

		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: <u>0049569</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Manorcare of Rolling Meadows IL, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/2010</u> to <u>05/31/2011</u> 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.																							
Address: <u>425 Kirchoff Road</u> <u>Rolling Meadows</u> <u>60008</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 397-2400</u> Fax # <u>(847) 397-2414</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Barry A. Lazarus</u></td></tr><tr><td>(Title) <u>Vice President - Reimbursement</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Barry A. Lazarus</u>	(Title) <u>Vice President - Reimbursement</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Barry A. Lazarus</u>																								
	(Title) <u>Vice President - Reimbursement</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>07-01-77</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Raymond Lewis</u> Telephone Number: <u>(419) 252-5783</u>																									
Email Address: _____																									

Facility Name & ID Number Manorcare of Rolling Meadows IL, LLC

0049569 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

III. STATISTICAL DATA

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

	1	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>155</u>	Skilled (SNF)	<u>155</u>	<u>56,575</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>155</u>	TOTALS	<u>155</u>	<u>56,575</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>21,633</u>	<u>5,316</u>	<u>15,168</u>	<u>42,117</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>21,633</u>	<u>5,316</u>	<u>15,168</u>	<u>42,117</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.44%

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

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

N/A

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

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

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 07/01/77

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 155 and days of care provided 8,826

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: 5/31

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

Facility Name & ID Number Manorcare of Rolling Meadows IL, LLC # 0049569 Report Period Beginning: 06/01/2010 Ending: 05/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	330,511	30,131	9,058	369,700	9,275	378,975		378,975			1
2	Food Purchase		299,054		299,054		299,054	(2,565)	296,489			2
3	Housekeeping	186,620	24,846	160	211,626		211,626		211,626			3
4	Laundry	63,926	19,265	9,019	92,210		92,210		92,210			4
5	Heat and Other Utilities			238,845	238,845	2,500	241,345		241,345			5
6	Maintenance	63,873	7,861	137,587	209,321		209,321		209,321			6
7	Other (specify):* Medical Waste			722	722		722		722			7
8	TOTAL General Services	644,930	381,157	395,391	1,421,478	11,775	1,433,253	(2,565)	1,430,688			8
	B. Health Care and Programs											
9	Medical Director			44,500	44,500		44,500		44,500			9
10	Nursing and Medical Records	3,434,695	214,819	100,662	3,750,176	11,331	3,761,507	(15)	3,761,492			10
10a	Therapy	834,373	6,708	151,843	992,924		992,924		992,924			10a
11	Activities	162,023	3,616	7,852	173,491	2,170	175,661	(50)	175,611			11
12	Social Services	148,788			148,788		148,788		148,788			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,579,879	225,143	304,857	5,109,879	13,501	5,123,380	(65)	5,123,315			16
	C. General Administration											
17	Administrative	103,900		475,285	579,185	(79,677)	499,508		499,508			17
18	Directors Fees											18
19	Professional Services			12,151	12,151	(2,682)	9,469	(9,469)				19
20	Dues, Fees, Subscriptions & Promotions			62,659	62,659		62,659	(41,303)	21,356			20
21	Clerical & General Office Expenses	448,870	49,477	332,400	830,747	182	830,929	(261,527)	569,402			21
22	Employee Benefits & Payroll Taxes			1,051,199	1,051,199	42,252	1,093,451		1,093,451			22
23	Inservice Training & Education			3,684	3,684		3,684		3,684			23
24	Travel and Seminar			1,997	1,997		1,997		1,997			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			435,623	435,623		435,623		435,623			26
27	Other (specify):*											27
28	TOTAL General Administration	552,770	49,477	2,374,998	2,977,245	(39,925)	2,937,320	(312,299)	2,625,021			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,777,579	655,777	3,075,246	9,508,602	(14,649)	9,493,953	(314,929)	9,179,024			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			361,797	361,797	14,649	376,446		376,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,607	51,607		51,607	(51,607)				32
33	Real Estate Taxes			462,854	462,854		462,854		462,854			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			45,703	45,703		45,703		45,703			35
36	Other (specify):*											36
37	TOTAL Ownership			921,961	921,961	14,649	936,610	(51,607)	885,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,327	1,327		1,327		1,327			38
39	Ancillary Service Centers		317,579		317,579		317,579		317,579			39
40	Barber and Beauty Shops			13,702	13,702		13,702		13,702			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):* IV Therapy		37,774	33,616	71,390		71,390		71,390			43
44	TOTAL Special Cost Centers		355,353	133,508	488,861		488,861		488,861			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,777,579	1,011,130	4,130,715	10,919,424		10,919,424	(366,536)	10,552,888			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	\$ (15)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,565)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(187)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,469)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(223,509)	21		24
25	Fund Raising, Advertising and Promotional	(41,303)	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 See Attached pg 5A	(88,488)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (366,536)		\$	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))	\$ (366,536)		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#0049569

06/01/2010

05/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wage - Marketing Expense	\$ (28,159)	21	1
2	Employee Benefits - Marketing Expense	(7,933)	21	2
3	HCP Lease Interest Expense	(51,657)	32	3
4	Vending Income	(480)	21	4
5	Misc. Income	(259)	21	5
6	Activity Income	(50)	11	6
7	Interest Income	50	32	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(88,488)		49

Summary B

05/31/2011

[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	\$ 475,285	HCR Manor Care Services, LLC	100.00%	\$ 475,285	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	5,777,579	Heartland Employment Services, LLC	100.00%	5,777,579		4
5	V	10a	Therapy Management	7,260	Heartland Rehabilitation Services, LLC	100.00%	7,260		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			\$ 6,260,124			\$ 6,260,124	\$ *	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 of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights West IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights IL, LLC	Palos Heights				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 Rolling Meadows IL, LLC # 0049569 Report Period Beginning: 06/01/2010 Ending: 5/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ 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	10,201,677	\$ 9,275	1
2	1	Dietary - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	10,201,677	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	0	0	10,201,677	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	0	0	10,201,677	0	4
5	5	Utilities - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	10,201,677	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551	0	10,201,677	2,500	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	10,201,677	9,441	7
8	10	Nursing - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	10,201,677	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	10,201,677	1,560	9
10	17	General & Admin - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	10,201,677	86,518	10
11	17	General & Admin - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	1,871,124	5,027,701	10,201,677	27,558	11
12	17	General & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	10,201,677	281,531	12
13	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	10,201,677	25,494	13
14	22	Employee Benefits - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	10,201,677	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146	0	10,201,677	16,757	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954	0	10,201,677	1,000	16
17	30	Depreciation - Direct to Central Division	Accumulated Cost	692,663,974	92 NFs	0	0	10,201,677	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801	0	10,201,677	13,649	18
19										19
20	32	Directly Assigned Interest				12,736,052				20
21		Non Central Division Nursing Home Allocation				29,513,406			2	21
22										22
23										23
24										24
25	TOTALS					\$ 185,111,177	\$ 62,809,840		\$ 475,285	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				N/A			\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	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.			\$	348,711	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.)			\$	365,454	2
3. Under or (over) accrual (line 2 minus line 1).			\$	16,743	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	431,337	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.)			\$	14,774	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.			\$	462,854	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	377,844	8	
		2007	419,183	9	
		2008	429,128	10	
		2009	388,048	11	
		2010	455,127	12	
Line 2: \$365,454 = \$152,028 for 2nd half of '09 paid in Nov 10 + \$213,426 for first half of '10 paid in Feb 2011				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
Line 4: \$431,337 = \$241,701 for 2nd half of 10 payable in Dec 11 + \$189,636 for estimate of 1st half of 2011				14	PLUS APPEAL COST FROM LINE 5 \$ 14
Line 5: \$14,774 = \$3,000 for appraisal for 2010 Appeal + \$11,774 for Rock, Fusco \$ Assoc LLC to file Appeal for 2009				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 Rolling Meadows IL, LLC

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0049569

CONTACT PERSON REGARDING THIS REPORT

Raymond Lewis

TELEPHONE

(419) 252-5783

FAX #:

(800) 422-2089

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 02-26-400-25-0000	See Attached	\$ 455,127.20	\$ 455,127.20
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 455,127.20	\$ 455,127.20

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: 38,523

B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

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

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

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

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

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

N/A

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

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1977</u>	<u>\$ 155,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			<u>\$ 155,000</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	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	155			1977	\$ 1,350,315	\$ 51,356		\$ 51,356	\$	\$ 1,538,542
5				1990	765,804					
6										
7										
8										
	Improvement Type**									
9	Building Improvements (Current Year Depreciation)					164,689		164,689		2,404,896
10				1987	72,739					
11	RETIREMENTS			1987	(44,531)					
12				1988	33,303					
13				1989	74,517					
14				1990	157,389					
15				1991	127,927					
16				1992	107,998					
17	RETIREMENTS			1992	(36,743)					
18				1993	73,889					
19				1994	71,280					
20				1995	236,489					
21	CR 5/31/99 AUDIT ADJ-CORPORATE O/H			1995	(791)					
22	HVAC/DUCTWORK			1996	3,845					
23	PLUMBING			1996	2,184					
24	CORPORATE OVERHEAD-ARCADIA/DINING			1996	7,272					
25	REMODEL ARCADIA/DINING/BEDROOM			1996	95,560					
26	PROFESSIONAL FEES-ARCADIA/DINING			1996	1,737					
27	CORNER GUARDS			1996	1,340					
28	WOODEN DOORS			1996	11,077					
29	WALLCOVERINGS			1996	5,279					
30	ELECTRICAL/LIGHTING			1996	7,005					
31	CARPETING			1996	3,300					
32	REBUILD GENERATOR			1996	1,927					
33	REPLACE SMOKE DETECTOR			1996	2,156					
34	CR 5/31/99 AUDIT ADJ-CORPORATE O/H			1996	(7,272)					
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Rolling Meadows IL, LLC

0049569

Report Period Beginning:

06/01/2010 Ending: 05/31/2011

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

1	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	INSTALL HANDRAILS	1997	\$ 8,660	\$		\$	\$	37
38	WALL GUARDS	1997	2,756					38
39	REPLACE CEILING TILES	1997	12,173					39
40	REMOVE & INSTALL FIRE DOORS	1997	2,012					40
41	INSTALL CLOSET DOORS	1997	10,821					41
42	WALL COVERINGS	1997	4,812					42
43	DECORATING	1997	10,594					43
44	CARPETING	1997	2,343					44
45	FLOORING	1997	11,254					45
46	REPAIR ELEVATOR	1997	3,430					46
47	ROOFING	1997	1,679					47
48	REMODELING-ARCADIA	1997	8,663					48
49	CONNECT WATER AND GAS LINES	1997	1,705					49
50	CORPORATE OVERHEAD-ARCADIA/DINING	1997	10,515					50
51	FACILITY PLAN ALLOC.-ARCADIA/DINING	1997	5,964					51
52	REPLACE CLOSET DOORS	1997	12,000					52
53	PROFESSIONAL FEES-ARCADIA/DINING	1997	1,396					53
54	CEILING TILES	1997	10,349					54
55	INSTALL CIRCULATING PUMPS	1997	2,250					55
56	BOILER WORK	1997	5,613					56
57	WALLPAPER	1997	482					57
58	STORAGE SHED	1997	789					58
59	REMODELING	1997	(8,489)					59
60	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1997	(10,515)					60
61	C/R 5/31/99 AUDIT ADJ. - FACILITY PLAN ALLOC	1997	(5,964)					61
62	ROOF WORK	1998	53,389					62
63	DOORS/WINDOWS	1998	10,090					63
64	PLUMBING	1998	3,838					64
65	RENOVATE PT & OT ROOMS	1998	4,500					65
66	DOOR & WINDOW CASINGS	1998	4,500					66
67	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,416					67
68	INSTALL STEEL DOORS	1998	4,224					68
69								69
70	TOTAL (lines 4 thru 69)		\$ 3,315,244	\$ 216,045		\$ 216,045	\$ 3,943,438	70

**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 12A, Carried Forward		\$ 3,315,244	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	1
2 ELECTRICAL	1998	754						2
3 PAINTING/WALLCOVERING	1998	36,239						3
4 PLUMBING	1998	13,534						4
5 ELECTRICAL	1998	10,004						5
6 DEVELOPERS-PT & OT ROOMS	1998	11,097						6
7 FLOORING/CEILING	1998	985						7
8 HVAC	1998	37,124						8
9 DOOR/WINDOW	1998	8,160						9
10 SIGN	1998	11,862						10
11 ROOFING	1998	92,520						11
12 MASONARY	1998	1,499						12
13 CARPENTRY	1998	1,475						13
14 FINISH STUDS	1998	26,279						14
15 GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,601						15
16 CONCRETE SIDEWALK	1998	1,482						16
17 FLOORING/CEILING	1999	1,340						17
18 CARPENTRY	1999	19,278						18
19 FINISH STUDS	1999	25,000						19
20 PAINTING/WALLCOVERING	1999	750						20
21 WINDOW TREATMENTS	1999	525						21
22 ROOF WORK	1999	6,098						22
23 C/R 5/31/03 AUDIT ADJ #1-ROOF WORK	1999	(6,098)						23
24 ROOFING CONTRACT	1999	876						24
25 C/R 5/31/03 AUDIT ADJ #2-ROOFING CONTRACT	1999	(876)						25
26 DRAIN/FLASH SCUPPERS/OVERFLOW	1999	1,782						26
27 ROOFING CONTRACT	1999	6,098						27
28 C/R 5/31/03 AUDIT ADJ #3-ROOFING CONTRACT	1999	(6,098)						28
29 BUILDING IMPROVEMENTS-NURSES STATIONS	1999	4,554						29
30 BUILDING IMPROVEMENTS-NURSES STATIONS	1999	22,150						30
31 INSTALL CLOSETS	1999	2,895						31
32 25 EXIT SIGNS FOR BU	1999	4,810						32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,655,943	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,655,943	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	1
2	VINYL WALLCOVERING	1999	336						2
3	WALLCOVERING	1999	226						3
4	RENOVATE NURSING STATIONS	1999	11,478						4
5	WALLCOVERING	1999	2,245						5
6	DAMPER MOTOR	1999	2,693						6
7	CHART RACK	2000	1,450						7
8	ELECTRICAL FOR A/C UNITS	2000	1,214						8
9	WALLCOVERING	2000	294						9
10	ELECTRICAL FOR A/C UNITS	2000	1,151						10
11	WORK STATIONS BOOKKEEPING & PAYROLL	2000	5,975						11
12	WORK STATIONS	2000	728						12
13	EXTERIOR LIGHTING	2000	19,956						13
14	CEILING TILE, PAINTING, CARPET	2000	900						14
15	FENCING	2000	17,820						15
16	FENCING	2000	1,980						16
17	CONCRETE, MASONRY, CARPENTRY	2000	49,335						17
18	CARPET	2000	35,925						18
19	C/R 5/31/03 AUDIT ADJ #4-CARPET	2000	(14,231)						19
20	WALLCOVERING	2000	52,636						20
21	C/R 5/31/03 AUDIT ADJ #5-WALLCOVERING	2000	(466)						21
22	ELECTRICAL	2000	34,947						22
23	C/R 5/31/03 AUDIT ADJ #6-ELECTRICAL	2000	(9,885)						23
24	INTEREST - CONST & GENERAL O/H ARCADIA	2000	74,862						24
25	C/R 5/31/03 AUDIT ADJ #15-CONST & GEN O/H	2000	(74,862)						25
26	ARCADIA RENOVATION	2000	12,075						26
27	C/R 5/31/03 AUDIT ADJ #10-ARCADIA RENOV	2000	(12,075)						27
28	ARCADIA RENO - DRAPES	2001	2,843						28
29	C/R 5/31/03 AUDIT ADJ #11-ARCADIA DRAPES	2001	(184)						29
30	ARCADIA RENO - CARPENTRY	2001	6,748						30
31	C/R 5/31/03 AUDIT ADJ #12-CARPENTRY	2001	(2,200)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,879,857	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	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		\$ 3,879,857	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	1
2 ARCAIDA RENO - CONTRACTOR	2001	50,636						2
3 C/R 5/31/03 AUDIT ADJ #13-CONTRACTOR	2001	(25,985)						3
4 ARCADIA RENO - ELECTRICAL	2001	3,560						4
5 BORDER	2001	170						5
6 KITCHEN WALLS AND FLOOR	2002	2,566						6
7 KITCHEN WALLS AND FLOOR	2002	14,796						7
8 DOORS	2002	6,445						8
9 DOORS	2002	1,868						9
10 DOORS	2002	7,740						10
11 PAINTING	2002	204						11
12 CEILING TILE	2002	517						12
13 DUCT WORK AND DAMPERS	2002	8,301						13
14 DOORS AND DRYWALL	2002	9,694						14
15 GENERAL CONSTRUCTION	2002	4,640						15
16 OVERHEAD AND INTEREST	2002	15,405						16
17 CARPENTRY	2002	85,703						17
18 C/R 5/31/03 AUDIT ADJ #7-CARPENTRY	2002	(650)						18
19 VINYL WALL COVERING	2002	10,495						19
20 C/R 5/31/03 AUDIT ADJ #8-VINYL WALL COVERING	2002	(979)						20
21 HVAC, ELECTRIC	2002	12,530						21
22 C/R 5/31/03 AUDIT ADJ #9-RECLASS HVAC, ELECTRIC	2002	(4,808)						22
23 PARKING LOT UPGRADE	2002	17,482						23
24 PARKING LOT UPGRADE	2003	1,943						24
25 METAL DOOR	2003	1,968						25
26 WALLCOVERINGS	2003	563						26
27 CARPET	2003	335						27
28 FLOORING & CARPENTRY	2003	100,275						28
29 CARPENTRY	2003	27,714						29
30 DOORS AND FRAMES	2003	24,849						30
31 SPRINKLER SYSTEM	2003	9,660						31
32 DOORS	2004	4,464						32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,271,957	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	34

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

Facility Name & ID Number Manorcare of Rolling Meadows IL, LLC

0049569

Report Period Beginning:

06/01/2010 Ending: 05/31/2011

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

1	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 12D, Carried Forward		\$ 4,271,957	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	1
2	HERITAGE WING ROOF	2004	10,976						2
3	HERITAGE WING	2004	10,976						3
4	VWC	2004	291						4
5	VWC	2004	203						5
6	CARPET	2004	659						6
7	FREIGHT ON CARPET	2004	37						7
8	CARPET & BASE	2004	674						8
9	FREIGHT ON CARPET	2004	109						9
10	CARPET	2004	5,250						10
11	COVE BASE	2004	3,545						11
12	INSTALL CARPET	2004	4,222						12
13	INSTALL CARPET	2004	(4,222)						13
14	VWC	2005	697						14
15	PHONE LINES	2005	1,700						15
16	CABINETS	2005	6,000						16
17	MED ROOM RENOVATION	2005	2,850						17
18	door	2005	1,107						18
19	CEILING TILE	2006	10,305						19
20	vwc	2006	9,776						20
21	Renov - Doors/Frames/Drywall/ Stud/Plumbing	2006	32,276						21
22	Renov - Wall covering	2006	3,128						22
23	Renov - Interest & Gen Overhead	2006	6,615						23
24	2 Elevator door operators	2006	4,400						24
25	flooring and painting in	2006	19,120						25
26	Renov - Basic Electrical	2006	28,016						26
27	Renov - Arch & Engineering	2006	197,182						27
28	Renov - Interest & Gen Overhead	2006	62,439						28
29	ceiling & painting in lau	2006	3,245						29
30	INSTALL GENERATOR- Basic Electrical	2007	24,160						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,717,692	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	34

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

Facility Name & ID Number Manorcare of Rolling Meadows IL, LLC

0049569

Report Period Beginning:

06/01/2010 Ending: 05/31/2011

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

1	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 12E, Carried Forward		\$ 4,717,692	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	1
2	1306 TELEPHONE SYSTEM	2007	7,072						2
3	LIGHT FIXTURES IN CORRI	2007	3,260						3
4	electrical for steamers	2007	2,760						4
5	SOFFIT PANELS AROUND BO	2007	5,702						5
6	FLOORING	2007	3,844						6
7	METAL DOORS	2007	6,105						7
8	PRCH PR ADJ 522 023-07C	2007	(33,606)						8
9	PRCH PR ADJ 522 023-07C	2007	(8,326)						9
10	2307 INTERIOR RENOV	2007	8,326						10
11	2307 INTERIOR RENOV	2007	33,606						11
12	sprinkler heads	2008	10,500						12
13	5 door holders	2008	5,793						13
14	000000002491 SEALCOAT PARKING LOT	2008	13,216						14
15	000000002479 AUTO TRANSFER SWITCH	2008	2,295						15
16	000000002478 CEILING TILE	2008	8,554						16
17	000000002477 CO2 SYSTEM	2008	7,476						17
18	000000002483 WIRING FOR LIGHT POLES	2008	18,455						18
19	000000002490 FRENCH DOORS	2008	3,415						19
20	000000002492 2307 INT RENOV - GENL O/H, Heritage Wing	2008	31,554						20
21	000000002492 2307 INT RENOV - INT, Heritage Wing	2008	6,290						21
22	000000002492 2307 INT RENOV - FLOORING, Heritage Wing	2008	63,632						22
23	000000002492 2307 INT RENOV - WALL COVERING, Heritage	2008	8,254						23
24	000000002496 2307 INT RENOV - CARPENTRY & ELECTRICA	2008	57,268						24
25	000000002499 METAL DOORS - Arcadia Entrance	2008	5,427						25
26	000000002505 KITCHEN WASH SINK	2009	19,750						26
27									27
28	000000002534 ASPHALT	2009	3,746						28
29	000000002535 ENTRANCE CONCRETE PATIO	2009	6,965						29
30	000000002543 ADDL COST ENTRANCE CONTRETE PATIO	2009	600						30
31	000000002523 STEEL DOOR	2009	1,048						31
32	000000002526 1209 NEW SECURITY SYSTEM - HM DOORS &	2009	18,210						32
33	000000002549 1209 NEW SECURITY SYSTEM - FACILITY ALA	2010	26,000						33
34	TOTAL (lines 1 thru 33)		\$ 5,064,882	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	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 12F, Carried Forward		\$ 5,064,882	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	1
20000000025511209 NEW SECURITY SYSTEM - UPGRADE ALAR	2010	7,552						2
3000000002536CARPET & VCT TILE	2009	6,165						3
40000000025370409 ELEVATOR UPGRADE - ELEVATORS	2009	74,800						4
500000000253911 STEEL DOORS	2009	9,577						5
600000000254011 STEEL DOORS	2009	350						6
7000000002542THERMAL DETECTION FOR FIRE	2009	6,145						7
80000000025461409 1ST FLOOR CORRIDOR - CEILING TILE	2009	48,078						8
90000000025461409 1ST FLOOR CORRIDOR - RESILIENT FLOOR	2009	61,225						9
10000000025461409 1ST FLOOR CORRIDOR - CARPETING	2009	6,607						10
110000000025461409 1ST FLOOR CORRIDOR - WALL COVERING	2009	63,459						11
120000000025461409 1ST FLOOR CORRIDOR - CORNER GUARDS	2009	3,307						12
130000000025471409 1ST FLOOR CORRIDOR - MILLWORK	2009	29,820						13
14000000002557KITCHEN ELECTRICAL	2010	3,442						14
15								15
162558 LIGHT POLE 15 FEET	2010	2,419						16
172580 STAIRCASE RAILING	2011	6,800						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)		\$ 5,394,628	\$ 216,045		\$ 216,045	\$	\$ 3,943,438	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	\$ 2,070,505	\$ 145,752	\$ 145,752	\$		\$ 1,582,831	71
72	Current Year Purchases	98,962						72
73	Fully Depreciated Assets							73
74	Home Office			14,649	14,649			74
75	TOTALS	\$ 2,169,467	\$ 145,752	\$ 160,401	\$ 14,649		\$ 1,582,831	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)			\$ 7,719,095
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 361,797
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 376,446
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 14,649
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 5,526,269

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		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YESNO
- If NO, see instructions.

		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:

YESNO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$45,703Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.

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)	\$			

- (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	3183	hrs	\$ 130,979	1,163	\$ 69,786	\$ 1,119	4,346	\$ 201,884	1
2	Licensed Speech and Language Development Therapist	10a	4728	hrs	185,377				4,728	185,377	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	7446	hrs	331,922	924	55,413	5,589	8,370	392,924	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts				317,579		317,579	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy							37,774		37,774	12
13	Other (specify): PS X-Ray, Lab						33,616			33,616	13
14	TOTAL				\$ 648,278	2,087	\$ 158,815	\$ 362,061	17,444	\$ 1,169,154	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 16,489	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 334,135)	939,898		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,741		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 961,128	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	155,000		13
14	Buildings, at Historical Cost	5,394,628		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,169,467		16
17	Accumulated Depreciation (book methods)	(5,526,269)		17
18	Deferred Charges	1,378,193		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,571,019	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,532,147	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 101,112	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	551,507		30
31	Accrued Taxes Payable (excluding real estate taxes)	95,916		31
32	Accrued Real Estate Taxes(Sch.IX-B)	431,338		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Acc Payables	134,460		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,314,333	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,917,907		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	99,724		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,017,631	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,331,964	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 200,183	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,532,147	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,473,681	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,473,681	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(88,515)	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)	\$ (88,515)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(2,184,983)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,184,983)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 200,183	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	\$ 10,751,129	1
2	Discounts and Allowances for all Levels	(2,728,362)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,022,767	3
	B. Ancillary Revenue		
4	Day Care	15	4
5	Other Care for Outpatients		5
6	Therapy	2,380,910	6
7	Oxygen	191	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,381,116	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	480	12
13	Barber and Beauty Care	15,305	13
14	Non-Patient Meals	2,565	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	325,942	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,851	19
20	Radiology and X-Ray		20
21	Other Medical Services	63,624	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 426,767	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	259	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 259	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,830,909	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,421,478	31
32	Health Care	5,109,879	32
33	General Administration	2,977,245	33
	B. Capital Expense		
34	Ownership	921,961	34
	C. Ancillary Expense		
35	Special Cost Centers	403,998	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,919,424	40
41	Income before Income Taxes (line 30 minus line 40)**	(88,515)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (88,515)	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	2,194	2,376	\$ 102,819	\$ 43.27	1
2	Assistant Director of Nursing	5,746	6,223	225,272	36.20	2
3	Registered Nurses	38,537	41,736	1,329,897	31.86	3
4	Licensed Practical Nurses	17,819	19,298	465,144	24.10	4
5	CNAs & Orderlies	90,244	98,005	1,290,045	13.16	5
6	CNA Trainees					6
7	Licensed Therapist	15,807	17,115	724,607	42.34	7
8	Rehab/Therapy Aides	4,871	5,274	109,766	20.81	8
9	Activity Director	11,553	12,526	162,023	12.93	9
10	Activity Assistants					10
11	Social Service Workers	5,593	6,063	148,788	24.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,550	26,627	330,511	12.41	15
16	Dishwashers					16
17	Maintenance Workers	2,236	2,425	63,873	26.34	17
18	Housekeepers	14,785	16,029	186,620	11.64	18
19	Laundry	6,477	7,023	63,926	9.10	19
20	Administrator	2,080	2,080	103,900	49.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,953	20,519	412,778	20.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,811	1,964	21,518	10.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,256	285,283	\$ 5,741,487 *	\$ 20.13	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	44,500	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)		\$ 44,500		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.

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount	Description	Amount		
Barbara Beake	Administrator	0	\$ 20,416	Workers' Compensation Insurance	\$ 173,362	IDPH License Fee	\$ 3,479				
Kathryn Berg	Administrator	0	83,484	Unemployment Compensation Insurance	66,284	Advertising: Employee Recruitment	5,011				
				FICA Taxes	404,771	Health Care Worker Background Check	3,307				
				Employee Health Insurance	351,690	(Indicate # of checks performed 160)					
				Employee Meals		Patient Background Checks	180 1,800				
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,371				
				Disability Payments		Association Dues	15,738				
				401K	50,639	Advertising	30,953				
				Appreciation, Other Benefits & Marketing Adjust	279	Public Relations					
				Tuition Program							
				SMSP Match & RSU		Less: Public Relations Expense	()				
				Employee Uniforms	4,174	Non-allowable advertising	(30,953)				
				Home Office Allocation	42,252	Yellow page advertising	(10,350)				
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		TOTAL (agree to Sch. V,					
(List each licensed administrator separately.)			\$ 103,900	line 22, col.8)		line 20, col. 8)					
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			\$ 475,285			\$	Out-of-State Travel	\$			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 475,285				In-State Travel				
(Attach a copy of any management service agreement)							Includes travel expense to the Home	1,997			
C. Professional Services							Office in Toledo, OH for regional meetings				
Vendor/Payee	Type		Amount								
Foote, Meyers, Mielke & Flowers LL	Legal		\$ 5,377				Seminar Expense				
Elvidge Kelley Attorney at Law	Legal		783								
Benjamin Bronstein Attorney at Law	Legal		225								
United Collections Bureau	Collections		3,084								
(All above adjusted off via Page 5 Line 22, therefore no invoices are attached)											
Christine Toolan	Medical Records Consultant		330								
Chris Webb	Activities Consultant		2,170								
The Weissman Group	HR/Union Consultant		182								
(Reclassified consultants to Lines 10, 11, and 21 respectively, no invoices attached)											
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()			
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 12,151				(agree to Sch. V,				
							line 24, col. 8)	\$ 1,997			

* 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 \$5,388

(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 \$10,350

(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.

\$

69,226

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.

\$

84,863

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.

\$

2,565

(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.