomb IL, LLC	Moline				6
7			Heartland of Moline IL, LLC	Normal				7
8			Heartland of Normal IL, LLC	Paxton				8
9			Heartland of Paxton IL, LLC	Peoria				9
10			Heartland of Peoria IL, LLC	East Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	Arlington Heights				11
12			Manor Care at Arlington Heights	Elgin				12
13			Manor Care of Elgin IL, LLC	Elk Grove Village				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights West IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30								30

Facility Name & ID Number

Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

06/01/13

Ending:

05/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Geneva IL, LLC	Geneva				1
2			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				2
3			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				3
4			Arden Courts of Northbrook IL, LLC	Northbrook				4
5			Arden Courts of Palos Heights IL, LLC	Palos Heights				5
6			Arden Courts of South Holland IL, LLC	South Holland				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

Facility Name & ID Number Manorcare of Elk Grove Vlg # 0049387 Report Period Beginning: 06/01/13 Ending: 05/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

06/01/13

Ending: 05/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	\$ 702,082	\$ 21,382,334	\$ 3,830	1	
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs		21,382,334	0	2	
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs		21,382,334	0	3	
4	10	Nursing - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	421,070	303,971	21,382,334	2,297	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	2,331,970	10,787,378	21,382,334	14,397	5
6	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			21,382,334	0	6
7	17	Gen / Admin - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	66,712,258	34,047,414	21,382,334	363,901	7
8	17	Gen / Admin - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	18,712,683	6,531,152	21,382,334	115,531	8
9	17	Gen/Admin-Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs	1,887,403	1,136,236	21,382,334	81,661	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	7,831,139		21,382,334	42,717	10
11	22	Empl Benefits - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	6,717,577		21,382,334	41,474	11
12	22	Empl Benefits-Dir to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			21,382,334	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	4,454,722		21,382,334	24,300	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	653,747		21,382,334	4,036	14
15	30	Depr - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			21,382,334	0	15
16										16
17	32	Pooled Interest	Accumulated Cost	3,919,925,578		25,923,280		21,382,334	141,406	17
18	32	Directly Assigned Interest	Not Allocated			18,563,246			15,846	18
19										19
20		H/O Costs Allocated to Non-SNFs & Oth Div				30,324,259				20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 185,235,436	\$ 52,806,151	\$	851,396	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Conv Sub Debentures		X	Various			\$ 241,832	\$ 241,832		0.0655	\$ 15,846	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7	Pooled Interest										141,406	7					
8	Interest Expense / Interest Income										(77,951)	8					
9	TOTAL Facility Related																
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related																
15	TOTALS (line 9+line14)																
							\$ 241,832	\$ 241,832			\$ 79,301	15					

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

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

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

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

Report Period Beginning:

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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 2013 report.		\$	<u>655,387</u>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>753,144</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>97,757</u>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>733,027</u>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		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 \$ <u>537</u> For <u>2003</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	<u>(537)</u>	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>830,247</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>301,576</u>	8		
	2010	<u>657,870</u>	9		
	2011	<u>696,875</u>	10		
	2012	<u>733,178</u>	11		
	2013	<u>802,076</u>	12		
Line 2: \$753,144.45 = \$349,896.54 for 2nd half of 2012 + \$403,247.91 for 1st half of 2013					
Line 4: \$733,026.72 = \$398,828.39 for 2nd half 2013 + \$334,198.33 for Jan-May 2014					
Line 6: Refund from Worsek & Vihon for 2003 RE Tax Appeal for Specific Rate Objections					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2013 \$ 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.

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,963 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	120		1990	\$ 5,025,494	\$ 204,245		\$ 204,245	\$	\$ 4,072,574
5	60		1996	1,726,800					
6	10		2000	1,063,936					
7	5/31/03 Audit Adjustment		2000	(277,211)					
8			2009	631,865					
Improvement Type**									
9	Current Year Depreciation				256,744		256,744		2,779,587
10			1990	12,954					
11			1991	41,034					
12			1992	89,111					
13			1993	29,775					
14			1994	18,939					
15			1995	182,383					
16			1996	485,188					
17			1997	111,890					
18			1998	127,587					
19			1999	60,314					
20			2000	68,449					
21			2001	5,850					
22			2002	53,586					
23	HOLLOW METAL DOOR		2003	975					
24	ARCH & ENGINEERING COSTS		2003	975					
25	BORDER		2003	162					
26	VWC		2003	1,710					
27	VWC		2003	219					
28	ARCHITECTIRAL ENGINEERING		2003	258					
29	VWC		2003	427					
30	NEW BATHROOM FLOORING & TILE		2003	22,640					
31	ARCHITECT & ENGINEERING		2003	258					
32	FLOORING		2003	4,599					
33	VWC, BORDER, AND PAINTING		2003	3,317					
34	ADDITIONAL COST FOR FLOORING		2003	2,820					
35	ARCHITECT AND ENGINEERING COSTS		2003	2,064					
36			2003	3,629					

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

06/01/13

Ending:

05/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BORDER	2003	\$ 54	\$		\$	\$	\$	37
38	ARCHITECT AND ENGINEERING COSTS	2003	455						38
39	ELECTRICAL WORK	2003	5,182						39
40	VCT FLOORING	2003	7,005						40
41	BASE AND FLOOR TILE	2003	4,118						41
42	CARPET	2004	609						42
43	INSTALL CARPET	2004	550						43
44	PAVING	2003	67,500						44
45	CONCRETE WALK	2003	3,822						45
46	PAVING	2004	7,500						46
47	Renov. - General Construction Overhead & Interest	2004	19,622						47
48	Renov. - Carpeting	2004	595						48
49	Renov. - Painting	2004	14,000						49
50	Renov. - Wallcovering & Corner Guards	2004	37,811						50
51	Renov. - Carpentry	2004	8,201						51
52	Renov. - Plumbing	2004	2,880						52
53	Renov. - Electrical	2004	2,931						53
54	Carpet	2004	1,324						54
55	Ceramic Cove Base	2004	3,360						55
56	Renov. - Wood Doors & Hardware for Lobby	2004	8,597						56
57	Renov. - Electrical	2004	2,484						57
58	Electric Door Strike at Service Door	2004	1,509						58
59	CARPETING & DELIVERY OF CARPETTING	2005	2,435						59
60	REBUILD SHOWER STALLS (5)	2006	14,000						60
61	VWC, BASE, & CEILING TILES IN BREAK ROOM	2006	2,470						61
62	Ceramic Tile - Wall/Floor	2006	3,300						62
63	Wallcovering	2006	3,605						63
64	Plumbing Work on Sprinkler System	2006	4,727						64
65	Architecture/Engineering for Parking Lot	2007	9,285						65
66	Drywall Work	2007	8,378						66
67	DOOR HOLDER & CLOSER	2007	1,556						67
68	DOOR HOLDER & CLOSER	2007	1,869						68
69	Renov. - Carpeting & Pad	2007	1,742						69
70	TOTAL (lines 4 thru 69)		\$ 9,755,473	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	70

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

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

Report Period Beginning:

06/01/13

Ending:

05/31/14**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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		\$ 9,755,473	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	1
2	Renov. - Wallcovering	2007	84,542						2
3	Renov. - Carpentry - Subtractor	2007	38,200						3
4	Renov. - Basic Electrical	2007	7,626						4
5	Renov. - HM Doors & Frames	2007	10,505						5
6	Renov. - Generator, Permit	2007	3,096						6
7	Renov. - Basic Electrical	2007	9,357						7
8	Renov. - Generator, Engineering	2007	13,539						8
9	Renov. - Parking Lot Expansion & Landscaping	2007	83,045						9
10	BLACKTOP PATCHING	2007	12,078						10
11	Roofing	2008	7,221						11
12	Roofing - additional	2008	802						12
13	Generator - Installation & Materials	2008	36,317						13
14	Generator - Equipment	2008	10,814						14
15	Generator - Installation & Materials	2008	62,613						15
16	Renov. - CORRIDOR DOORS (35)	2008	50,575						16
17	CO2 Detectors & Control Panel	2008	11,781						17
18	Generator - Equipment	2008	63,883						18
19	Storm Drain Enhancements	2008	4,100						19
20	Sealcoating & Restriping	2008	13,362						20
21	Renov. - Internet Café Construction (Contracted Total)	2009	88,371						21
22	Double Egress Kitchen Doors	2009	6,076						22
23	Renov. - Carpentry	2009	76,000						23
24	Renov. - Millwork (Hand Rails)	2009	14,910						24
25	Renov. - Electrical (Light Fixtures)	2009	5,990						25
26	Renov. - Carpet	2009	6,195						26
27	Renov. - Wallcovering, Corner Guards	2009	8,076						27
28	Generator - Installation & Materials	2009	11,108						28
29	Renov. - Carpentry	2009	45,000						29
30	Renov. - Millwork (Hand Rails)	2009	16,827						30
31	Renov. - Carpet	2009	9,331						31
32	Renov. - Wallcovering	2009	9,237						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,576,050	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	34

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

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,576,050	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	1
2	<u>THERAPY ADD - SOIL TESTING</u>	2009	600						2
3	<u>THERAPY ADD - CONCRETE TESTING</u>	2009	2,155						3
4	<u>THERAPY ADD - SITE PREPARATION</u>	2009	240,173						4
5	<u>THERAPY ADD - LANDSCAPING</u>	2009	14,240						5
6	<u>LIGHTPOLE W/ CONCRETE BASE</u>	2009	5,483						6
7	<u>THERAPY ADD - ARCH & ENGINEER COST</u>	2009	56,780						7
8	<u>THERAPY ADD - ARCHITECT REIMB EXTER</u>	2009	7,886						8
9	<u>THERAPY ADD - ENGINEERING - CIVIL</u>	2009	4,740						9
10	<u>THERAPY ADD - INTERIOR DESIGN CONSULTANT</u>	2009	102,773						10
11	<u>THERAPY ADD - LANDSCAPE DESIGN CONSULTANT</u>	2009	8,487						11
12	<u>THERAPY ADD - PLAN REVIEWS</u>	2009	8,853						12
13	<u>THERAPY ADD - SALES USE TAX</u>	2009	22						13
14	<u>THERAPY ADD - WALL COVERING</u>	2009	14,602						14
15	<u>THERAPY ADD - CORNER GUARDS</u>	2009	1,548						15
16	<u>THERAPY ADD - TV IN PT WAITING ROOM</u>	2010	1,745						16
17	<u>THERAPY ADD - CRASH RAIL</u>	2010	3,941						17
18	<u>PAINTING FOR NOURISHMENT</u>	2009	3,800						18
19	<u>10 DOORS</u>	2009	27,900						19
20	<u>CARPETING</u>	2009	1,040						20
21	<u>HM DOOR</u>	2009	4,867						21
22	<u>HM DOOR</u>	2010	4,830						22
23	<u>C-WING SPRINKLERS</u>	2010	25,181						23
24	<u>3808 C WING REHAB RENO - CARPENTRY</u>	2009	43,296						24
25	<u>3808 C WING REHAB RENO - HM DOORS & FRAMES</u>	2009	3,324						25
26	<u>3808 C WING REHAB RENO - ELECTRICAL</u>	2009	6,930						26
27	<u>3808 C WING REHAB RENO - CORNER GUARDS</u>	2009	268						27
28	<u>2107 GENERATOR REPLACE - LABOR & MATERIALS</u>	2009	25,804						28
29	<u>1409 SPRINKLER HEADS - SPRINKLERS</u>	2009	32,500						29
30	<u>1809 INTERIOR RENO - FLOORING</u>	2010	1,906						30
31	<u>1809 INTERIOR RENO - CARPETING</u>	2010	9,289						31
32	<u>1809 INTERIOR RENO - WALL COVERING</u>	2010	45,056						32
33	<u>1809 INTERIOR RENO - ELECTRICAL</u>	2010	1,984						33
34	TOTAL (lines 1 thru 33)		\$ 11,288,053	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	34

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

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

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Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,288,053	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	1
2	1809 INTERIOR RENOVATION - Wall Covering	2010	44,154						2
3	HM Doors	2010	10,350						3
4	0910 HERITAGE RENOVATION - Lobby Finishes	2010	76,149						4
5	0910 HERITAGE RENOVATION - Carpeting & Pads	2010	8,725						5
6	0910 HERITAGE RENOVATION - Wall Covering	2010	8,753						6
7	0910 HERITAGE RENOVATION - Corner Guards	2010	2,827						7
8	0910 HERITAGE RENOVATION - Millwork	2010	15,549						8
9	0910 HERITAGE RENOVATION - Basic Electrical	2010	8,612						9
10	SMOKE DETECTOR SYSTEM	2011	10,890						10
11	1211 C-WING RES BTHRM HEATERS	2011	18,560						11
12	HM DOORS - ASST ADMIN OFFICE & BATHROOM	2011	19,050						12
13	DRAINAGE SYSTEM (COURTYARD)	2011	28,203						13
14	300 FT OF SEWER PIPING	2011	27,190						14
15	concrete walk sections	2011	14,426						15
16	CABINETS (NOURISHMENT RM)	2011	3,969						16
17	ELEC HEATERS IN LAUNDRY/RMS 421/141/C-WING SHOWE	2011	14,233						17
18	208 volt 30 amp circuit (steam	2011	2,153						18
19	HERITAGE WING RENOV - GEN OVERHEAD & INTEREST	2011	79,909						19
20	HERITAGE WING RENOV - RESILIENT FLOORING	2011	109,165						20
21	HERITAGE WING RENOV - CARPETING	2011	21,188						21
22	HERITAGE WING RENOV - WALLCOVERING	2011	85,740						22
23	HERITAGE WING RENOV - BASIC ELECTRICAL	2011	25,016						23
24	SHOWER RENOVATIONS HERITAGE WING	2011	4,857						24
25	PLANTER BOXES, ADDL CONCRETE FOR COURTYARD	2011	3,375						25
26	SPRINKLER PIPING	2012	15,836						26
27	DOUBLE DOORS @ STORAGE SHED	2012	2,915						27
28									28
29	FIRE DAMPERS in C-Wing	2012	13,320						29
30	5 DOORS-rms 115, 126, 320 ,328, & DCD office	2012	17,084						30
31	PATIO CANOPY	2012	2,086						31
32	Roof	2012	39,130						32
33	MINOR KITCHEN RENOV - flooring	2012	9,804						33
34	TOTAL (lines 1 thru 33)		\$ 12,031,271	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12D, Carried Forward		\$ 12,031,271	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	1
2	MINOR KITCHEN RENOV -tile	2012	2,280						2
3	FIRE SPRINKLER UPGRADE	2012	14,504						3
4	FLOORING-employee baths	2012	6,785						4
5	PIPE INSULATION - in janitors closets	2013	4,860						5
6	DOORWAY UPGRADE to kitchen entrance	2013	7,443						6
7	DOORS - PAT RM/CORR @ rm 118-119, 308, 313, & conf room.								7
8	A-Wing hallway and central bath	2013	22,752						8
9	5 Fire Doors- RM 111, C-WING SHWR RM, SPEECH THERAPY, BOM OFFICE								9
10	AND FRONT OFC HALL	2013	24,401						10
11	repairs on 3 smoke walls due to penetrations found during life safety survey								11
12	-sprinkler piping, PVC piping & data cables.	2013	17,019						12
13	ELECTRIC UPGRADES-DISH MACHINE	2014	3,631						13
14	ELECTRIC UPGRADES-DISH MACHINE ADDITIONAL	2014	1,090						14
15	Wall Mounted Workstation in dietary mgr ofc	2014	2,770						15
16	UPGRADE FIRESTOPPING at 5 smoke walls & elec rm at data lines, sprinkler piping, conduits,ducktwork.								16
17	Install new EZ path devices around data and TV cabling	2014	29,700						17
18	WINDOW UPGRADES IN 14 RESIDENT ROOMS	2013	5,950						18
19	ELECTRIC UPGRADES-MAINT OFF A/C	2014	2,455						19
20	SMOKE WALL ADD'L to firestop around cluster of plumbing pipes penetrating								20
21	smoke wall above ceiling	2014	2,200						21
22	FIRE DOORS at B-Wing Shower room, Womans restrm by room 300, and								22
23	soiled utility	2014	8,158						23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,187,269	\$ 460,989		\$ 460,989	\$	\$ 6,852,161	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 3,955,651	\$ 229,694	\$ 229,694	\$		\$ 3,329,140	71
72	Current Year Purchases	232,000						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			28,336	28,336			74
75	TOTALS	\$ 4,187,651	\$ 229,694	\$ 258,030	\$ 28,336		\$ 3,329,140	75

D. Vehicle Costs. (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)	\$ 17,228,548	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 690,683	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 719,019	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,336	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,181,301	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387

Report Period Beginning: 06/01/13

Ending: 05/31/14

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 42,996

Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Manorcare of Elk Grove Vlg # 0049387 Report Period Beginning: 06/01/13 Ending: 05/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist	10a	16430	hrs	\$ 669,563	1,428	\$ 83,960	\$ 835	17,858	\$ 754,358	1	
2	Licensed Speech and Language Development Therapist	10a	3917	hrs	159,623	19	1,089	500	3,936	161,212	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	18310	hrs	746,148	1,219	71,674	18,207	19,529	836,029	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	39, 2		# of prescripts				1,052,457		1,052,457	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): <u>Inhal Therapist</u>	10a	1123		45,782	232	13,646		1,355	59,428	12	
13	Other (specify): <u>IV Ther/Xray/Lab</u>	43, 2 & 2					99,164	219,129		318,293	13	
14	TOTAL				\$ 1,621,116	2,898	\$ 269,533	\$ 1,291,128	42,678	\$ 3,181,777	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare of Elk Grove Vlg# 0049387Report Period Beginning: 06/01/13Ending: 05/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/14

(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	\$ (2,287)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (912,108))	2,742,072		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,642		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,746,427	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	853,628		13
14	Buildings, at Historical Cost	12,187,269		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,187,651		16
17	Accumulated Depreciation (book methods)	(10,181,301)		17
18	Deferred Charges	14,580,372		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)	\$ 21,627,619	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 24,374,046	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 297,124	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,004,679		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	733,027		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	290,012		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,324,842	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	241,832		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 241,832	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,566,674	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 21,807,372	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 24,374,046	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 21,782,866	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 21,782,866	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	367,210	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)	\$ 367,210	17
B. Transfers (Itemize):			
18	Change in Interdivision	(342,704)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (342,704)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 21,807,372	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 23,741,616	1
2	Discounts and Allowances for all Levels	(11,793,053)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,948,563	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,815,358	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,815,358	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	1,162	12
13	Barber and Beauty Care	28,938	13
14	Non-Patient Meals	2,593	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,068,313	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	73,566	19
20	Radiology and X-Ray	127,143	20
21	Other Medical Services	144,639	21
22	Laundry	2,382	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,448,736	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,212,657	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,251,986	31
32	Health Care	10,017,913	32
33	General Administration	4,838,313	33
B. Capital Expense			
34	Ownership	4,024,003	34
C. Ancillary Expense			
35	Special Cost Centers	1,392,750	35
36	Provider Participation Fee	320,482	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,845,447	40
41	Income before Income Taxes (line 30 minus line 40)**	367,210	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 367,210	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,990,105	44
45	Private Pay - Net Inpatient Revenue	1,970,856	45
46	Medicare - Net Inpatient Revenue	5,917,403	46
47	Other-(specify)	112,603	47
48	Other-(specify)	957,596	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,948,563	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Manorcare of Elk Grove Vlg

0049387

Report Period Beginning:

06/01/13

Ending:

05/31/14

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	2,033	2,198	\$ 104,679	\$ 47.62	1
2	Assistant Director of Nursing	5,303	5,733	219,020	38.20	2
3	Registered Nurses	83,411	90,161	3,163,683	35.09	3
4	Licensed Practical Nurses	16,027	17,324	442,689	25.55	4
5	CNAs & Orderlies	144,980	157,099	1,997,347	12.71	5
6	CNA Trainees					6
7	Licensed Therapist	42,574	46,035	1,875,991	40.75	7
8	Rehab/Therapy Aides	24,622	26,624	689,258	25.89	8
9	Activity Director	10,564	11,427	167,317	14.64	9
10	Activity Assistants					10
11	Social Service Workers	12,371	13,382	356,745	26.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,724	14,900	207,000	13.89	15
16	Dishwashers					16
17	Maintenance Workers	3,968	4,292	112,538	26.22	17
18	Housekeepers	18,867	20,413	258,095	12.64	18
19	Laundry	6,413	6,938	70,949	10.23	19
20	Administrator	2,080	2,080	142,150	68.34	20
21	Assistant Administrator	1,455	1,455	66,125	45.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,250	32,867	763,857	23.24	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	2,132	2,307	41,726	18.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	420,774	455,235	\$ 10,679,169 *	\$ 23.46	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 30,000	9, 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			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)	\$ 30,000		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-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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

Report Period Beginning:

06/01/13

Ending:

05/31/14**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. ICHA \$5,811
- (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 \$2391
- (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. \$ 124,095 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? YES
If YES, give effective date of lease. 04/07/11
- (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. \$ 320,482
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,593
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NO
Attach invoices and a summary of services for all architect and appraisal fees.