



Facility Name & ID Number Manorcare of Elgin

# 0049692 Report Period Beginning: 06/01/14 Ending: 05/31/15

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,190	1,082	7,624	26,896	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,190	1,082	7,624	26,896	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.74%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/07/11 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 88 and days of care provided 3,972

Medicare Intermediary Novitas Solutions, Inc.

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31 Fiscal Year: 05/31

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

Facility Name &amp; ID Number

Manorcare of Elgin

# 0049692

Report Period Beginning:

06/01/14

Ending:

05/31/15

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	145,224	24,882	112,430	282,536		282,536	282,536			1
2	Food Purchase		204,234		204,234		204,234	(1,731)	202,503		2
3	Housekeeping	146,392	16,030	2,449	164,871		164,871		164,871		3
4	Laundry	32,980	13,942		46,922		46,922		46,922		4
5	Heat and Other Utilities			141,616	141,616	1,202	142,818		142,818		5
6	Maintenance	62,151	22,398	159,619	244,168		244,168		244,168		6
7	Other (specify):*			1,115	1,115		1,115		1,115		7
8	<b>TOTAL General Services</b>	386,747	281,486	417,229	1,085,462	1,202	1,086,664	(1,731)	1,084,933		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	2,197,666	162,604	48,377	2,408,647	4,096	2,412,743		2,412,743		10
10a	Therapy	557,438	7,077	14,946	579,461		579,461		579,461		10a
11	Activities	68,365	2,758	1,245	72,368		72,368	(50)	72,318		11
12	Social Services	112,933			112,933		112,933		112,933		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,936,402	172,439	80,168	3,189,009	4,096	3,193,105	(50)	3,193,055		16
	<b>C. General Administration</b>										
17	Administrative	92,798		309,231	402,029	(141,611)	260,418		260,418		17
18	Directors Fees										18
19	Professional Services			8,116	8,116		8,116	(8,116)			19
20	Dues, Fees, Subscriptions & Promotions			50,954	50,954		50,954	(27,626)	23,328		20
21	Clerical & General Office Expenses	338,004	46,114	280,109	664,227		664,227	(217,214)	447,013		21
22	Employee Benefits & Payroll Taxes			531,871	531,871	22,262	554,133		554,133		22
23	Inservice Training & Education			750	750		750		750		23
24	Travel and Seminar			3,117	3,117		3,117		3,117		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			168,368	168,368		168,368		168,368		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	430,802	46,114	1,352,516	1,829,432	(119,349)	1,710,083	(252,956)	1,457,127		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,753,951	500,039	1,849,913	6,103,903	(114,051)	5,989,852	(254,737)	5,735,115		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Manorcare of Elgin

#0049692

Report Period Beginning:

06/01/14

Ending:

05/31/15

## 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	
	<b>D. Ownership</b>											
30	Depreciation			184,583	184,583	7,949	192,532		192,532			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,879	80,879	106,102	186,981	(85,514)	101,467			32
33	Real Estate Taxes			40,074	40,074		40,074		40,074			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			76,889	76,889		76,889		76,889			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			382,425	382,425	114,051	496,476	(85,514)	410,962			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,528		179,528		179,528		179,528			39
40	Barber and Beauty Shops			9,111	9,111		9,111		9,111			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,506	176,506		176,506		176,506			42
43	Other (specify):* <b>IV   X-Ray &amp; Lab</b>		28,699	58,716	87,415		87,415		87,415			43
44	<b>TOTAL Special Cost Centers</b>		208,227	244,333	452,560		452,560		452,560			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,753,951	708,266	2,476,671	6,938,888		6,938,888	(340,251)	6,598,637			45

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

Facility Name & ID Number Manorcare of Elgin

# 0049692

Report Period Beginning: 06/01/14

Ending: 05/31/15

**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	(1,731)	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	(17)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(41)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(1,107)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,335)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(215,838)	21		24
25	Fund Raising, Advertising and Promotional	(27,626)	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	(88,556)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (340,251)</b>		<b>\$</b>	<b>30</b>

**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)		10a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (340,251)</b>		<b>37</b>

\*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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Manorcare of Elgin

ID# 0049692

Report Period Beginning: 06/01/14

Ending: 05/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Activity Income	\$ (50)	11	1
2	Vending Income	(211)	21	2
3	Accounting/Collection Fees	(2,781)	19	3
4	HCP Lease Interest	(85,514)	32	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	<b>Total</b>		(88,556)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Elgin# 0049692

Report Period Beginning:

06/01/14

Ending:

05/31/15

## 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	(1,731)	0	0	0	0	0	0	0	0	0	0	(1,731)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,731)</b>	<b>0</b>	<b>(1,731)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(50)	0	0	0	0	0	0	0	0	0	0	(50)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(50)</b>	<b>0</b>	<b>(50)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,116)	0	0	0	0	0	0	0	0	0	0	(8,116)	19
20	Fees, Subscriptions & Promotions	(27,626)	0	0	0	0	0	0	0	0	0	0	(27,626)	20
21	Clerical & General Office Expenses	(217,214)	0	0	0	0	0	0	0	0	0	0	(217,214)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(252,956)</b>	<b>0</b>	<b>(252,956)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(254,737)</b>	<b>0</b>	<b>(254,737)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Elgin

# 0049692

Report Period Beginning:

06/01/14 Ending:

05/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(85,514)	0	0	0	0	0	0	0	0	0	0	(85,514)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(85,514)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(85,514)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(340,251)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(340,251)</b>	<b>45</b>

**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

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						1
2	V	Page 8						2
3	V							3
4	V	I-44						4
5	V	10a						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		\$ 4,072,371			\$ 4,072,371	\$ *	14

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

Facility Name &amp; ID Number

Manorcare of Elgin

# 0049692

Report Period Beginning:

06/01/14

Ending:

05/31/15

## 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	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elk Grove Village 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			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number

Manorcare of Elgin

# 0049692

Report Period Beginning:

06/01/14

Ending:

05/31/15

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 Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				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

Facility Name & ID Number Manorcare of Elgin # 0049692 Report Period Beginning: 06/01/14 Ending: 05/31/15

## 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

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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	564 NFs, HHs, & R	\$ 700,139		6,816,642	\$ 1,202	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	356 NFs			6,816,642	0	2
3	5	Utilities - direct to MW Div SNFs	Accumulated Cost	45 NFs			6,816,642	0	3
4	10	Nursing - Pooled	Accumulated Cost	564 NFs, HHs, & R	365,628	262,581	6,816,642	628	4
5	10	Nursing - Direct to all SNFs	Accumulated Cost	356 NFs	1,781,417	1,228,977	6,816,642	3,468	5
6	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	45 NFs			6,816,642	0	6
7	17	General & Administrative - Pooled	Accumulated Cost	564 NFs, HHs, & R	68,653,771	35,393,585	6,816,642	117,900	7
8	17	General & Administrative - Direct	Accumulated Cost	356 NFs	12,665,127	2,400,695	6,816,642	24,657	8
9	17	General & Administrative - Direct	Accumulated Cost	40 NFs Jan - Sept	1,411,275		5,112,482	20,802	9
10	17	General & Administrative - Direct	Accumulated Cost	45 NFs Oct-Dec	536,860		1,704,161	4,261	10
11	22	Employee Benefits - Pooled	Accumulated Cost	564 NFs, HHS, & R	5,418,631		6,816,642	9,306	11
12	22	Employee Benefits - Direct to All	Accumulated Cost	356 NFs	6,655,045		6,816,642	12,956	12
13	22	Employee Benefits - Direct to Western	Accumulated Cost	45 NFs			6,816,642	0	13
14	30	Depreciation - Pooled	Accumulated Cost	564 NFs, HHs, & R	3,871,414		6,816,642	6,648	14
15	30	Depreciation - Direct to All SNFs	Accumulated Cost	356 NFs	668,272		6,816,642	1,301	15
16	30	Depreciation - Direct to Western	Accumulated Cost	45 NFs			6,816,642	0	16
17	32	Pooled Interest	Accumulated Cost		25,971,677		6,816,642	44,602	17
18	32	Directly Assigned Interest	Not Allocated		17,184,434			61,500	18
19		H/O Costs Allocated to Non-SNFs and Other Divisions			33,870,689			0	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 179,754,379	\$ 39,285,838		\$ 309,231	25

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Manorcare of Elgin

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**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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Conv. Sub. Debentures		X	Various			\$ 935,949	\$ 935,949		6.5709	\$ 61,500						
2																	
3																	
4																	
5																	
	<b>Working Capital</b>																
6	Home Office Pooled Interest Expense										44,602						
7	Interest Income /Interest Expense										(4,635)						
8																	
9	<b>TOTAL Facility Related</b>						\$ 935,949	\$ 935,949			\$ 101,467						
	<b>B. Non-Facility Related*</b>																
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 935,949	\$ 935,949			\$ 101,467						

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

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

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

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

B. Real Estate Taxes

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>			
1. Real Estate Tax accrual used on 2014 report.		\$ 28,584	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.)		\$ 34,321	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 5,736	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 34,338	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 40,074	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2010	35,849	8
	2011	34,207	9
	2012	33,796	10
	2013	31,182	11
	2014	37,459	12
<b>Line 2: \$34,320 = \$15,591 for the 2nd half of 2013 + \$18,729 for the 1st half of 2014.</b>			
<b>Line 4: \$34,338 = \$18,730 for the 2nd half 2014 + \$15,608 estimate for Jan-May 2015.</b>			
		<b>FOR BHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2014 \$	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?                 YES        X   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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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.**

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**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

N/A

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>1967</u>	<u>\$ 107,499</u>	<u>1</u>
2			<u>2003</u>	<u>21,361</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 128,860</b>	<b>3</b>

**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	73			1965	\$ 562,637	\$ 3,959		\$ 3,959		\$ 1,092,171	4
5	7			1991	325,282						5
6	8			2003	686,404						6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>Current Year Depreciation</b>					109,611		109,611		2,431,972	9
10				1987	11,654						10
11				1988	164,890						11
12				1989	26,729						12
13				1990	64,209						13
14				1991	99,431						14
15				1992	69,948						15
16				1993	62,901						16
17				1994	59,739						17
18				1995	141,422						18
19				1996	111,267						19
20				1997	103,146						20
21				1998	338,111						21
22				1999	37,350						22
23				2000	98,791						23
24				2001	70,110						24
25				2002	75,611						25
26		WINDOW TREATMENTS		2003	2,265						26
27		COVE BASE		2003	3,086						27
28		RISER PIPE REPLACEMENT		2003	94,382						28
29		15 DOORS for resident rooma (1 of 3 pymts.)		2003	10,500						29
30		PAINTING, BORDER, VCT FLO		2003	1,010						30
31		VWC		2003	771						31
32		VWC		2003	545						32
33		VWC		2003	152						33
34		PAINTING AND BORDER		2003	463						34
35		PAINTING AND BORDER		2003	5,887						35
36		WALLCOVERINGS		2003	399						36

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

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

See Page 12A, Line 70 for total

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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	
37	15 DOORS for resident rooma (2 of 3 pymts.)	2003	\$ 7,790	\$		\$	\$	\$	37
38	LAUNDRY ROOM DOORS	2003	4,266						38
39	NEW ADDITION - Updated for audit	2003	127,111						39
40	NEW ADDITION - Carpet & wallcovering	2003	9,623						40
41	NEW ADDITION - Millwork	2003	2,359						41
42	VWC, FLOORING, PAINTING	2003	15,124						42
43	VINYL CEILING & PAINTING	2003	6,274						43
44	ADJUST ASSETS 1583 & 1598 CARPET - per audit S/B 2002	2003							44
45	PAINTING AND BORDER	2003	5,887						45
46	15 DOORS for resident rooma (3 of 3 pymts.)	2003	2,312						46
47	TRIM HANDLE (COURTYARD DOOR)	2003	428						47
48	DOORS	2003	2,650						48
49	NEW ADDITION - Soil & concrete testing	2003	5,445						49
50	NEW ADDITION - Site preparation Per audit include w/Bldg.	2003							50
51	OUTSIDE LIGHT	2003	1,782						51
52	EXTERIOR DOORS (1 of 3 pymts)	2003	3,000						52
53	EXTERIOR DOORS (2 of 3 pymts)	2004	2,000						53
54	EXTERIOR DOORS (3 of 3 pymts)	2004	680						54
55	DOORS AND KICKPLATES	2004	30,571						55
56	WALLCOVERING	2004	869						56
57	FLUORESCENT LIGHT FIXTURES	2005	21,157						57
58	DOORS AND KICKPLATES	2005	1,190						58
59	ARCH & ENGINEERING COST	2005	5,718						59
60	O/H & INTEREST Nonallowable per audit	2005							60
61	FLOORING 465 003-05C	2005	2,540						61
62	WALL COVERING 465 003-05C	2005	1,106						62
63	CARPENTRY WORK 465 003-05C	2005	10,452						63
64	WINDOWS 465 003-05C	2005	36,400						64
65	GENERATOR EMERGENCY LIGHT	2005	1,964						65
66	RESURFACE ASPHALT PARKING LOT	2005	23,537						66
67	CONSTRUCT STONE WALL & GRADE AREAS	2006	1,110						67
68	DOORS (2) HOLLOW METAL	2006	5,272						68
69	VINYL FLOORING	2006	3,845						69
70	TOTAL (lines 4 thru 69)		\$ 3,571,554	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	70

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

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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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,571,554	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	1
2	Overhead & Interest on Renov.	2006	3,122						2
3	Renov. - Concrete Work - Landings, Ramps, & Handrail	2006	24,850						3
4	Renov. - Doors & Frames	2006	35,440						4
5	Renov. - Electrical Work	2006	1,347						5
6	Door at 1st floor Stairwell	2006	1,400						6
7	Flooring	2006	5,090						7
8	Door and Frame	2006	4,235						8
9	Panic hardware on new doors per Life Safety Survey	2007	3,220						9
10	FENCE	2007	5,600						10
11	PAVING	2007	3,240						11
12	DRAINAGE IN PARKING LOT	2007	39,440						12
13	CARPET	2007	4,314						13
14	SECOND FLOOR DINING RM DO	2007	5,654						14
15	carpet	2007	1,659						15
16	FLOORING ON FIRST FLOOR	2007	7,830						16
17	000000001843 DOORS	2008	5,980						17
18	000000001845 WATER SOFTNER	2008	23,985						18
19	000000001848 CARPET	2008	1,438						19
20	000000001849 CARPET	2008	1,200						20
21	000000001853 1008 ROOF REPLACEMENT	2008	2,708						21
22	000000001854 1008 ROOF REPLACEMENT	2008	33,376						22
23	000000001856 DRYWALL AND PAINT	2008	2,968						23
24	000000001864 DRYWALL AND APINT	2008	6,004						24
25	000000001866 PAINT KITCHEN	2008	4,980						25
26	000000001869 ELECTRICAL UPGRADE FOR APPLIANCE	2008	1,360						26
27	000000001871 GAS AIR UNIT	2008	11,700						27
28	000000001874 2 doors restrictors	2008	3,950						28
29	000000001875 EPDM ROOF PATCHES	2008	3,500						29
30	000000001879 1508 ELEVATOR UPGRADE	2008	1,052						30
31	000000001880 1508 ELEVATOR UPGRADE	2008	30,800						31
32	000000001885 2 ELGIN WINDOWS	2008	2,551						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,855,547	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	34

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

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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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,855,547	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	1
2	00000001861 patio sidewalk	2008	1,740						2
3	00000001862 upgrade delivery entrance	2008	2,160						3
4	00000001870 100 FT FENCE	2008	5,475						4
5	00000001876 ELGIN ENTR SIDEWALK	2008	1,485						5
6	00000001883 CONCRETE SIDEWALK	2008	1,740						6
7	00000001884 PAVING / SEALCOATING	2008	2,160						7
8	1893 HM door	2009	5,725						8
9	1895 WEG cooling tower moter	2009	3,830						9
10	1898 Painting of Basement	2009	2,063						10
11	1899 Painting of Basement	2009	6,585						11
12	1900 Dishwasher area flooring	2009	5,344						12
13	1901 Carpeting & Installation	2009	11,349						13
14	1903 0409 Lobby, Corridor, Admin floor tile	2009	4,085						14
15	1907 0409 Lobby, Corridor front door	2009	6,142						15
16	1902 0409 Lobby, Corridor, Admin floor tile	2009	11,814						16
17	1909 1309 Replace underground Electrical Service	2010	38,471						17
18	1910 0310 2nd floor Nurse station	2010	1,075						18
19	1912 0310 2nd floor Nurse Station, Elect, Walls,Cabin,floor	2010	37,488						19
20	1896 Southside paving of parking lot	2009	10,830						20
21	1918 Painting	2010	4,743						21
22									22
23	Electrical for Heater Overhead	2011	2,246						23
24	Cooling Tower - Renov. 0311	2011	32,334						24
25	Electric Heater	2011	5,600						25
26	Ceiling, Painting, Drywall	2011	13,104						26
27	Exit Alarm (East Ext Stairwell	2011	4,820						27
28	Paint Ceilings in four rooms	2011	1,237						28
29	Rooftop Units (2) 2 ton, Bkkpg & Pvt. Dining	2011	13,800						29
30	Doors (2) (Laundry, Linen)	2011	4,370						30
31	Roof Curbes for 2 New RTUs	2011	1,153						31
32	Fan Coil Units (8)	2011	26,225						32
33	LED Packs Installation (11)	2011	15,324						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,140,064	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	34

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

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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	<b>Totals from Page 12C, Carried Forward</b>		\$ 4,140,064	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	1
2	Replace Flat Roof - Renov. 16-11	2011	86,895						2
3	Electrical for new RTU	2011	5,951						3
4	Carpeting & Frt. for Corridor	2012	12,505						4
5	Fan Coil Units (7)	2012	27,700						5
6	Sewer Access	2012	21,493						6
7									7
8	Painting - 2nd Floor Dining Room	2012	4,499						8
9	Cornices - 2nd Floor	2012	5,573						9
10	A/C for Elevator Room	2012	7,995						10
11	Generator Circuits	2012	12,253						11
12									12
13	Grease Trap Interceptor in Kitchen	2013	2,193						13
14	Fire Sprinkler System 4" backflow preventer	2013	3,996						14
15	Replace cooling tower pipes for chiller	2013	29,644						15
16	Light fixture upgrade - whole building	2013	23,631						16
17	Hot Water Tank 200 gallon	2013	6,536						17
18	Circulation pump for chiller	2013	1,874						18
19	Mixing Valve for proper temperature at Resident Rooms	2013	4,280						19
20	HVAC Fan Coil Units(5) Rms 269, 271, 273, Dining 2nd Flr N.& S.	2013	17,807						20
21	Elevator Door Operators	2013	11,500						21
22	Paint-Dinning, Reception, Receiving Hallway	2013	3,600						22
23	Relocate 1st Flr Nurse Station to Lounge - chart stations, carpet, w	2014	27,918						23
24	Door Security Digital Locks(6)	2014	6,185						24
25	HVAC Fan Coil Units(2) Rm 143 & Riverside Dining Rm	2014	8,460						25
26	HVAC Fan Coil Units(3) Kitchen, 1st Flr East & West	2014	13,320						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,485,872	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	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	<b>Totals from Page 12D, Carried Forward</b>		\$ 4,485,872	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	1
2	Electric Panel - Washing Machine & Dryer	2015	8,377						2
3	HVAC Upgrade - 4 units	2015	12,582						3
4	2.5 Ton Condenser Unit Upgrade - Kitchen	2014	3,240						4
5	Mixing Valve	2014	2,134						5
6	Kitchen Electric Upgrades	2014	3,600						6
7	Kitchen Walls Flooring Upgrade - Dishwasher area	2014	19,750						7
8	Door Security Upgrades	2014	16,070						8
9	Door Security Upgrades	2014	5,709						9
10	PTC Units - Res. Rms (4), Lounge (2)	2014	2,925						10
11	Generator - Refurbish	2014	16,165						11
12	Generator - Switches	2014	14,962						12
13	Generator - Additional Circuits	2014	108,395						13
14	Electric Upgrade - Res. Rms., Nurse Station, Dining, Lounge	2014	103,985						14
15	Fire Sprinkler Upgrade - stairwells	2014	1,116						15
16	Fire Sprinklers - Laundry, Shower Rms., Basement, Dining	2014	2,839						16
17	Chiller Upgrade (proj #1614)	2015	61,195						17
18	Check Valve	2015	2,927						18
19	Paving Repairs	2014	9,320						19
20	Fencing - at property lines 154' x 6'	2014	4,140						20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,885,303	\$ 113,570		\$ 113,570	\$	\$ 3,524,143	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	\$ 1,743,650	\$ 71,015	\$ 71,015	\$		\$ 1,542,516	71
72	Current Year Purchases	52,983						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			7,949	7,949			74
75	TOTALS	\$ 1,796,633	\$ 71,015	\$ 78,964	\$ 7,949		\$ 1,542,516	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)	\$ 6,810,797	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,585	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 192,534	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,949	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,066,659	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	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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: \$ 76,889 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	<b>TOTAL</b>		\$	\$	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 Elgin # 0049692 Report Period Beginning: 06/01/14 Ending: 05/31/15  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	2499	hrs	\$ 107,626		\$	742	2,499	\$ 108,368	1
2	Licensed Speech and Language Development Therapist	10a	1386	hrs	59,693			481	1,386	60,174	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	3007	hrs	129,486			5,854	3,007	135,340	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				179,528		179,528	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>	43,2						28,699		28,699	12
13	Other (specify): <u>X-Ray &amp; Lab</u>	43,3					58,716			58,716	13
14	TOTAL				\$ 296,805		\$ 58,716	\$ 215,304	6,892	\$ 570,825	14

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

Facility Name & ID Number Manorcare of Elgin

# 0049692

Report Period Beginning: 06/01/14

Ending:

05/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 15,224	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>216,881</u> )	886,405		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,926		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 904,555	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	128,860		13
14	Buildings, at Historical Cost	4,885,303		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,796,633		16
17	Accumulated Depreciation (book methods)	(5,066,659)		17
18	Deferred Charges	98,987		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,843,124	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,747,679	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 75,809	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	333,398		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,338		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Payable</u>	75,993		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 519,538	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	935,949		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 935,949	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,455,487	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,292,192	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,747,679	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,335,054	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,335,054	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(524,322)	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)	\$ (524,322)	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	481,460	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 481,460	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,292,192	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		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 6,635,872	1	
2	Discounts and Allowances for all Levels	(2,123,539)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,512,333	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,493,020	6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,493,020	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	211	12	
13	Barber and Beauty Care	8,792	13	
14	Non-Patient Meals	1,731	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	359,098	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services	39,314	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 409,146	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***		25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<u>Activ Inc</u>	50	28	
28a	<u>Purch Disc</u>	17	28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 67	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,414,566	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,085,462	31	
32	Health Care	3,189,009	32	
33	General Administration	1,829,432	33	
<b>B. Capital Expense</b>				
34	Ownership	382,425	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	276,054	35	
36	Provider Participation Fee	176,506	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,938,888	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(524,322)	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (524,322)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,867,815	44
45	Private Pay - Net Inpatient Revenue	273,208	45
46	Medicare - Net Inpatient Revenue	844,102	46
47	Other-(specify) <u>Hospice</u>	280,794	47
48	Other-(specify) <u>Insurance</u>	246,414	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,512,333	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 Elgin

# 0049692

Report Period Beginning:

06/01/14

Ending:

05/31/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,921	2,080	\$ 88,843	\$ 42.71	1
2	Assistant Director of Nursing	3,899	4,221	153,593	36.39	2
3	Registered Nurses	23,893	25,869	819,919	31.70	3
4	Licensed Practical Nurses	11,030	11,942	311,163	26.06	4
5	CNAs & Orderlies	56,910	61,687	808,776	13.11	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	8,796	9,512	409,558	43.06	7
8	Rehab/Therapy Aides	4,645	5,022	147,880	29.45	8
9	Activity Director	5,311	5,756	68,365	11.88	9
10	Activity Assistants					10
11	Social Service Workers	3,814	4,132	112,933	27.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,033	11,913	145,224	12.19	15
16	Dishwashers					16
17	Maintenance Workers	2,393	2,592	62,151	23.98	17
18	Housekeepers	10,604	11,484	146,392	12.75	18
19	Laundry	3,061	3,316	32,980	9.95	19
20	Administrator	2,080	2,080	95,592	45.96	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,244	16,569	335,210	20.23	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	801	867	15,372	17.73	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	165,435	179,042	\$ 3,753,951 *	\$ 20.97	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 15,600	9,3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant		10,1	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)	\$ 15,600		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$	10,3	50
51	Licensed Practical Nurses		10,3	51
52	Certified Nurse Assistants/Aides		10,3	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Manorcare of Elgin

# 0049692

Report Period Beginning: 06/01/14

Ending: 05/31/15

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 \$1898 & AHCA \$1,254
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 49,840 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. \$ 176,506  
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. \$ 1,731
- (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.