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: 0049411

Facility Name: Manor Care of Libertyville IL, LLC

Address: 1500 W. Milwaukee Avenue (Number) Libertyville (City) 60048 (Zip Code)

County: Lake

Telephone Number: 708-816-3200 **Fax #** 708-816-8981

HFS ID Number:

Date of Initial License for Current Owners: 02/02/88

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 06/01/10 to 05/31/11 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 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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,993	3,370	20,699	41,062	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,993	3,370	20,699	41,062	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.00%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 02/23/88

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 150 and days of care provided 15,520

Medicare Intermediary Highmark Medicare Service

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: 05/31

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	395,598	26,326	8,235	430,159	10,441	440,600		440,600			1
2	Food Purchase		294,162		294,162		294,162	(525)	293,637			2
3	Housekeeping	146,814	24,258	259	171,331		171,331		171,331			3
4	Laundry	45,266	29,324	2,175	76,765		76,765		76,765			4
5	Heat and Other Utilities			204,103	204,103	2,815	206,918		206,918			5
6	Maintenance	45,280	23,081	115,556	183,917		183,917		183,917			6
7	Other (specify):* **Medical Waste**			1,544	1,544		1,544		1,544			7
8	**TOTAL General Services**	632,958	397,151	331,872	1,361,981	13,256	1,375,237	(525)	1,374,712			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	3,309,253	336,499	259,317	3,905,069	12,384	3,917,453		3,917,453			10
10a	Therapy	1,424,545	18,322	189,984	1,632,851		1,632,851		1,632,851			10a
11	Activities	87,370	3,347	5,143	95,860		95,860		95,860			11
12	Social Services	175,841		232	176,073		176,073		176,073			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,997,009	358,168	476,276	5,831,453	12,384	5,843,837		5,843,837			16
	C. General Administration											
17	Administrative	104,056		710,138	814,194	(264,798)	549,396		549,396			17
18	Directors Fees											18
19	Professional Services			24,804	24,804	(847)	23,957	(23,957)				19
20	Dues, Fees, Subscriptions & Promotions			155,900	155,900		155,900	(63,230)	92,670			20
21	Clerical & General Office Expenses	597,519	48,472	488,948	1,134,939	847	1,135,786	(446,959)	688,827			21
22	Employee Benefits & Payroll Taxes			1,228,126	1,228,126	47,563	1,275,689		1,275,689			22
23	Inservice Training & Education			421	421		421		421			23
24	Travel and Seminar			11,723	11,723		11,723		11,723			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			429,581	429,581		429,581		429,581			26
27	Other (specify):*											27
28	**TOTAL General Administration**	701,575	48,472	3,049,641	3,799,688	(217,235)	3,582,453	(534,146)	3,048,307			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,331,542	803,791	3,857,789	10,993,122	(191,595)	10,801,527	(534,671)	10,266,856			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 Libertyville IL, LLC #0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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			430,383	430,383	16,490	446,873		446,873			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			206,846	206,846	175,105	381,951	(210,422)	171,529			32
33	Real Estate Taxes			138,501	138,501		138,501		138,501			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			111,014	111,014		111,014		111,014			35
36	Other (specify):*											36
37	TOTAL Ownership			886,744	886,744	191,595	1,078,339	(210,422)	867,917			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		679,930		679,930		679,930		679,930			39
40	Barber and Beauty Shops			19,444	19,444		19,444		19,444			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* IV, Xray, Lab		168,827	123,361	292,188		292,188		292,188			43
44	TOTAL Special Cost Centers		848,757	224,930	1,073,687		1,073,687		1,073,687			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,331,542	1,652,548	4,969,463	12,953,553		12,953,553	(745,093)	12,208,460			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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	(525)	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	(120)	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	(1,230)	21		18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,957)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(392,153)	21		24
25	Fund Raising, Advertising and Promotional	(63,230)	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	(262,878)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (745,093)		$	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))**	$ (745,093)		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

STATE OF ILLINOIS

Manor Care of Libertyville IL, LLC

ID# 0049411

Report Period Beginning: 06/01/10

Ending: 05/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Wage - Marketing	$ (39,628)	21	1
2	Employee Benefits - Marketing	(11,726)	21	2
3	HCP Lease Interest Expense	(210,422)	32	3
4	Vending Income	(1,102)	21	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**	(262,878)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 **Report Period Beginning:** 06/01/10 **Ending:** 05/31/11

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	(525)	0	0	0	0	0	0	0	0	0	0	(525)	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**	(525)	0	0	0	0	0	0	0	0	0	0	(525)	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	(23,957)	0	0	0	0	0	0	0	0	0	0	(23,957)	19
20	Fees, Subscriptions & Promotions	(63,230)	0	0	0	0	0	0	0	0	0	0	(63,230)	20
21	Clerical & General Office Expenses	(446,959)	0	0	0	0	0	0	0	0	0	0	(446,959)	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**	(534,146)	0	0	0	0	0	0	0	0	0	0	(534,146)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(534,671)	0	0	0	0	0	0	0	0	0	0	(534,671)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 **Report Period Beginning:** 06/01/10 **Ending:** 05/31/11

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	(210,422)	0	0	0	0	0	0	0	0	0	0	(210,422)	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**	(210,422)	0	0	0	0	0	0	0	0	0	0	(210,422)	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)**	(745,093)	0	0	0	0	0	0	0	0	0	0	(745,093)	45

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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

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	$ 710,138	HCR Manor Care Services, LLC	100.00%	$ 710,138	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,331,542	Heartland Employment Services, LLC	100.00%	6,331,542		4
5	V	10a	Therapy Management	11,999	Heartland Rehabilitation Services, LLC	100.00%	11,999		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			$ 7,053,679			$ 7,053,679	$ *	14

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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 Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				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 South Holland IL, LLC	South Holland				30

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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								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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	11,484,132	$ 10,441	1
2	1	Dietary - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs			11,484,132	0	2
3	1	Direct - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs,			11,484,132	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs			11,484,132	0	4
5	5	Utilities - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs			11,484,132	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs,	817,551		11,484,132	2,815	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	11,484,132	10,628	7
8	10	Nursing - Direct to Central Divisio	Accumulated Cost	692,663,974	92 NFs			11,484,132	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs,	510,057	376,446	11,484,132	1,756	9
10	17	General & Admin - Direct to All S	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	11,484,132	97,395	10
11	17	General & Admin - Direct Cen Div	Accumulated Cost	692,663,974	92 NFs	1,871,124	5,027,701	11,484,132	31,023	11
12	17	General & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs,	92,052,254	34,999,867	11,484,132	316,923	12
13	22	Employee Benefits - Direct to All S	Accumulated Cost	2,917,243,659	353 NFs	7,290,309		11,484,132	28,699	13
14	22	Employee Benefits - Direct Centra	Accumulated Cost	692,663,974	92 NFs			11,484,132	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs,	5,479,146		11,484,132	18,864	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954		11,484,132	1,126	16
17	30	Depreciation - Direct Central Divi	Accumulated Cost	692,663,974	92 NFs			11,484,132	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs,	4,462,801		11,484,132	15,365	18
19										19
20	32	Interest				12,736,052			175,105	20
21		Non-Nursing Home Allocations				29,513,406			(2)	21
22										22
23										23
24										24
25	TOTALS					$ 185,111,177	$ 62,809,840		$ 710,138	25

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv Sub Debentures		X	Facility			$ 3,895,128	$ 3,895,128		0.0452	$ 175,105	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income Other										(3,576)	8
9	TOTAL Facility Related						$ 3,895,128	$ 3,895,128			$ 171,529	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,895,128	$ 3,895,128			$ 171,529	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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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.**	$ 114,277	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.)		$ 129,549	2
3. Under or (over) accrual (line 2 minus line 1).		$ 15,272	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 123,229	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.		$ 138,501	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	114,218	8
	2007	114,392	9
	2008	119,948	10
	2009	124,666	11
	2010	134,432	12

Line 2: $129549 = $62333 for 2nd half of '09 paid in Aug 10 + $67216 for 1st half '10 paid in May 11

Line4: $123229 = $67216 for 2nd half '10 payable in Sep 11 + $56013 for estimate of 1st half of 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 Libertyville IL, LLC COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0049411

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.	11-28-401-003	See attached	$ 134,431.98	$ 134,431.98
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 134,431.98	$ 134,431.98

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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

X. BUILDING AND GENERAL INFORMATION:

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

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		1988	$ 476,076	1
2					2
3	TOTALS			$ 476,076	3

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	150			1988	$ 4,592,131	$ 117,249		$ 117,249	$	$ 2,632,040	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements current year Depreciation										9
10				1988	68,073	136,898		136,898		2,371,951	10
11				1989	52,434						11
12				1990	30,247						12
13				1991	67,316						13
14				1992	175,480						14
15	RETIREMENTS			1992	(10,437)						15
16				1993	55,746						16
17				1994	135,262						17
18				1995	66,532						18
19	FLOOR VINYL/TILE & INSTALLATION			1996	31,353						19
20	CAPITALIZED LABOR-NURSES STATION RENOV			1996	7,272						20
21	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR			1996	(7,272)						21
22	WALL VINYL/SIGNS			1996	5,576						22
23	CARPET			1996	4,210						23
24	INNER CAMERA MONITOR			1996	4,177						24
25	SIDING			1996	2,205						25
26	REPAIR LOOSE BRICKS			1996	2,183						26
27	NURSES STATION RENOVATION			1996	11,271						27
28	DOOR RELEASE			1996	2,071						28
29	REMODELING			1996	1,129						29
30	WATER HEATER			1996	5,313						30
31	CARPER/INSTALLATION			1996	2,991						31
32	FLOORING/TILE			1996	23,312						32
33	DOOR FRAME/GUARDS			1996	4,941						33
34	KITCHEN CEILING TILE			1996	3,638						34
35	WALLCOVERING			1996	4,964						35
36	ELECTRICAL/LIGHTING			1996	3,055						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	CABINETRY	1996	$ 5,880	$		$	$	$	37
38	REBUILD NURSES STATION	1996	8,500						38
39	INSTALL SWING DOORS	1996	8,826						39
40	INSTALL BALLUSTER POSTS	1996	2,500						40
41	FLOOR COVING	1996	7,791						41
42	BRICK PIER/CONCRETE SIDEWALK	1996	3,880						42
43	INSTALL BOULDER EDGE	1996	4,830						43
44	NURSES STATION RENOVATIONS	1996	1,506						44
45	WALLVINYL	1997	18,304						45
46	CARPETING	1997	1,624						46
47	DECORATING	1997	45,045						47
48	BRICK PIER	1997	1,500						48
49	EXTERIOR ENTRY DOORS	1997	3,317						49
50	PAINTING	1997	7,449						50
51	INSTALL CONDENSING COILS	1997	2,583						51
52	LANDSCAPE	1997	59,118						52
53	CURBING/ASPHALT	1997	30,000						53
54	ROOFING	1997	1,536						54
55	CORPORATE OVERHEAD-PARKING LOT	1997	10,516						55
56	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)						56
57	PARKING LOT WORK	1997	25,000						57
58	FACILITY PLAN ALLOC	1997	5,964						58
59	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)						59
60	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)						60
61	ELEVATOR REPAIRS	1997	5,018						61
62	SECURITY SYSTEM	1997	16,954						62
63	NEW EXHAUSTERS	1997	6,310						63
64	BUILD & INSTALL CABINETS	1997	6,512						64
65	CARPET	1997	5,148						65
66	LANDSCAPE	1997	25,279						66
67	CURB/ASPHALT	1997	45,210						67
68	INSTALL CEDAR FENCE	1997	2,750						68
69	DRUM SLUDGE REMOVAL	1997	2,563						69
70	TOTAL (lines 4 thru 69)		$ 5,700,105	$ 254,147		$ 254,147	$	$ 5,003,991	70

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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		$ 5,700,105	$ 254,147		$ 254,147	$	$ 5,003,991	1
2	INSTALL OIL TANK	1997	11,780						2
3	FLOORING/CEILING	1998	1,115						3
4	CARPETING	1998	2,574						4
5	ARCHITECT/PROFESSIONAL FEES-ADMIN OFFICE	1998	3,685						5
6	PAINTING/WALLPAPER	1998	10,125						6
7	RENOVATE ADMIN OFFICE	1998	2,533						7
8	ENERGY AUDITS	1998	1,875						8
9	GENERAL CONTRACTOR FEES-ADMIN OFFICE	1998	4,165						9
10	CORPORATE OVERHEAD-ADMIN OFFICE	1998	1,651						10
11	C/R 5/31/99 AUDIT ADJ - MONTHLY CAP BUDGET	1998	(1,651)						11
12	INSTALL FENCE/GAZEBO	1998	2,153						12
13	PAINTING/WALLCOVERING	1998	5,821						13
14	PLUMBING	1998	5,250						14
15	ELECTRICAL	1998	8,883						15
16	DEVELOPERS-ADMIN OFFICE	1998	5,555						16
17	SIGN	1998	11,862						17
18	ROOFING	1998	5,520						18
19	MASONARY	1998	4,766						19
20	CARPENTRY	1998	3,137						20
21	PAINTING/WALLCOVERING	1999	6,873						21
22	ELECTRICAL	1999	6,590						22
23	FLOORING/CEILING	1999	8,230						23
24	CARPENTRY	1999	12,373						24
25	MILLWORK	1999	540						25
26	FINISH STUDS	1999	20,000						26
27	PAVING	1999	35,325						27
28	CARPET FOR BUILDING	1999	11,611						28
29	WINDOW TREATMENTS	1999	10,291						29
30	KNOBLOCKS, CYPHER	1999	1,448						30
31	CARPET, CREDIT	1999	(13,990)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,890,195	$ 254,147		$ 254,147	$	$ 5,003,991	34

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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		$ 5,890,195	$ 254,147		$ 254,147	$	$ 5,003,991	1
2	SALES TAX, CARPET	1999	71						2
3	CARPET	1999	148						3
4	DOOR FRAME FOR BOILER ROOM	1999	2,550						4
5	ELECTRICAL CIRCUITS, HEATER	1999	5,937						5
6	PTAC UNITS	1999	2,920						6
7	DOOR, HARDWARE, & STAIN	2000	1,025						7
8	ADDTL COST GARAGE	2000	1,671						8
9	SECURE CARE SYS 2ND FL STAIRWELL	2000	3,147						9
10	DOOR - SOUTH CORRIDOR EXIT	2000	2,440						10
11	PANIC DEVICE - EXTERIOR DOOR	2000	760						11
12	2 A/C UNITS	2000	1,156						12
13	GARAGE	2000	21,256						13
14	LANDSCAPING	2000	2,675						14
15	LANDSCAPING - ARBORIVITAE	2000	3,784						15
16	GARAGE	2000	19,209						16
17	GARAGE	2000	5,556						17
18	BOILER	2001	4,525						18
19	FIRE WALL IN ATTIC	2001	7,422						19
20	A/C UNIT	2001	597						20
21	4 A/C UNITS	2001	2,680						21
22	WORKCOUNTER & CABINETS	2001	2,219						22
23	GATES	2001	4,760						23
24	ELECTRICAL CIRCUITS	2001	1,279						24
25	ARCADIA CORRIDORS & LOUNGE (See Line 32)	2001	132,623						25
26	ARCADIA CORRIDORS & LOUNGE	2001	5,666						26
27	ARCADIA CORRIDORS & LOUNGE (See Line 32)	2001	124,865						27
28	ARCADIA CORRIDORS & LOUNGE	2001	20,483						28
29	ARCADIA CORRIDORS & LOUNGE	2001	181,656						29
30	CARPENTRY, DOORS, ELECT.	2001	52,344						30
31	VWC, CORNER GUARDS	2001	10,041						31
32	Per 7/06 Cap. Rate Audit Adjustments	2001	(122,832)						32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,392,829	$ 254,147		$ 254,147	$	$ 5,003,991	34

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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 12C, Carried Forward		$ 6,392,829	$ 254,147		$ 254,147	$	$ 5,003,991	1
2	Invoice #13216 Per 7/06 Cap Rate Audit Adj.	2002	21,952						2
3	Invoice #13233 Pre 7/16 Cap Rate Audit Adj.	2002	24,155						3
4	Per 7/06 Cap Rate Audit Adj. Move (See Lines 2 & 3)	2003	(46,107)						4
5									5
6	DINING ROOM & BREAKROOM	2003	21,720						6
7	RETROACTIVE ADDITION	2003	(588)						7
8	ARCH&ENGINEER COSTS, PLANS REVIEWS	2003	16,667						8
9	GENERAL OVERHEAD & INTEREST	2003	33,439						9
10	GENERAL OH & INT Pr 7/06 Cap Rate Audit Adj.	2003	(33,439)						10
11	CARPETING & PADS, WALLCOVERINGS	2003	74,310						11
12	CARPENTRY & MILLWORK	2003	5,750						12
13	HVAC & ELECTRICIAL WORK	2003	30,572						13
14	HM DOORS & FRAMES	2003	3,662						14
15	WARDROBES	2004	11,000						15
16	FLOORING	2004	761						16
17	GENERAL OVERHEAD & INTEREST (See Line 18)	2004	32,935						17
18	Gen OH & Int Per 7/06 Cap Rate Audit Adj.	2004	(32,935)						18
19	SOWER ROOM RENOVATION	2004	3,000						19
20	Building décor/3 yrs Ta (See Line 21)	2004	21						20
21	Building décor/3 yrs Ta Per Cap Rate Audit Adjs.	2004	(21)						21
22	VWC	2004	252						22
23	SECOND FLOORING	2004	13,500						23
24	FRP FIRE WALL	2004	2,941						24
25	WINDOWS	2004	18,532						25
26	PAINTING EXTERIOR	2004	13,667						26
27	SHOWER ROOM RENOVATION	2004	3,800						27
28	ADD'L FLOORING	2004	1,238						28
29	SHOWER ROOM RENOVATION RE	2004	690						29
30	VWC	2004	83						30
31	INSTALL CARPET	2004	4,364						31
32	Per 7/06 Cap Rate Audit Adj.	2004	43,112						32
33	Per 7/06 Cap Rate Audit Adj.	2004	5,300						33
34	TOTAL (lines 1 thru 33)		$ 6,667,162	$ 254,147		$ 254,147	$	$ 5,003,991	34

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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 12D, Carried Forward		$ 6,667,162	$ 254,147		$ 254,147	$	$ 5,003,991	1
2	INSTALL VCT FLOORING	2005	3,436						2
3	Renov -Lobby Finishes	2005	1,680						3
4	Renov -Custom Casework (See Line 29)	2005	16,000						4
5	Renov -Carpeting & Pads & Guards & WC	2005	26,679						5
6	Renov -General Overhead & Interest (See Line 19)	2005	6,015						6
7	Stainles Steel Flashing	2005	20,000						7
8	Linen&Bathroom doors	2005	2,482						8
9	Renov -Roof Covering	2005	101,050						9
10	Renov -General Overhead (See Line 30)	2005	4,327						10
11	Renov -Interest on Construction (See Line 30)	2005	546						11
12	VWC	2005	4,168						12
13	Stainless steel flashing	2005	15,440						13
14	Bathroom Exhaust fans	2005	4,426						14
15	Carpet	2005	1,648						15
16	Renov -Drywall/Studs	2005	1,430						16
17	Renov -Resilient Flooring	2005	16,153						17
18	Renov -General Overhead & Interest (See Line 31)	2005	866						18
19	Adj. out OH & Int Per 7/06 Cap Rate Audit Adjs.	2005	(6,015)						19
20	To 2004 Per 7/06 Cap Rate Audit Adjs.	2005	(28,179)						20
21	Adj. out OH & Int Per 7/06 Cap Rate Audit Adjs.	2005	(5,670)						21
22	RENOVATION/ 440 018 04C (See Line 21)	2005	25,904						22
23	RENOVATION/ 440 018 04C (See Line 20)	2005	27,234						23
24	RENOVATION/ 440 018 04C (See Line 20)	2005	945						24
25	FLOORING	2005	1,636						25
26	INSTALL DOORS	2005	6,480						26
27	2 LIGHT FIXTURES	2005	1,650						27
28	INSTALL SMOKE WALL & SIDE	2005	10,129						28
29	Per 7/06 Cap Rate Audit Adjs.	2005	(5,000)						29
30	Per 7/06 Cap Rate Audit Adjs.	2005	(4,873)						30
31	Per 7/06 Cap Rate Audit Adjs.	2005	(866)						31
32	Per 7/06 Cap Rate Audit Adjs.	2005	(20,234)						32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,896,649	$ 254,147		$ 254,147	$	$ 5,003,991	34

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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 12E, Carried Forward		$ 6,896,649	$ 254,147		$ 254,147	$	$ 5,003,991	1
2	KVA TRANSFORMER	2006	2,838						2
3	21 doors	2006	37,670						3
4	sheet vinyl & ceramic flo	2006	4,074						4
5	metsl doors	2006	3,317						5
6	electrical	2006	827						6
7	DOORS ON KITCHEN	2007	14,124						7
8	DOORS ON 3RD & 2ND FLOOR	2007	5,940						8
9	Renov - Carpentry	2007	29,850						9
10	Renov - Doors/Frames/Drywall/Studs/Plumbing	2007	14,674						10
11	Renov - Resilient Flooring	2007	79,144						11
12	Renov - Carpeting & ads	2007	19,746						12
13	Renov - Fire Sprinkler	2007	3,752						13
14	Renov - Basic Electric	2007	21,558						14
15	Renov - 'Interest on Construction	2007	1,493						15
16	Renov - General Overhead	2007	20,811						16
17	Fire Rated Doors	2007	22,384						17
18	000000001811Concrete Sidewalk	2008	2,862						18
19	000000001815 Seal Parking Lot	2008	8,031						19
20	000000001821 Asphalt	2008	1,706						20
21	000000001809 Fire Proofing	2008	8,820						21
22	000000001810 Kitchen Make Air	2008	4,903						22
23	000000001812 30 amp 277 volt Circuit	2008	5,238						23
24	000000001813 0208 Door Alarm System	2008	1,382						24
25	000000001834 Ceramic Tile in 4 Showers	2008	22,440						25
26	000000001835 Elevator Switches	2008	4,757						26
27	000000001839 Added Sprinklers	2009	9,700						27
28	000000001840 2208 Water Heaters	2009	7,056						28
29	000000001841 2208 Water Heaters	2009	48,816						29
30	000000001844 0908 Rms & Bthrms Gen Overhead & Interest	2009	41,216						30
31	000000001846 0908 Rms & Bthrms Carpentry & Milwork	2009	137,855						31
32	000000001847 0908 Rms & Bthrms Ceiling tile, flooring VWC	2009	26,975						32
33	1847 0908 Rms & Bathrms VWC	2009	396						33
34	TOTAL (lines 1 thru 33)		$ 7,511,002	$ 254,147		$ 254,147	$	$ 5,003,991	34

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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 12F, Carried Forward		$ 7,511,002	$ 254,147		$ 254,147	$	$ 5,003,991	1
2	1864 Door	2009	2,076						2
3	1866 Adj Asset #1847 VWC	2009	(30)						3
4	1870 Steel Railing & Gate	2010	2,250						4
5	1883 25 Smoke Detectors	2010	11,770						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	TOTAL (lines 1 thru 33)		$ 7,527,068	$ 254,147		$ 254,147	$	$ 5,003,991	34

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	$ 2,054,792	$ 176,236	$ 176,236	$		$ 1,644,167	71
72	Current Year Purchases	101,545						72
73	Fully Depreciated Assets							73
74	Home Office			16,490	16,490			74
75	TOTALS	$ 2,156,337	$ 176,236	$ 192,726	$ 16,490		$ 1,644,167	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)	$ 10,159,481	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 430,383	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 446,873	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,490	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,648,158	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Various	$ 221,384	92
93			93
94			94
95		$ 221,384	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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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: $ 111,014 Description: 02 Concentrators, wheelchairs, beds, etc
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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.

Facility Name & ID Number Manor Care of Libertyville IL, LLC

STATE OF ILLINOIS
0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	6846 hrs	$ 291,624	525	$ 29,918	$ 251	7,371	$ 321,793	1
2	Licensed Speech and Language Development Therapist	10a	2077 hrs	67,110				2,077	67,110	2
3	Licensed Recreational Therapist	10a	hrs		874	49,846		874	49,846	3
4	Licensed Physical Therapist	10a	15000 hrs	600,755	1,522	86,748	18,071	16,522	705,574	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				679,930		679,930	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV therapy	10a & 43, 2				8,391	168,827		177,218	12
13	Other (specify): Lab/Xray	43, 3				123,361			123,361	13
14	TOTAL			$ 959,489	2,921	$ 298,264	$ 867,079	26,844	$ 2,124,832	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 Libertyville IL, LLC **#** 0049411 **Report Period Beginning:** 06/01/10 **Ending:** 05/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/11 **(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	$ 20,794	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,599,415		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,589		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,624,798	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	476,076		13
14	Buildings, at Historical Cost	7,527,068		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,156,337		16
17	Accumulated Depreciation (book methods)	(6,648,158)		17
18	Deferred Charges	681,254		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	221,384		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,413,961	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,038,759	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 230,078	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	511,970		30
31	Accrued Taxes Payable (excluding real estate taxes)	107,903		31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,229		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	149,165		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,122,345	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	24,473,049		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	35,218		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 24,508,267	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 25,630,612	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (19,591,853)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,038,759	$	48

***(See instructions.)**

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 **Report Period Beginning:** 06/01/10 **Ending:** 05/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 748,202	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 748,202	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,173,891	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)**	$ 1,173,891	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(21,513,946)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (21,513,946)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (19,591,853)	24 *

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

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	$ 14,115,097	1
2	Discounts and Allowances for all Levels	(4,822,805)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,292,292	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,862,875	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,862,875	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,102	12
13	Barber and Beauty Care	22,658	13
14	Non-Patient Meals	525	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	733,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,554	19
20	Radiology and X-Ray	31,916	20
21	Other Medical Services	122,551	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 972,277	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,127,444	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,361,981	31
32	Health Care	5,831,453	32
33	General Administration	3,799,688	33
	B. Capital Expense		
34	Ownership	886,744	34
	C. Ancillary Expense		
35	Special Cost Centers	991,562	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,953,553	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,173,891	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,173,891	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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	1,985	2,142	$ 104,422	$ 48.75	1
2	Assistant Director of Nursing	5,408	5,835	224,142	38.41	2
3	Registered Nurses	45,309	48,887	1,505,895	30.80	3
4	Licensed Practical Nurses	1,496	16,083	363,200	22.58	4
5	CNAs & Orderlies	86,728	93,786	1,083,797	11.56	5
6	CNA Trainees					6
7	Licensed Therapist	23,990	25,843	1,056,866	40.90	7
8	Rehab/Therapy Aides	13,596	14,646	367,679	25.10	8
9	Activity Director	3,748	4,045	87,370	21.60	9
10	Activity Assistants					10
11	Social Service Workers	7,612	8,224	175,841	21.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,989	33,478	395,598	11.82	15
16	Dishwashers					16
17	Maintenance Workers	2,083	2,249	45,280	20.13	17
18	Housekeepers	10,879	11,744	146,814	12.50	18
19	Laundry	3,942	4,256	45,266	10.64	19
20	Administrator	2,080	2,080	104,056	50.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,565	26,464	546,165	20.64	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	1,986	2,143	27,797	12.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	266,396	301,905	$ 6,280,188 *	$ 20.80	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	21,600	9, 3	36
37	Medical Records Consultant	Monthly	2,860	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly		10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,460		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pamela Lamb	Administrator	0	$ 104,056
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 104,056

B. Administrative - Other

Description	Amount
Various Home Office Services	$ 710,138
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 710,138

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, & Flowers	Legal	$ 22,384
United Collection Bureau	Collection Services	1,573
(All above are adjusted off via page 5, Line 22, therefore no invoices attached)		
The Weissman Group	Consulting Fees	847
(Reclassed consultants to Line 21, no invoices attached)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 24,804

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 297,061
Unemployment Compensation Insurance	67,926
FICA Taxes	451,398
Employee Health Insurance	353,168
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	53,521
Tuition Program	1,167
SMSP Company Match	672
Employee Uniforms	5,940
Home Office Allocation	47,563
Appreciation, other benefits, marketing adjustmer	(2,727)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,275,689

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,877
Advertising: Employee Recruitment	62,390
Health Care Worker Background Check	1,368
(Indicate # of checks performed 118)	
Patient Background Checks 1062	12,308
Dues & Subscriptions	7,511
Association Dues	15,192
Advertising	53,254
Less: Non Allow Dues	(9,976)
Less: Public Relations Expense	( )
Non-allowable advertising	(53,254)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 92,670

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Inlcudes travel expense to the Home	11,723
Office in Toledo, Oh for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,723

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manor Care of Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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			$		$	$	$	$	$	$	$	$	$
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 Libertyville IL, LLC # 0049411 Report Period Beginning: 06/01/10 Ending: 05/31/11

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 $5216**

(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 $9976**

(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. $ **66,348** 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 **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **525**

(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.