FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0049692

Facility Name: Manor Care of Elgin IL, LLC

Address: 180 South State St. (Number) Elgin (City) 60123 (Zip Code)

County: Kane

Telephone Number: 847-742-3310 **Fax #** 847-742-0924

HFS ID Number:

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Raymond Lewis **Telephone Number:** 419-252-5783
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2010 to 05/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,103	966	8,257	27,326	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,103	966	8,257	27,326	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.07%

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)

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 [X]

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

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 [X] Date 04/07/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 88 and days of care provided 5,551

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

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

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

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	256,002	21,515	9,541	287,058	5,678	292,736		292,736			1
2	Food Purchase		206,995		206,995		206,995	(435)	206,560			2
3	Housekeeping	101,852	22,720	6,566	131,138		131,138		131,138			3
4	Laundry	38,346	18,907	3,940	61,193		61,193		61,193			4
5	Heat and Other Utilities			154,491	154,491	1,531	156,022		156,022			5
6	Maintenance	53,844	28,977	97,371	180,192		180,192		180,192			6
7	Other (specify):* Medical Waste			418	418		418		418			7
8	TOTAL General Services	450,044	299,114	272,327	1,021,485	7,209	1,028,694	(435)	1,028,259			8
	B. Health Care and Programs											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	2,211,666	215,201	96,513	2,523,380	6,734	2,530,114		2,530,114			10
10a	Therapy	581,909	8,096	71,875	661,880		661,880		661,880			10a
11	Activities	71,911	6,528	3,492	81,931		81,931		81,931			11
12	Social Services	94,974		1,342	96,316		96,316		96,316			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,960,460	229,825	193,622	3,383,907	6,734	3,390,641		3,390,641			16
	C. General Administration											
17	Administrative	90,678		333,023	423,701	(90,850)	332,851		332,851			17
18	Directors Fees											18
19	Professional Services			28,057	28,057	(182)	27,875	(27,875)				19
20	Dues, Fees, Subscriptions & Promotions			62,914	62,914		62,914	(40,385)	22,529			20
21	Clerical & General Office Expenses	306,834	43,502	145,112	495,448	182	495,630	(84,104)	411,526			21
22	Employee Benefits & Payroll Taxes			640,196	640,196	25,865	666,061		666,061			22
23	Inservice Training & Education			6,868	6,868		6,868		6,868			23
24	Travel and Seminar			4,681	4,681		4,681		4,681			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			243,761	243,761		243,761		243,761			26
27	Other (specify):*											27
28	TOTAL General Administration	397,512	43,502	1,464,612	1,905,626	(64,985)	1,840,641	(152,364)	1,688,277			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,808,016	572,441	1,930,561	6,311,018	(51,042)	6,259,976	(152,799)	6,107,177			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manor Care of Elgin IL, LLC #0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			262,502	262,502	8,967	271,469		271,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,680	10,680	42,075	52,755	(13,041)	39,714			32
33	Real Estate Taxes			36,368	36,368		36,368		36,368			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,072	20,072		20,072		20,072			35
36	Other (specify):*											36
37	**TOTAL Ownership**			329,622	329,622	51,042	380,664	(13,041)	367,623			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		214,116		214,116		214,116		214,116			39
40	Barber and Beauty Shops			6,522	6,522		6,522		6,522			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):* **IV, Xray, Lab**		31,753	55,280	87,033		87,033		87,033			43
44	**TOTAL Special Cost Centers**		245,869	109,982	355,851		355,851		355,851			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,808,016	818,310	2,370,165	6,996,491		6,996,491	(165,840)	6,830,651			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 Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(435)	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	(36)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(27,875)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(83,063)	21		24
25	Fund Raising, Advertising and Promotional	(40,385)	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	(13,046)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (165,840)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (165,840)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manor Care of Elgin IL, LLC

ID# 0049692

Report Period Beginning: 06/01/2010

Ending: 05/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	HCP Lease Interest Expense	$ (13,041)	32	1
2	Misc Inc	(5)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,046)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 **Report Period Beginning:** 06/01/2010 **Ending:** 05/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(435)	0	0	0	0	0	0	0	0	0	0	(435)	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**	(435)	0	0	0	0	0	0	0	0	0	0	(435)	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	(27,875)	0	0	0	0	0	0	0	0	0	0	(27,875)	19
20	Fees, Subscriptions & Promotions	(40,385)	0	0	0	0	0	0	0	0	0	0	(40,385)	20
21	Clerical & General Office Expenses	(84,104)	0	0	0	0	0	0	0	0	0	0	(84,104)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(152,364)	0	0	0	0	0	0	0	0	0	0	(152,364)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(152,799)	0	0	0	0	0	0	0	0	0	0	(152,799)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 **Report Period Beginning:** 06/01/2010 **Ending:** 05/31/2011

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

	Capital Expense D. Ownership	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)	
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	(13,041)	0	0	0	0	0	0	0	0	0	0	(13,041)	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**	(13,041)	0	0	0	0	0	0	0	0	0	0	(13,041)	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(165,840)	0	0	0	0	0	0	0	0	0	0	(165,840)	45

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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 Svcs	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 PG6-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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 333,023	HCR Manor Care Services, LLC	100.00%	$ 333,023	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,808,016	Heartland Employment Services, LLC	100.00%	3,808,016		4
5	V	10a	Therapy Management	3,857	Heartland Rehabilitation Services, LLC	100.00%	3,857		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			$ 4,144,896			$ 4,144,896	$ *	14

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

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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								30

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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 Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 5/31/2011

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	$ 2,652,139	$ 1,448,591	6,245,004	$ 5,677	1
2	1	Dietary - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs	0	0	6,245,004	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	0	0	6,245,004	0	3
4	5	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	0	0	6,245,004	0	4
5	5	Dietary - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs	0	0	6,245,004	0	5
6	5	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551	0	6,245,004	1,531	6
7	10	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	6,245,004	5,780	7
8	10	Dietary - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs	0	0	6,245,004	0	8
9	10	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	6,245,004	955	9
10	17	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	6,245,004	52,963	10
11	17	Dietary - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs	1,871,124	5,027,701	6,245,004	16,870	11
12	17	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	6,245,004	172,341	12
13	22	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	6,245,004	15,607	13
14	22	Dietary - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs	0	0	6,245,004	0	14
15	22	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146	0	6,245,004	10,258	15
16	30	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954	0	6,245,004	612	16
17	30	Dietary - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs	0	0	6,245,004	0	17
18	30	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801	0	6,245,004	8,355	18
19										19
20	32	Directly Assigned Interest							42,075	20
21		Non Central Division Nursing Home Allocations							(1)	21
22										22
23										23
24										24
25	TOTALS					$ 142,861,719	$ 62,809,840		$ 333,023	25

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv Sub Debentures		X	Facility			$ 935,949	$ 935,949		0.0452	$ 42,075	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income Other										(2,361)	8
9	TOTAL Facility Related						$ 935,949	$ 935,949			$ 39,714	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 935,949	$ 935,949			$ 39,714	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 Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 31,719	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.)		$ 35,226	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,507	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 32,861	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 36,368	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	33,849	8
	2007	32,307	9
	2008	32,691	10
	2009	34,602	11
	2010	35,849	12

Line 2: $35,226 = 17,301 2nd half 2009 paid Aug 2010 + $17,925 for 1st half 2010 paid May 2011

Line 4: $32,861 = 17,924 for 2nd half 2010 (payable in Dec 2011) + 14,937 for estimate for Jan-May 2011

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Care of Elgin IL, LLC COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0049692

CONTACT PERSON REGARDING THIS REPORT Raymond Lewis

TELEPHONE 419-252-5783 FAX #: 419-254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-14-476-028	See Attached	$ 35,848.96	$ 35,848.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,848.96	$ 35,848.96

B. **Real Estate Tax Cost Allocations**

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1967	$ 107,499	1
2			2003	21,361	2
3	TOTALS			$ 128,860	3

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	73		1967	1965	$ 562,637	$ 50,879		$ 50,879	$	$ 1,056,718	4
5	7			1991	325,282						5
6	8			2003	686,404						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					93,318		93,318		2,010,634	9
10				1987	11,654						10
11				1988	164,890						11
12				1989	26,729						12
13				1990	64,209						13
14				1991	99,431						14
15				1992	69,948						15
16				1993	62,901						16
17				1994	59,739						17
18				1995	141,422						18
19				1996	111,267						19
20				1997	103,146						20
21				1998	338,111						21
22				1999	37,350						22
23				2000	98,791						23
24				2001	70,110						24
25				2002	75,611						25
26	WINDOW TREATMENTS			2003	2,265						26
27	COVE BASE			2003	3,086						27
28	RISER PIPE REPLACEMENT			2003	94,382						28
29	15 DOORS for resident rooma (1 of 3 pymts.)			2003	10,500						29
30	PAINTING, BORDER, VCT FLO			2003	1,010						30
31	VWC			2003	771						31
32	VWC			2003	545						32
33	VWC			2003	152						33
34	PAINTING AND BORDER			2003	463						34
35	PAINTING AND BORDER			2003	5,887						35
36				2003	399						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	15 DOORS for resident rooma (2 of 3 pymts.)	2003	$ 7,790	$		$	$	$	37
38	LAUNDRY ROOM DOORS	2003	4,266						38
39	NEW ADDITION - Updated for audit	2003	127,111						39
40	NEW ADDITION - Carpet & wallcovering	2003	9,623						40
41	NEW ADDITION - Millwork	2003	2,359						41
42	VWC, FLOORING, PAINTING	2003	15,124						42
43	VINYL CEILING & PAINTING	2003	6,274						43
44	ADJUST ASSETS 1583 & 1598 CARPET - per audit S/B 2002	2003							44
45	PAINTING AND BORDER	2003	5,887						45
46	15 DOORS for resident rooma (3 of 3 pymts.)	2003	2,312						46
47	TRIM HANDLE (COURTYARD DOOR)	2003	428						47
48	DOORS	2003	2,650						48
49	NEW ADDITION - Soil & concrete testing	2003	5,445						49
50	NEW ADDITION - Site preperation Per audit include w/Bldg.	2003							50
51	OUTSIDE LIGHT	2003	1,782						51
52	EXTERIOR DOORS (1 of 3 pymts)	2003	3,000						52
53	EXTERIOR DOORS (2 of 3 pymts)	2004	2,000						53
54	EXTERIOR DOORS (3 of 3 pymts)	2004	680						54
55	DOORS AND KICKPLATES	2004	30,571						55
56	WALLCOVERING	2004	869						56
57	FLUORESCENT LIGHIT 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	$ 144,197		$ 144,197	$	$ 3,067,352	70

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

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,571,554	$ 144,197		$ 144,197	$	$ 3,067,352	1
2	Overhead & Interest on Renov.	2006	3,122						2
3	Renov. - Concrete Work - Landings, Ramps, & Handrail	2006	24,850						3
4	Renov. - Doors & Frames	2006	35,440						4
5	Renov. - Electrical Work	2006	1,347						5
6	Door at 1st floor Stairwell	2006	1,400						6
7	Flooring	2006	5,090						7
8	Door and Frame	2006	4,235						8
9	Panic hardware on new doors per Life Saftey Survey	2007	3,220						9
10	FENCE	2007	5,600						10
11	PAVING	2007	3,240						11
12	DRAINAGE IN PARKING LOT	2007	39,440						12
13	CARPET	2007	4,315						13
14	SECOND FLOOR DINING RM DO	2007	5,654						14
15	carpet	2007	1,659						15
16	FLOORING ON FIRST FLOOR	2007	7,830						16
17	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	33,377						22
23	000000001856 DRYWALL AND PAINT	2008	2,969						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	TOTAL (lines 1 thru 33)		$ 3,855,550	$ 144,197		$ 144,197	$	$ 3,067,352	34

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

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,855,550	$ 144,197		$ 144,197	$	$ 3,067,352	1
2	000000001861 patio sidewalk	2008	1,740						2
3	000000001862 upgrade delivery entrance	2008	2,160						3
4	000000001870 100 FT FENCE	2008	5,475						4
5	000000001876 ELGIN ENTR SIDEWALK	2008	1,485						5
6	000000001883 CONCRETE SIDEWALK	2008	1,740						6
7	000000001884 PAVING / SEALCOATING	2008	2,160						7
8	1893 HM door	2009	5,725						8
9	1895 WEG cooling tower moter	2009	3,830						9
10	1898 Painting of Basement	2009	2,063						10
11	1899 Painting of Basement	2009	6,585						11
12	1900 Dishwasher area flooring	2009	5,344						12
13	1901 Carpeting & Installation	2009	11,349						13
14	1903 0409 Lobby, Corridor, Admin floor tile	2009	4,085						14
15	1907 0409 Lobby, Corridor front door	2009	6,142						15
16	1902 0409 Lobby, Corridor, Admin floor tile	2009	11,814						16
17	1909 1309 Replace underground Electrical Service	2010	38,471						17
18	1910 0310 2nd floor Nurse station	2010	1,075						18
19	1912 0310 2nd floor Nurse Station, Elect, Walls,Cabin,floor	2010	37,488						19
20	1896 Southside paving of parking lot	2009	10,830						20
21	1918 Painting	2010	4,743						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,019,854	$ 144,197		$ 144,197	$	$ 3,067,352	34

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

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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	$ 1,413,644	$	$	$		$	71
72	Current Year Purchases	151,907	118,305	118,305			1,172,150	72
73	Fully Depreciated Assets							73
74	Home Office			8,967	8,967			74
75	TOTALS	$ 1,565,551	$ 118,305	$ 127,272	$ 8,967		$ 1,172,150	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)	$ 5,714,265	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 262,502	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 271,469	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,967	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,239,502	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 Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

STATE OF ILLINOIS

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1943	hrs	$ 80,615	61	$ 3,973	$ 697	2,004	$ 85,285	1
2	Licensed Speech and Language Development Therapist	10a	1986	hrs	62,600	7	438		1,993	63,038	2
3	Licensed Recreational Therapist	10a		hrs		689	44,620		689	44,620	3
4	Licensed Physical Therapist	10a	4322	hrs	197,241	27	1,726	7,399	4,349	206,366	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts				214,116		214,116	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy						8,740	31,753		40,493	12
13	Other (specify): Xray, Lab						55,280			55,280	13
14	TOTAL				$ 340,456	784	$ 114,777	$ 253,965	9,035	$ 709,198	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.

STATE OF ILLINOIS

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/2011 (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	$ 8,613	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 313,381)	699,103		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,692		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 710,408	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	128,860		13
14	Buildings, at Historical Cost	4,019,851		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,565,551		16
17	Accumulated Depreciation (book methods)	(4,239,502)		17
18	Deferred Charges	301,614		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): CIP	32,334		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,808,708	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,519,116	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 121,687	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,995		30
31	Accrued Taxes Payable (excluding real estate taxes)	64,936		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,861		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	41,102		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 576,581	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,937,740		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	6,012		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,943,752	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,520,333	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,217)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,519,116	$	48

***(See instructions.)**

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 **Report Period Beginning:** 06/01/2010 **Ending:** 05/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 704,415	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 704,415	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(648,119)	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)**	$ (648,119)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(57,513)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (57,513)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,217)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,317,277	1
2	Discounts and Allowances for all Levels	(1,466,490)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,850,787	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,240,755	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,240,755	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		12
13	Barber and Beauty Care	6,465	13
14	Non-Patient Meals	435	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	222,458	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	27,467	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 256,825	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	Other income	5	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,348,372	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,021,485	31
32	Health Care	3,383,907	32
33	General Administration	1,905,626	33
	B. Capital Expense		
34	Ownership	329,622	34
	C. Ancillary Expense		
35	Special Cost Centers	307,671	35
36	Provider Participation Fee	48,180	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,996,491	40
41	**Income before Income Taxes (line 30 minus line 40)****	(648,119)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (648,119)	43

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

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

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

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

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,970	2,125	$ 84,257	$ 39.65	1
2	Assistant Director of Nursing	3,575	3,855	140,544	36.46	2
3	Registered Nurses	23,622	25,477	767,292	30.12	3
4	Licensed Practical Nurses	12,974	13,994	348,952	24.94	4
5	CNAs & Orderlies	61,151	66,014	853,207	12.92	5
6	CNA Trainees					6
7	Licensed Therapist	8,659	9,336	384,914	41.23	7
8	Rehab/Therapy Aides	6,539	7,050	196,995	27.94	8
9	Activity Director	6,059	6,537	71,911	11.00	9
10	Activity Assistants					10
11	Social Service Workers	3,780	4,078	94,974	23.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,333	20,866	256,002	12.27	15
16	Dishwashers					16
17	Maintenance Workers	2,224	2,399	53,844	22.44	17
18	Housekeepers	8,709	9,398	101,852	10.84	18
19	Laundry	3,487	3,760	38,346	10.20	19
20	Administrator	2,080	2,080	90,678	43.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,067	18,454	306,834	16.63	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	955	1,029	17,414	16.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,184	196,452	$ 3,808,016 *	$ 19.38	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	20,400	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)		$ 20,400		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pamela Crenshaw	Administrator	0	$ 90,678
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,678

B. Administrative - Other

Description	Amount
Various Home Office Services	$ 333,023
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 333,023

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, & Flowers, LLC	Legal Fees	$ 6,784
Littler Mendelson, PC	Legal Fees	5,087
Kalland Law Office	Legal Fees	8,906
Michigan Peer Review Org	Legal Fees	3,510
United Collections Bureau, Inc.	Collection Services	3,588
(All above are adjusted off via page 5, Line 22, therefore no invoices attached)		
The Weissman Group	HR/Union Consultant	182
(Reclassed to Line 21, therefore no invoices attached)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 28,057

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,613
Unemployment Compensation Insurance	43,567
FICA Taxes	272,989
Employee Health Insurance	257,111
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	38,377
Appreciation & Other Emp Benefits	6,162
Home Office Allocation	25,865
Tuition Program	321
Employee Uniform	3,056
TOTAL (agree to Schedule V, line 22, col.8)	$ 666,061

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,445
Advertising: Employee Recruitment	7,655
Health Care Worker Background Check	4,139
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	1,230
Associaton Dues	8,912
Advertising	34,533
Less: Non-allowable Association Dues	(5,852)
Less: Public Relations Expense	( )
Non-allowable advertising	(34,533)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,529

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Includes travel expense to the Home	4,681
Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,681

**See instructions.

Facility Name & ID Number Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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	Amount of Expense Amortized Per Year								
					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 Manor Care of Elgin IL, LLC # 0049692 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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 $3060**

(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, $5852**

(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. $ **56,979** Line **10,2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **Yes**
If YES, give effective date of lease. **04/07/2011**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **48,180**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **435**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.