

		FOR BHF USE					

LL1

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

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.

I. IDPH License ID Number: 0049387

Facility Name: Manorcare of Elk Grove Village IL, LLC

Address: 1920 Nerge Road Elk Grove Village 60007
Number City Zip Code

County: Cook

Telephone Number: (847) 301-0550 Fax # (847) 301-0013

HFS ID Number:

Date of Initial License for Current Owners: 07-30-90

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
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)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid
Preparer

(Signed)
(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 Manorcare of Elk Grove Village IL, LLC

0049387 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>190</u>	Skilled (SNF)	<u>190</u>	<u>69,350</u>	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	<u>190</u>	TOTALS	<u>190</u>	<u>69,350</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>23,449</u>	<u>5,821</u>	<u>35,413</u>	<u>64,683</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,449</u>	<u>5,821</u>	<u>35,413</u>	<u>64,683</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.27%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/30/90

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 190 and days of care provided 27,423

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Manorcare of Elk Grove Village IL, LLC # 0049387 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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	559,158	47,123	10,924	617,205	15,831	633,036		633,036			1
2	Food Purchase		476,482		476,482		476,482	(3,826)	472,656			2
3	Housekeeping	257,742	39,090	3,510	300,342		300,342		300,342			3
4	Laundry	82,930	34,883	2,214	120,027		120,027	(4,655)	115,372			4
5	Heat and Other Utilities			312,376	312,376	4,268	316,644		316,644			5
6	Maintenance	90,400	26,405	232,852	349,657		349,657		349,657			6
7	Other (specify):* Medical Waste			2,509	2,509		2,509		2,509			7
8	TOTAL General Services	990,230	623,983	564,385	2,178,598	20,099	2,198,697	(8,481)	2,190,216			8
	B. Health Care and Programs											
9	Medical Director			30,330	30,330		30,330		30,330			9
10	Nursing and Medical Records	5,828,747	562,530	213,658	6,604,935	18,779	6,623,714		6,623,714			10
10a	Therapy	1,700,767	23,557	731,817	2,456,141		2,456,141		2,456,141			10a
11	Activities	169,353	6,049	6,342	181,744		181,744		181,744			11
12	Social Services	349,721		472	350,193		350,193		350,193			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,048,588	592,136	982,619	9,623,343	18,779	9,642,122		9,642,122			16
	C. General Administration											
17	Administrative	193,969		822,163	1,016,132	(146,877)	869,255		869,255			17
18	Directors Fees											18
19	Professional Services			44,365	44,365	(3,399)	40,966	(40,966)				19
20	Dues, Fees, Subscriptions & Promotions			98,922	98,922	3,217	102,139	(59,027)	43,112			20
21	Clerical & General Office Expenses	628,859	86,152	323,050	1,038,061	2,165	1,040,226	(133,272)	906,954			21
22	Employee Benefits & Payroll Taxes			1,563,463	1,563,463	72,122	1,635,585		1,635,585			22
23	Inservice Training & Education			15,235	15,235		15,235		15,235			23
24	Travel and Seminar			10,661	10,661		10,661		10,661			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			558,524	558,524		558,524		558,524			26
27	Other (specify):*											27
28	TOTAL General Administration	822,828	86,152	3,436,383	4,345,363	(72,772)	4,272,591	(233,265)	4,039,326			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,861,646	1,302,271	4,983,387	16,147,304	(33,894)	16,113,410	(241,746)	15,871,664			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			688,426	688,426	25,005	713,431		713,431			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			395,349	395,349	8,889	404,238	(404,238)				32
33	Real Estate Taxes			786,528	786,528		786,528		786,528			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			66,907	66,907		66,907		66,907			35
36	Other (specify):*											36
37	TOTAL Ownership			1,937,210	1,937,210	33,894	1,971,104	(404,238)	1,566,866			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		977,207	1,200	978,407		978,407		978,407			39
40	Barber and Beauty Shops			26,036	26,036		26,036		26,036			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):* X-Ray, Lab		322,559	231,722	554,281		554,281		554,281			43
44	TOTAL Special Cost Centers		1,299,766	362,983	1,662,749		1,662,749		1,662,749			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,861,646	2,602,037	7,283,580	19,747,263		19,747,263	(645,984)	19,101,279			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	(3,826)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,655)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(100)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(212)	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	(7,740)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(40,966)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(102,444)	21		24
25	Fund Raising, Advertising and Promotional	(59,027)	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	(427,009)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (645,984)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (645,984)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#0049387

06/01/10

05/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Wage - Marketing Expense	\$ (16,948)	21	1
2	Employee Benefits - Marketing Expense	(4,282)	21	2
3	HCP Lease Interest Expense	(404,238)	32	3
4	Vending Income	(727)	21	4
5	Misc Income	(814)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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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	(427,009)		49

Summary A

05/31/11

[illegible]

Summary B

05/31/11

[illegible]

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.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 822,163	HCR Manor Care Services, LLC	100.00%	\$ 822,163	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	9,861,646	Heartland Employment Services, LLC	100.00%	9,861,646		4
5	V	10a	Therapy Management	16,255	Heartland Rehabilitation Services, LLC	100.00%	16,255		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			\$ 10,700,064			\$ 10,700,064	\$ *	14

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

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 - 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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Elk Grove Village IL, LLC # 0049387 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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	\$ 2,652,139	\$ 1,448,591	17,413,839	\$ 15,831	1
2	1	Dietary - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	17,413,839	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	0	0	17,413,839	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	0	0	17,413,839	0	4
5	5	Utilities - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	17,413,839	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551	0	17,413,839	4,268	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	17,413,839	16,116	7
8	10	Nursing - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	17,413,839	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	17,413,839	2,663	9
10	17	General & Admin - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	17,413,839	147,683	10
11	17	General & Admin - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	1,871,124	5,027,701	17,413,839	47,041	11
12	17	General & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	17,413,839	480,562	12
13	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	17,413,839	43,518	13
14	22	Employee Benefits - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	17,413,839	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146	0	17,413,839	28,604	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954	0	17,413,839	1,707	16
17	30	Depreciation - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	17,413,839	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801	0	17,413,839	23,298	18
19										19
20	32	Directly Assigned Interest				12,736,052			10,872	20
21		Non Central Division Nursing Home Allocation				29,513,406				21
22										22
23										23
24										24
25	TOTALS					\$ 185,111,177	\$ 62,809,840		\$ 822,163	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		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			\$ 241,832	\$ 241,832		0.0452	\$ 10,872	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income Other										(10,872)	8	
9	TOTAL Facility Related						\$ 241,832	\$ 241,832			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 241,832	\$ 241,832			\$	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.)

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

B. Real Estate Taxes

			Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	265,027	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.)			\$	248,143	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	(16,884)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	766,116	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.)			\$	37,296	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.			\$	786,528	7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	403,287	8		
		2007	388,185	9		
		2008	398,728	10		
		2009	301,576	11		
		2010	657,870	12		
Line 2: \$248,143 = \$82,276 for 2nd half of 2009 paid in Nov 10 + \$165,867 for 1st half of 2010 paid in Feb 11						
Line 4: \$766,116 = \$492,003 for 2nd half of 2010 to be paid in 2011 + \$274,113 Estimate for Jan-May 2010						
Line 5: \$37,196 = \$2,800 appraisal 2010 appeal + \$34,496 appeal filed by Rock, Fusco & Assoc for FYE 2009 RE Tax						

	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 Manorcare of Elk Grove Village IL, LLC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049387

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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>07-35-200-022-0000</u>	<u>See Attached</u>	\$ <u>657,869.84</u>	\$ <u>657,869.84</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>657,869.84</u>	\$ <u>657,869.84</u>

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,128

B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120			1990	\$ 5,025,494	\$ 204,208		\$ 204,208	\$	\$ 3,459,839	4
5	60			1996	1,726,800						5
6	10			2000	1,063,936						6
7	5/31/03 Audit Adjustment			2000	(277,211)						7
8				2009	631,865						8
	Improvement Type**										
9	Current Year Depreciation					236,584		236,584		1,935,310	9
10				1990	12,954						10
11				1991	41,034						11
12				1992	89,111						12
13				1993	29,775						13
14				1994	18,939						14
15				1995	182,383						15
16				1996	485,188						16
17				1997	111,890						17
18				1998	127,587						18
19				1999	60,314						19
20				2000	68,449						20
21				2001	5,850						21
22				2002	53,586						22
23	HOLLOW METAL DOOR			2003	975						23
24	ARCH & ENGINEERING COSTS			2003	975						24
25	BORDER			2003	162						25
26	VWC			2003	1,710						26
27	VWC			2003	219						27
28	ARCHITECTIRAL ENGINEERING			2003	258						28
29	VWC			2003	427						29
30	NEW BATHROOM FLOORING & TILE			2003	22,640						30
31	ARCHITECT & ENGINEERING			2003	258						31
32	FLOORING			2003	4,599						32
33	VWC, BORDER, AND PAINTING			2003	3,317						33
34	ADDITIONAL COST FOR FLOORING			2003	2,820						34
35	ARCHITECT AND ENGINEERING COSTS			2003	2,064						35
36	WINDOW TREATMENT			2003	3,629						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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 BORDER	2003	\$ 54	\$		\$	\$	\$	37
38 ARCHITECT AND ENGINEERING COSTS	2003	455						38
39 ELECTRICAL WORK	2003	5,182						39
40 VCT FLOORING	2003	7,005						40
41 BASE AND FLOOR TILE	2003	4,118						41
42 CARPET	2004	609						42
43 INSTALL CARPET	2004	550						43
44 PAVING	2003	67,500						44
45 CONCRETE WALK	2003	3,822						45
46 PAVING	2004	7,500						46
47 Renov. - General Construction Overhead & Interest	2004	19,622						47
48 Renov. - Carpeting	2004	595						48
49 Renov. - Painting	2004	14,000						49
50 Renov. - Wallcovering & Corner Guards	2004	37,811						50
51 Renov. - Carpentry	2004	8,201						51
52 Renov. - Plumbing	2004	2,880						52
53 Renov. - Electrical	2004	2,931						53
54 Carpet	2004	1,324						54
55 Ceramic Cove Base	2004	3,360						55
56 Renov. - Wood Doors & Hardware for Lobby	2004	8,597						56
57 Renov. - Electrical	2004	2,484						57
58 Electric Door Strike at Service Door	2004	1,509						58
59 CARPETING & DELIVERY OF CARPETTING	2005	2,435						59
60 REBUILD SHOWER STALLS (5)	2006	14,000						60
61 VWC, BASE, & CEILING TILES IN BREAK ROOM	2006	2,470						61
62								62
63 Ceramic Tile - Wall/Floor	2006	3,300						63
64 Wallcovering	2006	3,605						64
65 Plumbing Work on Sprinkler System	2006	4,727						65
66 Architecture/Engineering for Parking Lot	2007	9,285						66
67 Drywall Work	2007	8,378						67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 9,750,306	\$ 440,792		\$ 440,792	\$	\$ 5,395,149	70

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

Facility Name & ID Number Manorcare of Elk Grove Village IL, LLC

0049387

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,750,306	\$ 440,792		\$ 440,792	\$	\$ 5,395,149	1
2	<u>DOOR HOLDER & CLOSER</u>	2007	1,556						2
3	<u>DOOR HOLDER & CLOSER</u>	2007	1,869						3
4	<u>Renov. - Carpeting & Pad</u>	2007	1,742						4
5	<u>Renov. - Wallcovering</u>	2007	84,542						5
6	<u>Renov. - Carpentry - Subtractor</u>	2007	38,200						6
7	<u>Renov. - Basic Electrical</u>	2007	7,626						7
8	<u>Renov. - HM Doors & Frames</u>	2007	10,505						8
9	<u>Renov. - Generator, Permit</u>	2007	3,096						9
10	<u>Renov. - Basic Electrical</u>	2007	9,357						10
11	<u>Renov. - Generator, Engineering</u>	2007	13,539						11
12	<u>Renov. - Parking Lot Expansion & Landscaping</u>	2007	83,045						12
13	<u>BLACKTOP PATCHING</u>	2007	12,078						13
14									14
15	<u>Roofing</u>	2008	7,221						15
16	<u>Roofing - additional</u>	2008	802						16
17	<u>Generator - Installation & Materials</u>	2008	36,317						17
18	<u>Generator - Equipment</u>	2008	10,814						18
19	<u>Generator - Installation & Materials</u>	2008	62,613						19
20	<u>Renov. - CORRIDOR DOORS (35)</u>	2008	50,575						20
21	<u>CO2 Detectors & Control Panel</u>	2008	11,781						21
22	<u>Generator - Equipment</u>	2008	63,883						22
23	<u>Storm Drain Enhancements</u>	2008	4,100						23
24	<u>Sealcoating & Restriping</u>	2008	13,362						24
25	<u>Renov. - Internet Café Construction (Contracted Total)</u>	2009	88,371						25
26	<u>Double Egress Kitchen Doors</u>	2009	6,076						26
27	<u>Renov. - Carpentry</u>	2009	76,000						27
28	<u>Renov. - Millwork (Hand Rails)</u>	2009	14,910						28
29	<u>Renov. - Electrical (Light Fixtures)</u>	2009	5,990						29
30	<u>Renov. - Carpet</u>	2009	6,195						30
31	<u>Renov. - Wallcovering, Corner Guards</u>	2009	8,076						31
32	<u>Generator - Installation & Materials</u>	2009	11,108						32
33	<u>Renov. - Carpentry</u>	2009	45,000						33
34	TOTAL (lines 1 thru 33)		\$ 10,540,655	\$ 440,792		\$ 440,792	\$	\$ 5,395,149	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 10,540,655	\$ 440,792		\$ 440,792	\$	\$ 5,395,149	1
2 Renov. - Millwork (Hand Rails)	2009	16,827						2
3 Renov. - Carpet	2009	9,331						3
4 Renov. - Wallcovering	2009	9,237						4
5								5
6 THERAPY ADD - SOIL TESTING	2009	600						6
7 THERAPY ADD - CONCRETE TESTING	2009	2,155						7
8 THERAPY ADD - SITE PREPARATION	2009	240,173						8
9 THERAPY ADD - LANDSCAPING	2009	14,240						9
10 LIGHTPOLE W/ CONCRETE BASE	2009	5,483						10
11 THERAPY ADD - ARCH & ENGINEER COST	2009	56,780						11
12 THERAPY ADD - ARCHITECT REIMB EXTER	2009	7,886						12
13 THERAPY ADD - ENGINEERING - CIVIL	2009	4,740						13
14 THERAPY ADD - INTERIOR DESIGN CONSULTANT	2009	102,773						14
15 THERAPY ADD - LANDSCAPE DESIGN CONSULTANT	2009	8,487						15
16 THERAPY ADD - PLAN REVIEWS	2009	8,853						16
17 THERAPY ADD - SALES USE TAX	2009	22						17
18 THERAPY ADD - WALL COVERING	2009	14,602						18
19 THERAPY ADD - CORNER GUARDS	2009	1,548						19
20 THERAPY ADD - TV IN PT WAITING ROOM	2010	1,745						20
21 THERAPY ADD - CRASH RAIL	2010	3,941						21
22 PAINTING FOR NOURISHMENT	2009	3,800						22
23 10 DOORS	2009	27,900						23
24 CARPETING	2009	1,040						24
25 HM DOOR	2009	4,867						25
26 HM DOOR	2010	4,830						26
27 C-WING SPRINKLERS	2010	25,181						27
28 3808 C WING REHAB RENO - CARPENTRY	2009	43,296						28
29 3808 C WING REHAB RENO - HM DOORS & FRAMES	2009	3,324						29
30 3808 C WING REHAB RENO - ELECTRICAL	2009	6,930						30
31 3808 C WING REHAB RENO - CORNER GUARDS	2009	268						31
32 2107 GENERATOR REPLACE - LABOR & MATERIALS	2009	25,804						32
33 1409 SPRINKLER HEADS - SPRINKLERS	2009	32,500						33
34 TOTAL (lines 1 thru 33)		\$ 11,229,818	\$ 440,792		\$ 440,792	\$	\$ 5,395,149	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 11,229,818	\$ 440,792		\$ 440,792	\$	\$ 5,395,149	1
2	1809 INTERIOR RENO - FLOORING	2010	1,906						2
3	1809 INTERIOR RENO - CARPETING	2010	9,289						3
4	1809 INTERIOR RENO - WALL COVERING	2010	45,056						4
5	1809 INTERIOR RENO - ELECTRICAL	2010	1,984						5
6									6
7	1809 INTERIOR RENOVATION - Wall Covering	2010	44,154						7
8	HM Doors	2010	10,350						8
9	0910 HERITAGE RENOVATION - Lobby Finishes	2010	76,149						9
10	0910 HERITAGE RENOVATION - Carpeting & Pads	2010	8,725						10
11	0910 HERITAGE RENOVATION - Wall Covering	2010	8,753						11
12	0910 HERITAGE RENOVATION - Corner Guards	2010	2,827						12
13	0910 HERITAGE RENOVATION - Millwork	2010	15,549						13
14	0910 HERITAGE RENOVATION - Basic Electrical	2010	8,612						14
15	SMOKE DETECTOR SYSTEM	2011	10,890						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)		\$ 11,474,062	\$ 440,792		\$ 440,792	\$	\$ 5,395,149	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,255,908	\$ 247,634	\$ 247,634	\$		\$ 2,573,356	71
72	Current Year Purchases	224,037						72
73	Fully Depreciated Assets							73
74	Home Office			25,005	25,005			74
75	TOTALS	\$ 3,479,945	\$ 247,634	\$ 272,639	\$ 25,005		\$ 2,573,356	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets				1	2
		Reference			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)			\$ 15,807,635
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 688,426
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 713,431
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 25,005
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 7,968,505

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Various	\$ 285,979
93		
94		
95		\$ 285,979

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 66,907
- Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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	\$

* 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.

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

☒ 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)	\$			

(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.

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	

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

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

	1	2	3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	8472	hrs	\$ 335,229	9,632	\$ 525,904	\$ 3,344	18,104	\$ 864,477	1
2	Licensed Speech and Language Development Therapist	10a	4011	hrs	141,253			55	4,011	141,308	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	14954	hrs	644,968	1,699	92,782	20,158	16,653	757,908	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				977,207		977,207	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
	Academic Education			hrs							11
12	Other (specify): IV Therapy	43,2						322,559		322,559	12
13	Other (specify): X-Ray & Lab	43,3					231,722			231,722	13
14	TOTAL				\$ 1,121,450	11,331	\$ 850,408	\$ 1,323,323	38,768	\$ 3,295,181	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (3,779)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 652,918)	2,134,237		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,812		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,136,270	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	853,628		13
14	Buildings, at Historical Cost	11,474,062		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,479,945		16
17	Accumulated Depreciation (book methods)	(7,968,505)		17
18	Deferred Charges	24,362,051		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	285,979		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,487,160	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 34,623,430	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 408,286	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	837,077		30
31	Accrued Taxes Payable (excluding real estate taxes)	187,847		31
32	Accrued Real Estate Taxes(Sch.IX-B)	766,115		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	193,093		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,392,418	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	45,913,571		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	213,408		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 46,126,979	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 48,519,397	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (13,895,967)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 34,623,430	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,432,875	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,432,875	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,731,785	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)	\$ 3,731,785	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(26,060,627)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (26,060,627)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (13,895,967)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 23,673,768	1
2	Discounts and Allowances for all Levels	(7,342,523)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,331,245	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,791,206	6
7	Oxygen	17	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,791,223	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	727	12
13	Barber and Beauty Care	33,174	13
14	Non-Patient Meals	3,826	14
15	Telephone, Television and Radio	(5)	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,021,178	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	139,702	19
20	Radiology and X-Ray	21,113	20
21	Other Medical Services	131,296	21
22	Laundry	4,655	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,355,666	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	Misc Income	914	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 914	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,479,048	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,178,598	31
32	Health Care	9,623,343	32
33	General Administration	4,345,363	33
	B. Capital Expense		
34	Ownership	1,937,210	34
	C. Ancillary Expense		
35	Special Cost Centers	1,558,724	35
36	Provider Participation Fee	104,025	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,747,263	40
41	Income before Income Taxes (line 30 minus line 40)**	3,731,785	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,731,785	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,055	2,214	\$ 100,123	\$ 45.22	1
2	Assistant Director of Nursing	7,063	7,609	280,423	36.85	2
3	Registered Nurses	72,653	78,273	2,755,277	35.20	3
4	Licensed Practical Nurses	21,295	22,942	594,596	25.92	4
5	CNAs & Orderlies	148,170	159,955	2,035,111	12.72	5
6	CNA Trainees	38	41	434	10.59	6
7	Licensed Therapist	27,957	30,199	1,238,252	41.00	7
8	Rehab/Therapy Aides	19,437	20,996	462,515	22.03	8
9	Activity Director	10,914	11,769	169,353	14.39	9
10	Activity Assistants					10
11	Social Service Workers	13,809	14,888	349,721	23.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,543	40,482	559,158	13.81	15
16	Dishwashers					16
17	Maintenance Workers	3,592	3,873	90,400	23.34	17
18	Housekeepers	19,694	21,238	257,742	12.14	18
19	Laundry	7,424	8,004	82,930	10.36	19
20	Administrator	2,080	2,080	135,242	65.02	20
21	Assistant Administrator	1,359	1,359	58,727	43.21	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	28,757	31,232	607,629	19.46	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	3,827	4,127	62,783	15.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	427,667	461,281	\$ 9,840,416 *	\$ 21.33	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	30,330	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,330		49

C. CONTRACT NURSES

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

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

** See instructions.

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 \$6,606
- (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 \$12,633
- (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.

\$ 133,246

Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

Yes

If YES, give effective date of lease.

04/07/11
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 104,025

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.

\$ 727
- (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 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.