

		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: 0049445

Facility Name: Manor Care of Hinsdale IL, LLC

Address: 600 W. Ogden Ave. Hinsdale 60521
Number City Zip Code

County: DuPage

Telephone Number: (630) 325-9630 Fax # (630) 325-9648

HFS ID Number:

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

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Gary Geise Telephone Number: (419) 252-5731
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 A. Lazarus
(Title) Vice President, Reimbursement

Paid
Preparer

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

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

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

0049445 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 12/14/2010

	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>200</u>	Skilled (SNF)	<u>202</u>	<u>73,338</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>200</u>	TOTALS	<u>202</u>	<u>73,338</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,352</u>	<u>10,455</u>	<u>49,449</u>	<u>65,256</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>5,352</u>	<u>10,455</u>	<u>49,449</u>	<u>65,256</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.98%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 202 and days of care provided 38,191

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 Manor Care of Hinsdale IL, LLC # 0049445 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	634,258	47,435	26,128	707,821	17,947	725,768		725,768			1
2	Food Purchase		491,694		491,694		491,694	(9,577)	482,117			2
3	Housekeeping	310,209	43,087	4,080	357,376		357,376		357,376			3
4	Laundry	94,539	31,930	784	127,253		127,253		127,253			4
5	Heat and Other Utilities			338,919	338,919	4,838	343,757		343,757			5
6	Maintenance	110,197	41,174	242,446	393,817		393,817		393,817			6
7	Other (specify):* Medical Waste			1,457	1,457		1,457		1,457			7
8	TOTAL General Services	1,149,203	655,320	613,814	2,418,337	22,785	2,441,122	(9,577)	2,431,545			8
	B. Health Care and Programs											
9	Medical Director			36,256	36,256		36,256		36,256			9
10	Nursing and Medical Records	6,307,307	755,404	187,933	7,250,644	21,288	7,271,932	(4,253)	7,267,679			10
10a	Therapy	3,126,611	18,054	207,107	3,351,772		3,351,772		3,351,772			10a
11	Activities	143,762	3,343	8,415	155,520		155,520	(800)	154,720			11
12	Social Services	434,760	604	203	435,567		435,567		435,567			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	10,012,440	777,405	439,914	11,229,759	21,288	11,251,047	(5,053)	11,245,994			16
	C. General Administration											
17	Administrative	143,018		1,118,393	1,261,411	(352,877)	908,534		908,534			17
18	Directors Fees											18
19	Professional Services			131,597	131,597	(546)	131,051	(131,051)				19
20	Dues, Fees, Subscriptions & Promotions			142,631	142,631		142,631	(48,255)	94,376			20
21	Clerical & General Office Expenses	560,556	107,535	423,296	1,091,387	546	1,091,933	(259,914)	832,019			21
22	Employee Benefits & Payroll Taxes			1,855,555	1,855,555	81,759	1,937,314		1,937,314			22
23	Inservice Training & Education			2,903	2,903		2,903		2,903			23
24	Travel and Seminar			31,141	31,141		31,141		31,141			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			604,761	604,761		604,761		604,761			26
27	Other (specify):*											27
28	TOTAL General Administration	703,574	107,535	4,310,277	5,121,386	(271,118)	4,850,268	(439,220)	4,411,048			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,865,217	1,540,260	5,364,005	18,769,482	(227,045)	18,542,437	(453,850)	18,088,587			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			820,830	820,830	28,346	849,176	(103,141)	746,035			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			858,721	858,721	198,699	1,057,420	(862,798)	194,622			32
33	Real Estate Taxes			155,343	155,343		155,343		155,343			33
34	Rent-Facility & Grounds			22,399	22,399		22,399		22,399			34
35	Rent-Equipment & Vehicles			139,338	139,338		139,338		139,338			35
36	Other (specify):*											36
37	TOTAL Ownership			1,996,631	1,996,631	227,045	2,223,676	(965,939)	1,257,737			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			242	242		242		242			38
39	Ancillary Service Centers		1,514,730	2,537	1,517,267		1,517,267		1,517,267			39
40	Barber and Beauty Shops		1,161	44,783	45,944		45,944		45,944			40
41	Coffee and Gift Shops	17,787			17,787		17,787		17,787			41
42	Provider Participation Fee			109,953	109,953		109,953		109,953			42
43	Other (specify):* IV X-Ray & Lab		292,717	244,966	537,683		537,683		537,683			43
44	TOTAL Special Cost Centers	17,787	1,808,608	402,481	2,228,876		2,228,876		2,228,876			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,883,004	3,348,868	7,763,117	22,994,989		22,994,989	(1,419,789)	21,575,200			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	(9,577)	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	(103,141)	30		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	(390)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,253)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,000)	21		18
19	Entertainment				19
20	Contributions	(14,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(131,051)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(180,970)	21		24
25	Fund Raising, Advertising and Promotional	(48,255)	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	(911,652)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,419,789)		\$	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))	\$ (1,419,789)		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#

0049445

06/01/10

05/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Wages - Marketing	\$ (37,884)	21	1
2	Employee benefits - Marketing	(9,738)	21	2
3	HCP Lease Interest	(862,798)	32	3
4	Vending Income	(432)	21	4
5	Misc. Income	0	21	5
6	Activity Income	(800)	11	6
7	Loss on Disposal of Fixed Assets	0	36	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
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22				22
23				23
24				24
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28				28
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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	(911,652)		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	\$ 1,118,393	HCR Manor Care Services, LLC	100.00%	\$ 1,118,393	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	11,883,004	Heartland Employment Services, LLC	100.00%	11,883,004		4
5	V	10a	Therapy Management	21,493	Heartland Rehabilitation Services, LLC	100.00%	21,493		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			\$ 13,022,890			\$ 13,022,890	\$ *	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 (SNF), L	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 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 IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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 Manor Care of Hinsdale IL, LLC # 0049445 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	19,740,637	\$ 17,947	1
2	1	Dietary - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	19,740,637	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	0	0	19,740,637	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	0	0	19,740,637	0	4
5	5	Utilities - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	19,740,637	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551	0	19,740,637	4,838	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	19,740,637	18,269	7
8	10	Nursing - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	19,740,637	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	19,740,637	3,019	9
10	17	General & Admin - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	19,740,637	167,416	10
11	17	General & Admin - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	1,871,124	5,027,701	19,740,637	53,326	11
12	17	General & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	19,740,637	544,774	12
13	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	19,740,637	49,333	13
14	22	Employee Benefits - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	19,740,637	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146	0	19,740,637	32,426	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954	0	19,740,637	1,935	16
17	30	Depreciation - Direct to Central Division	Accumulated Cost	692,663,974	92NFs	0	0	19,740,637	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801	0	19,740,637	26,411	18
19										19
20	32	Directly Assigned Interest				12,736,052			198,699	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		\$ 1,118,393	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	Various			\$ 4,419,968	\$ 4,419,968		4.4955	\$ 198,699	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income Other										(4,077)	8	
9	TOTAL Facility Related						\$ 4,419,968	\$ 4,419,968			\$ 194,622	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,419,968	\$ 4,419,968			\$ 194,622	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.		\$	133,538	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.)		\$	149,089	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	15,551	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	139,792	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.		\$	155,343	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	140,710	8	
		2007	134,320	9	
		2008	141,026	10	
		2009	145,678	11	
		2010	152,500	12	
Line 2: \$149,089 = \$72,839 for the 2nd half of 2009 paid in Aug. '10 + 76,250 for the 1st half of 2010 paid in May '11.				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
Line 4: \$139,792 = \$76,250 2nd half 2010 + \$63,542 estimate for Jan-May 2011.				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.

FACILITY NAME	<u>Manor Care of Hinsdale IL, LLC</u>	COUNTY	<u>DuPage</u>
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CONTACT PERSON REGARDING THIS REPORT Gary Geise

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 Applicable to Nursing Home</u>
1.	09-02-404-001	See Attached	\$ 2,052.84	\$ 2,052.84
2.	09-02-212-006	See Attached	\$ 13,092.54	\$ 13,092.54
3.	09-02-212-001	See Attached	\$ 137,354.90	\$ 137,354.90
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 152,500.28	\$ 152,500.28

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: 78,479

B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1981	\$ 1,358,110	1
2					2
3	TOTALS			\$ 1,358,110	3

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	102		1972		\$ 1,160,300	\$ 95,391		\$ 95,391	\$	2,573,922	4
5	100			1980	1,913,000						5
6	Therapy addition			2006	400,868						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					260,328		260,328		4,447,336	9
10				1984	4,367						10
11				1985	6,383						11
12				1987	14,207						12
13				1988	22,849						13
14				1989	173,344						14
15				1990	114,281						15
16				1991	240,682						16
17				1992	111,750						17
18				1993	421,420						18
19				1994	145,930						19
20				1995	182,224						20
21				1996	326,618						21
22				1997	407,293						22
23				1998	392,286						23
24				1999	128,464						24
25				1999	(11,509)						25
26				2000	138,632						26
27				2001	142,009						27
28				2002	339,762						28
29	STEEL/METAL DOORS			2003	4,336						29
30	ROOF REPAIR			2003	1,084						30
31	ARCH AND ENGINEERING COSTS			2004	553						31
32	ELECTRICAL			2004	3,776						32
33	Arch and Engineering Costs			2004	42,165						33
34	General Construction Overhead Cost & Interest			2004	55,967						34
35	Flooring			2004	9,800						35
36	Carpeting			2004	11,210						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	Painting	2004	\$ 63,111	\$		\$	\$	37
38	Wallcovering & Corner Guards	2004	5,782					38
39	Carpentry	2004	27,527					39
40	Electrical	2004	24,620					40
41	Roofing & Doors	2004	1,685					41
42	Fire Wall	2004	4,625					42
43	VWC & Paint	2004	2,092					43
44	Exterior Painting	2004	7,405					44
45	Flooring	2004	12,981					45
46	Air Separator	2004	9,942					46
47	Flooring	2005	113,382					47
48	Doors	2005	4,865					48
49	VWC	2005	1,474					49
50	Flooring	2005	9,070					50
51	Shower Door	2005	6,140					51
52	Painting, Wallcovering, & Base	2005	3,531					52
53	Install fire server cabinet & shelves	2005	3,700					53
54	Fire Alarm Panels	2005	10,265					54
55	Masonry Work	2005	3,875					55
56	Smoke Detectors	2005	1,160					56
57	Electrical Circuit for Smoke Detecor	2005	801					57
58	Wallcovering	2005	5,240					58
59	Electrical Work in 28 patient rooms	2005	2,284					59
60	Wallcovering	2005	1,233					60
61	Smoke Detectors	2005	2,685					61
62	Remodel Janitor Closet & Greenhouse	2005	4,800					62
63	Remodel Janitor Closet & Greenhouse	2006	4,799					63
64	Electrical Work for Elevator - Hookup shunt switch	2006	503					64
65	Phone Wiring	2006	7,231					65
66	Exhaust Fan	2006	2,272					66
67	Phone Wiring Additional Work	2006	1,605					67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 7,254,736	\$ 355,719		\$ 355,719	\$ 7,021,258	70

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

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

0049445

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		\$ 7,254,736	\$ 355,719		\$ 355,719	\$	\$ 7,021,258	1
2	Corner guards	2006	353						2
3	Engineering for conceptual site plan - parking lot, lighting, lanscap	2006	6,767						3
4	Drywall & Paint to rebuild plumbing walls in 6 resident rooms	2006	8,023						4
5	Plumbing - Replace 4 wall hydrants	2006	3,224						5
6	Overhead & Interest on HVAC Project	2006	1,344						6
7	HVAC - 35 ton roof unit & related electrical work	2006	61,639						7
8	Overhead & Interest on addition/renovation project	2006	157,013						8
9	Addition/Renov. - Architect & Engineering	2006	71,504						9
10	Addition/Renov. - Permit fees, plan reveiws, consultant misc.	2006	16,591						10
11	Addition/Renov. - Drywall canopies on 41 light fictures	2006	1,017						11
12	Addition/Renov. - Ceil Tile & Paint Grid	2006	4,365						12
13	Addition/Renov. - Flooring	2006	5,147						13
14	Addition/Renov. - Wall Covering & Corner Guards	2006	17,428						14
15	Addition/Renov. - Fire Sprinkler System	2006	84,188						15
16	Addition/Renov. - Plumbing	2006	4,895						16
17	Addition/Renov. - HVAC	2006	2,594						17
18	Addition/Renov. - Electrical	2006	11,569						18
19	Addition/Renov. - Site Preparation	2006	39,350						19
20	Addition/Renov. - Fencing	2006	1,637						20
21	Addition/Renov. - Lanscaping block, trees, plants, etc.	2006	112,980						21
22	Electrical - Parking lot lights	2006	2,413						22
23	Roof Termination Strip	2006	967						23
24	Electrical work	2006	2,215						24
25	Patio with raised seating area	2006	24,113						25
26	Concrete curbs & pavement for new parking spaces	2006	28,645						26
27	Electrical - Parking lot lights	2006	13,005						27
28	Lawn sprinler system	2006	9,800						28
29	Carpet	2007	10,314						29
30	Remodel Shower Room - Tile, Sink, Faucets, Paint	2007	15,820						30
31	Flooring in Corridors	2007	11,448						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,985,104	\$ 355,719		\$ 355,719	\$	\$ 7,021,258	34

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

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

0049445

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 12B, Carried Forward		\$ 7,985,104	\$ 355,719		\$ 355,719	\$	\$ 7,021,258	1
2	Electrical at nurses station	2007	2,538						2
3	Windows (9)	2007	14,245						3
4	Drainage	2007	17,001						4
5	Wallcovering	2007	15,483						5
6	Electrical for pill dispenser	2007	1,773						6
7	Elevator Upgrade	2007	4,370						7
8	Piping in laundry room	2007	1,700						8
9	Parking lot paving	2007	9,900						9
10	Curbing in Parking lot	2007	2,550						10
11	Paving	2007	8,016						11
12	Sidewalk & Railing	2007	36,550						12
13									13
14	Roofing over generator - Wate Tight Membrane	2008	16,314						14
15	Renov. - Vinyl Flooring	2008	37,310						15
16	ELEVATOR SWITCHES	2008	4,370						16
17	20 AMP CIRCUIT	2008	2,250						17
18	AC ELECTRICAL	2008	9,505						18
19	CONCRETE BOARD IN SHOWER	2008	2,680						19
20	ELECTRIC Change outlets from 2 to 4	2009	5,040						20
21	CIRCUIT BREAKER	2009	3,880						21
22	LAUNDRY CIRCUIT BREAKER	2009	5,140						22
23	225 AMP CIRCUIT BREAKER	2009	2,120						23
24	15 AMP RECEPTACLES	2008	3,360						24
25	Renov.- Front Elevator Upgrade	2009	54,708						25
26	HM Doors	2009	6,500						26
27									27
28	Renov. - Elevator Upgrade	2009	11,209						28
29	Doors (8) HM	2009	18,810						29
30	Renov. - Fire Rate Access Panels	2009	27,588						30
31	Renov. - Fire dampers & access panels	2009	78,095						31
32	Frighits for Corner Guards	2009	240						32
33	Renov. - Fire Proof Acces Panels	2010	7,682						33
34	TOTAL (lines 1 thru 33)		\$ 8,396,031	\$ 355,719		\$ 355,719	\$	\$ 7,021,258	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 12C, Carried Forward		\$ 8,396,031	\$ 355,719		\$ 355,719	\$	\$ 7,021,258	1
2 Renov. - Flooring	2010	25,501						2
3 Renov. - Wallcovering & guards	2010	20,127						3
4 Radiant heaters	2010	16,131						4
5 Emergency lights (15) led wall packs	2010	16,017						5
6								6
7 Renov. - Surveys	2010	5,625						7
8 Renov. - Millwork	2010	24,495						8
9 Renov. - Gypsum, Studs, & Tile Work	2010	110,702						9
10 Wiring For Phones In Arcadia Wing	2010	4,027						10
11 Renov. - Acqustic Ceiling System & Other	2010	161,931						11
12 Renov. - Roof Replacement	2010	114,435						12
13 Renov. - Flooring	2010	108						13
14 Renov. - Flooring & Wallcovering	2010	2,700						14
15 Cabinetry and Faucet	2010	6,841						15
16 VCT Flooring & Paint	2010	5,168						16
17 Renov. - Overhead & Interest (\$19,887.59)	2010							17
18 Renov. - 40 Ton A/C Unit, Trane	2010	56,970						18
19 Renov. - Flooring, Paint, & Wallcoverings	2010	135,403						19
20 Renov. - Interior Renovations	2010	28,587						20
21 Renov. - Carpentry	2010	125,759						21
22 French Drain & pavers around F	2011	6,375						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)		\$ 9,262,933	\$ 355,719		\$ 355,719	\$	\$ 7,021,258	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	\$ 3,919,855	\$ 361,970	\$ 361,970	\$		\$ 2,868,931	71
72	Current Year Purchases	433,577						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			28,346	28,346			74
75	TOTALS	\$ 4,353,432	\$ 361,970	\$ 390,316	\$ 28,346		\$ 2,868,931	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	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)	\$ 14,974,475	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 717,689	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 746,035	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,346	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,890,189	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	Step-up Building Cost 1981	\$ 3,713,060	\$ 103,141	\$ 3,051,242	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,713,060	\$ 103,141	\$ 3,051,242	91

G. Construction-in-Progress

	Description	Cost	
92	Various	\$ 71,772	92
93			93
94			94
95		\$ 71,772	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MIH, LLC / HSS Management Company
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	Portion of Parking Lot			01/01/2010	22,399	1 1/2		5
6								6
7	TOTAL				\$ 22,399			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: \$ 134,822
- 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	Patient Transportation		\$	\$ 4,516	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,516	21

10. Effective dates of current rental agreement:

Beginning 01/01/2010

Ending 06/30/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	05/31/2012	\$ 22,399
13.	05/31/2013	\$ 1,867
14.	05/31/2014	\$ 0

* 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.

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

☒ 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.

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, 1	18,685	hrs	\$ 823,895	2,487	\$ 120,848	\$ 5,463	21,172	\$ 950,206	1
2	Licensed Speech and Language Development Therapist	10a, 1	5,460	hrs	240,771	44	2,153	16	5,504	242,940	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	21,952	hrs	967,987	97	4,706	12,575	22,049	985,268	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				1,514,730		1,514,730	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43, 2						292,717		292,717	12
13	Other (specify): X-Ray & Lab	43, 3					244,966			244,966	13
14	TOTAL				\$ 2,032,653	2,628	\$ 372,673	\$ 1,825,501	48,725	\$ 4,230,827	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,329	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 726,921)	3,576,929		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,244		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,597,502	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,358,110		13
14	Buildings, at Historical Cost	12,975,993		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,353,432		16
17	Accumulated Depreciation (book methods)	(12,941,431)		17
18	Deferred Charges	62,192,968		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	71,772		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 68,010,844	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 71,608,346	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 322,316	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,210,193		30
31	Accrued Taxes Payable (excluding real estate taxes)	154,232		31
32	Accrued Real Estate Taxes(Sch.IX-B)	139,792		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	172,210		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,998,743	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	82,352,765		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	430,265		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 82,783,030	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 84,781,773	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (13,173,427)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 71,608,346	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,725,722	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,725,722	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	9,090,444	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)	\$ 9,090,444	17
	B. Transfers (Itemize):		
18	Change in Interdivison	(24,989,593)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (24,989,593)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (13,173,427)	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	\$ 32,128,098	1
2	Discounts and Allowances for all Levels	(10,587,717)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 21,540,381	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,489,628	6
7	Oxygen	11,272	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,500,900	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	4,156	12
13	Barber and Beauty Care	38,939	13
14	Non-Patient Meals	9,577	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,633,812	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	133,228	19
20	Radiology and X-Ray	88,132	20
21	Other Medical Services	134,124	21
22	Laundry	2,184	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,044,152	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 & Purchase Discounts		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)	\$ 32,085,433	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,418,337	31
32	Health Care	11,229,759	32
33	General Administration	5,121,386	33
	B. Capital Expense		
34	Ownership	1,996,631	34
	C. Ancillary Expense		
35	Special Cost Centers	2,118,923	35
36	Provider Participation Fee	109,953	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,994,989	40
41	Income before Income Taxes (line 30 minus line 40)**	9,090,444	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 9,090,444	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	1,196	1,294	\$ 61,234	\$ 47.32	1
2	Assistant Director of Nursing	5,511	5,964	216,816	36.35	2
3	Registered Nurses	66,515	71,980	2,361,123	32.80	3
4	Licensed Practical Nurses	48,704	52,706	1,325,795	25.15	4
5	CNAs & Orderlies	161,720	175,324	2,281,613	13.01	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	47,591	51,526	2,271,954	44.09	7
8	Rehab/Therapy Aides	31,220	33,802	854,657	25.28	8
9	Activity Director	10,759	11,658	143,762	12.33	9
10	Activity Assistants					10
11	Social Service Workers	15,250	16,518	434,760	26.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	41,672	45,131	634,258	14.05	15
16	Dishwashers					16
17	Maintenance Workers	4,255	4,609	110,197	23.91	17
18	Housekeepers	24,166	26,179	310,209	11.85	18
19	Laundry	8,993	9,741	94,539	9.71	19
20	Administrator	2,080	2,080	110,529	53.14	20
21	Assistant Administrator	1,131	1,131	32,489	28.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,455	24,142	512,934	21.25	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	3,243	3,513	60,726	17.29	31
32	Other Health Care(specify)					32
33	Other(specify)	1,418	1,535	17,787	11.59	33
34	TOTAL (lines 1 - 33)	497,879	538,833	\$ 11,835,382 *	\$ 21.96	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	36,256	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	280	13,725	10, 1	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	280	\$ 49,981		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10, 3	50
51	Licensed Practical Nurses			10, 3	51
52	Certified Nurse Assistants/Aides	75	974	10, 3	52
53	TOTAL (lines 50 - 52)	75	\$ 974		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Diane Lube	Administrator	0	\$ 110,529	Workers' Compensation Insurance		\$ 109,359	IDPH License Fee	\$ 3,980	
Katherine Marrero (Dec. '10 - May '11)	Asst. Admin.	0	30,911	Unemployment Compensation Insurance		134,984	Advertising: Employee Recruitment	33,422	
Pamela Chappell (Jul. & Aug. '10)	Asst. Admin.	0	1,578	FICA Taxes		843,515	Health Care Worker Background Check	7,882	
				Employee Health Insurance		631,721	(Indicate # of checks performed 392)		
				Employee Meals			Patient Background Checks	990 9,900	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	20,395	
				Disability Payments		2,423	Association Dues	20,895	
				401K		82,271	Advertising	34,313	
				Appreciation, Other Benefits & Marketing Adjust		5,047	Other Licenses & Permits	11,844	
				Tuition Program		10,372	Less Non-allowable Association Dues	(13,942)	
				SMSP Match & RSU		25,187	Less: Public Relations Expense	()	
				Employee Uniforms		10,676	Non-allowable advertising	(34,313)	
				Home Office Allocation		81,759	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 143,018	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 94,376
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description		Amount
Various home office services			\$ 1,118,393			\$	Out-of-State Travel		\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							In-State Travel		31,141
C. Professional Services							Includes travel expense to the Home Office in Toledo, OH for regional meetings		
Vendor/Payee	Type		Amount						
Foote Meyers Mielde, Flowers, LLC	Legal Fees		\$ 110,516						
Littler Mendelson PC	Legal Fees		14,407						
MPRO	Legal Fees		455						
Querrey & Harros LTD	Legal Fees		4,222						
United Collection Bureau Inc.	Collection Services		1,451						
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)									
							Seminar Expense		
The Weissman Group	HR / Union Consultants		546						
	(reclass to line 21)								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)						\$	Entertainment Expense	()	
			\$ 131,597	TOTAL			(agree to Sch. V, line 24, col. 8)		
							TOTAL		\$ 31,141

*** Attach copy of IMRF notifications**

****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 \$6953

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5-10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 119,342

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.

\$ 109,953

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.

\$ 9,577

(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.