

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0049387

Facility Name: Manorcare of Elk Grove Village

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: 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 06/01/11 to 05/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid Preparer

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

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

Facility Name & ID Number Manorcare of Elk Grove Village# 0049387 Report Period Beginning: 06/01/11 Ending: 05/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>190</u>	Skilled (SNF)	<u>190</u>	<u>69,540</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>190</u>	TOTALS	<u>190</u>	<u>69,540</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>22,777</u>	<u>4,044</u>	<u>34,048</u>	<u>60,869</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>22,777</u>	<u>4,044</u>	<u>34,048</u>	<u>60,869</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.53%

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?

YesG. 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 7/30/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 04/07/11NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 190 and days of care provided 27,796Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL ☒ 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.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	548,349	54,360	6,518	609,227		609,227		609,227		1
2	Food Purchase		478,273		478,273		478,273	(2,972)	475,301		2
3	Housekeeping	255,185	36,942	1,818	293,945		293,945		293,945		3
4	Laundry	70,348	33,613	776	104,737		104,737		104,737		4
5	Heat and Other Utilities			310,873	310,873	4,308	315,181		315,181		5
6	Maintenance	103,429	20,722	198,930	323,081		323,081		323,081		6
7	Other (specify):* Med Waste\			3,149	3,149		3,149		3,149		7
8	TOTAL General Services	977,311	623,910	522,064	2,123,285	4,308	2,127,593	(2,972)	2,124,621		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	5,643,046	522,973	256,001	6,422,020	27,183	6,449,203		6,449,203		10
10a	Therapy	2,020,469	13,389	800,461	2,834,319		2,834,319		2,834,319		10a
11	Activities	163,666	5,261	2,744	171,671		171,671		171,671		11
12	Social Services	392,161	207	295	392,663		392,663		392,663		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	8,219,342	541,830	1,089,501	9,850,673	27,183	9,877,856		9,877,856		16
	C. General Administration										
17	Administrative	181,785		912,276	1,094,061	(281,951)	812,110		812,110		17
18	Directors Fees										18
19	Professional Services			62,896	62,896	(12,123)	50,773	(50,773)			19
20	Dues, Fees, Subscriptions & Promotions			131,086	131,086		131,086	(63,385)	67,701		20
21	Clerical & General Office Expenses	613,753	117,679	476,170	1,207,602	12,123	1,219,725	(345,923)	873,802		21
22	Employee Benefits & Payroll Taxes			1,411,163	1,411,163	58,109	1,469,272		1,469,272		22
23	Inservice Training & Education			21,048	21,048		21,048		21,048		23
24	Travel and Seminar			5,761	5,761		5,761		5,761		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			593,304	593,304		593,304		593,304		26
27	Other (specify):*							(203)	(203)		27
28	TOTAL General Administration	795,538	117,679	3,613,704	4,526,921	(223,842)	4,303,079	(460,284)	3,842,795		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,992,191	1,283,419	5,225,269	16,500,879	(192,351)	16,308,528	(463,256)	15,845,272		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			786,074	786,074	30,025	816,099		816,099			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,661,194	2,661,194	162,326	2,823,520	(2,665,564)	157,956			32
33	Real Estate Taxes			683,318	683,318		683,318		683,318			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			41,545	41,545		41,545		41,545			35
36	Other (specify):*											36
37	TOTAL Ownership			4,172,131	4,172,131	192,351	4,364,482	(2,665,564)	1,698,918			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		955,802	1,000	956,802		956,802		956,802			39
40	Barber and Beauty Shops			24,606	24,606		24,606		24,606			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			341,374	341,374		341,374		341,374			42
43	Other (specify):* IV Ther/Xray/Lab		208,204	242,548	450,752		450,752		450,752			43
44	TOTAL Special Cost Centers		1,164,006	609,528	1,773,534		1,773,534		1,773,534			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,992,191	2,447,425	10,006,928	22,446,544		22,446,544	(3,128,820)	19,317,724			45

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

Facility Name & ID Number Manorcare of Elk Grove Village # 0049387 Report Period Beginning: 06/01/11 Ending: 05/31/12
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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,972)	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	(157)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(203)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(150)	21		18
19	Entertainment				19
20	Contributions	(15,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(50,773)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(303,567)	21		24
25	Fund Raising, Advertising and Promotional	(63,385)	20		25
	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 5a	(2,692,613)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,128,820)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,128,820)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
Manorcare of Elk Grove Village

Report Period Beginning: ID# 0049387
Ending: 06/01/11
05/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (21,297)	21	1
2	P/R O/H Alloc - Mktg	(5,029)	21	2
3	HCP Lease Interest	(2,665,564)	32	3
4	Vending Income	(723)	21	4
5	Misc. Income		21	5
6	Activity Income		11	6
7	Loss on disposal of Fixed Asset		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
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	(2,692,613)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Elk Grove Village # 0049387 Report Period Beginning: 06/01/11 Ending: 05/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,972)	0	0	0	0	0	0	0	0	0	0	(2,972)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,972)	0	0	0	0	0	0	0	0	0	0	(2,972)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(50,773)	0	0	0	0	0	0	0	0	0	0	(50,773)	19
20	Fees, Subscriptions & Promotions	(63,385)	0	0	0	0	0	0	0	0	0	0	(63,385)	20
21	Clerical & General Office Expenses	(345,923)	0	0	0	0	0	0	0	0	0	0	(345,923)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(203)	0	0	0	0	0	0	0	0	0	0	(203)	27
28	TOTAL General Administration	(460,284)	0	0	0	0	0	0	0	0	0	0	(460,284)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(463,256)	0	0	0	0	0	0	0	0	0	0	(463,256)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,665,564)	0	0	0	0	0	0	0	0	0	0	(2,665,564)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,665,564)	0	0	0	0	0	0	0	0	0	0	(2,665,564)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,128,820)	0	0	0	0	0	0	0	0	0	0	(3,128,820)	45

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 Svc	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	\$ 912,277	HCR Manor Care Services, LLC	100.00%	\$ 912,277	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	9,992,191	Heartland Employment Services, LLC	100.00%	9,992,191		4
5	V	10a	Therapy Management	21,586	Heartland Rehabilitation Services, LLC	100.00%	21,586		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 10,926,054			\$ 10,926,054	\$ *	14

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

Facility Name & ID Number

Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/11

Ending:

05/31/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights West IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30								30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES

X

NO

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

Name of Related Organization

HCR Manor Care Services, LLC

Street Address

333 North Summit Street

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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs, & Re	\$ 775,999	\$	20,900,974	\$ 4,308	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs			20,900,974	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			20,900,974	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			20,900,974	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs, & Re	485,056	352,684	20,900,974	2,693	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	20,900,974	24,490	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			20,900,974	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			20,900,974	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs, & Re	71,430,003	38,287,220	20,900,974	396,511	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	20,900,974	147,978	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	20,900,974	46,380	11
12	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	20,900,974	39,457	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs, & Re	2,952,374		20,900,974	16,389	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		20,900,974	41,720	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			20,900,974	0	15
16	22	Empl Bnfts - Direct to MW Div S	Accumulated Cost	474,102,184	48 NFs			20,900,974	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs, & Re	4,719,938		20,900,974	26,201	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		20,900,974	3,824	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			20,900,974	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			20,900,974	0	20
21										21
22	32	Pooled Interest	Accumulated Cost			26,343,470		20,900,974	146,234	22
23	32	Directly Assigned Interest	Not Allocated			18,851,990			16,092	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				32,615,916				24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 912,277	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			\$ 241,832	\$ 241,832		0.0665	\$ 16,092	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Pooled Interest										146,234	7	
8	Interest Expense / Interest Income										(4,370)	8	
9	TOTAL Facility Related						\$ 241,832	\$ 241,832			\$ 157,956	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 241,832	\$ 241,832			\$ 157,956	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 2011 report.			\$	766,116	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.)			\$	881,533	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	115,417	3																			
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	567,901	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.			\$	683,318	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2007	388,185	8	<table><tr><td></td><td>FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2008	398,728	9																					
	2009	301,576	10																					
	2010	657,870	11																					
	2011	696,875	12																					
Line 2: \$881,532.87 = \$492,002.78 for 2nd half of 2010 + \$384,210.09 for 1st half of 2011 + \$5,320 to adjust expense																								
Line 4: \$567,901.38 = \$294,451.38 for 2nd half of 2011 + \$273,450 for Jan-May 2012																								

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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Elk Grove Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049387

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>07-35-200-022-0000</u>	<u>See Attached</u>	\$ <u>937,542.58</u>	\$ <u>696,875.40</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>937,542.58</u></u>	\$ <u><u>696,875.40</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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:	70,963	B. General Construction Type:	Exterior	Masonry	Frame	Steel	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	----------------	--------------	--------------	--------------------------	----------

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

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

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

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

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

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		1990	\$ 853,628	1
2					2
3	TOTALS			\$ 853,628	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	120			1990	\$ 5,025,494	\$ 204,245		\$ 204,245	\$	\$ 3,664,084	4
5	60			1996	1,726,800						5
6	10			2000	1,063,936						6
7	5/31/03 Audit Adjustment			2000	(277,211)						7
8				2009	631,865						8
	Improvement Type**										
9	Current Year Depreciation					318,655		318,655		2,253,965	9
10				1990	12,954						10
11				1991	41,034						11
12				1992	89,111						12
13				1993	29,775						13
14				1994	18,939						14
15				1995	182,383						15
16				1996	485,188						16
17				1997	111,890						17
18				1998	127,587						18
19				1999	60,314						19
20				2000	68,449						20
21				2001	5,850						21
22				2002	53,586						22
23	HOLLOW METAL DOOR			2003	975						23
24	ARCH & ENGINEERING COSTS			2003	975						24
25	BORDER			2003	162						25
26	VWC			2003	1,710						26
27	VWC			2003	219						27
28	ARCHITECTIRAL ENGINEERING			2003	258						28
29	VWC			2003	427						29
30	NEW BATHROOM FLOORING & TILE			2003	22,640						30
31	ARCHITECT & ENGINEERING			2003	258						31
32	FLOORING			2003	4,599						32
33	VWC, BORDER, AND PAINTING			2003	3,317						33
34	ADDITIONAL COST FOR FLOORING			2003	2,820						34
35	ARCHITECT AND ENGINEERING COSTS			2003	2,064						35
36				2003	3,629						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/11

Ending:

05/31/12

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	
37	<u>BORDER</u>	2003	\$ 54	\$		\$	\$	\$	37
38	<u>ARCHITECT AND ENGINEERING COSTS</u>	2003	455						38
39	<u>ELECTRICAL WORK</u>	2003	5,182						39
40	<u>VCT FLOORING</u>	2003	7,005						40
41	<u>BASE AND FLOOR TILE</u>	2003	4,118						41
42	<u>CARPET</u>	2004	609						42
43	<u>INSTALL CARPET</u>	2004	550						43
44	<u>PAVING</u>	2003	67,500						44
45	<u>CONCRETE WALK</u>	2003	3,822						45
46	<u>PAVING</u>	2004	7,500						46
47	<u>Renov. - General Construction Overhead & Interest</u>	2004	19,622						47
48	<u>Renov. - Carpeting</u>	2004	595						48
49	<u>Renov. - Painting</u>	2004	14,000						49
50	<u>Renov. - Wallcovering & Corner Guards</u>	2004	37,811						50
51	<u>Renov. - Carpentry</u>	2004	8,201						51
52	<u>Renov. - Plumbing</u>	2004	2,880						52
53	<u>Renov. - Electrical</u>	2004	2,931						53
54	<u>Carpet</u>	2004	1,324						54
55	<u>Ceramic Cove Base</u>	2004	3,360						55
56	<u>Renov. - Wood Doors & Hardware for Lobby</u>	2004	8,597						56
57	<u>Renov. - Electrical</u>	2004	2,484						57
58	<u>Electric Door Strike at Service Door</u>	2004	1,509						58
59	<u>CARPETING & DELIVERY OF CARPETTING</u>	2005	2,435						59
60	<u>REBUILD SHOWER STALLS (5)</u>	2006	14,000						60
61	<u>VWC, BASE, & CEILING TILES IN BREAK ROOM</u>	2006	2,470						61
62	<u>Ceramic Tile - Wall/Floor</u>	2006	3,300						62
63	<u>Wallcovering</u>	2006	3,605						63
64	<u>Plumbing Work on Sprinkler System</u>	2006	4,727						64
65	<u>Architecture/Engineering for Parking Lot</u>	2007	9,285						65
66	<u>Drywall Work</u>	2007	8,378						66
67	<u>DOOR HOLDER & CLOSER</u>	2007	1,556						67
68	<u>DOOR HOLDER & CLOSER</u>	2007	1,869						68
69	<u>Renov. - Carpeting & Pad</u>	2007	1,742						69
70	TOTAL (lines 4 thru 69)		\$ 9,755,473	\$ 522,900		\$ 522,900	\$	\$ 5,918,049	70

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

Facility Name & ID Number Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/11

Ending:

05/31/12

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,755,473	\$ 522,900		\$ 522,900	\$	\$ 5,918,049	1
2	<u>Renov. - Wallcovering</u>	2007	84,542						2
3	<u>Renov. - Carpentry - Subtractor</u>	2007	38,200						3
4	<u>Renov. - Basic Electrical</u>	2007	7,626						4
5	<u>Renov. - HM Doors & Frames</u>	2007	10,505						5
6	<u>Renov. - Generator, Permit</u>	2007	3,096						6
7	<u>Renov. - Basic Electrical</u>	2007	9,357						7
8	<u>Renov. - Generator, Engineering</u>	2007	13,539						8
9	<u>Renov. - Parking Lot Expansion & Landscaping</u>	2007	83,045						9
10	<u>BLACKTOP PATCHING</u>	2007	12,078						10
11	<u>Roofing</u>	2008	7,221						11
12	<u>Roofing - additional</u>	2008	802						12
13	<u>Generator - Installation & Materials</u>	2008	36,317						13
14	<u>Generator - Equipment</u>	2008	10,814						14
15	<u>Generator - Installation & Materials</u>	2008	62,613						15
16	<u>Renov. - CORRIDOR DOORS (35)</u>	2008	50,575						16
17	<u>CO2 Detectors & Control Panel</u>	2008	11,781						17
18	<u>Generator - Equipment</u>	2008	63,883						18
19	<u>Storm Drain Enhancements</u>	2008	4,100						19
20	<u>Sealcoating & Restriping</u>	2008	13,362						20
21	<u>Renov. - Internet Café Construction (Contracted Total)</u>	2009	88,371						21
22	<u>Double Egress Kitchen Doors</u>	2009	6,076						22
23	<u>Renov. - Carpentry</u>	2009	76,000						23
24	<u>Renov. - Millwork (Hand Rails)</u>	2009	14,910						24
25	<u>Renov. - Electrical (Light Fixtures)</u>	2009	5,990						25
26	<u>Renov. - Carpet</u>	2009	6,195						26
27	<u>Renov. - Wallcovering, Corner Guards</u>	2009	8,076						27
28	<u>Generator - Installation & Materials</u>	2009	11,108						28
29	<u>Renov. - Carpentry</u>	2009	45,000						29
30	<u>Renov. - Millwork (Hand Rails)</u>	2009	16,827						30
31	<u>Renov. - Carpet</u>	2009	9,331						31
32	<u>Renov. - Wallcovering</u>	2009	9,237						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,576,050	\$ 522,900		\$ 522,900	\$	\$ 5,918,049	34

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

Facility Name & ID Number Manorcare of Elk Grove Village

0049387

Report Period Beginning:

06/01/11

Ending:

05/31/12

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,576,050	\$ 522,900		\$ 522,900	\$	\$ 5,918,049	1
2	THERAPY ADD - SOIL TESTING	2009	600						2
3	THERAPY ADD - CONCRETE TESTING	2009	2,155						3
4	THERAPY ADD - SITE PREPARATION	2009	240,173						4
5	THERAPY ADD - LANDSCAPING	2009	14,240						5
6	LIGHTPOLE W/ CONCRETE BASE	2009	5,483						6
7	THERAPY ADD - ARCH & ENGINEER COST	2009	56,780						7
8	THERAPY ADD - ARCHITECT REIMB EXTER	2009	7,886						8
9	THERAPY ADD - ENGINEERING - CIVIL	2009	4,740						9
10	THERAPY ADD - INTERIOR DESIGN CONSULTANT	2009	102,773						10
11	THERAPY ADD - LANDSCAPE DESIGN CONSULTANT	2009	8,487						11
12	THERAPY ADD - PLAN REVIEWS	2009	8,853						12
13	THERAPY ADD - SALES USE TAX	2009	22						13
14	THERAPY ADD - WALL COVERING	2009	14,602						14
15	THERAPY ADD - CORNER GUARDS	2009	1,548						15
16	THERAPY ADD - TV IN PT WAITING ROOM	2010	1,745						16
17	THERAPY ADD - CRASH RAIL	2010	3,941						17
18	PAINTING FOR NOURISHMENT	2009	3,800						18
19	10 DOORS	2009	27,900						19
20	CARPETING	2009	1,040						20
21	HM DOOR	2009	4,867						21
22	HM DOOR	2010	4,830						22
23	C-WING SPRINKLERS	2010	25,181						23
24	3808 C WING REHAB RENO - CARPENTRY	2009	43,296						24
25	3808 C WING REHAB RENO - HM DOORS & FRAMES	2009	3,324						25
26	3808 C WING REHAB RENO - ELECTRICAL	2009	6,930						26
27	3808 C WING REHAB RENO - CORNER GUARDS	2009	268						27
28	2107 GENERATOR REPLACE - LABOR & MATERIALS	2009	25,804						28
29	1409 SPRINKLER HEADS - SPRINKLERS	2009	32,500						29
30	1809 INTERIOR RENO - FLOORING	2010	1,906						30
31	1809 INTERIOR RENO - CARPETING	2010	9,289						31
32	1809 INTERIOR RENO - WALL COVERING	2010	45,056						32
33	1809 INTERIOR RENO - ELECTRICAL	2010	1,984						33
34	TOTAL (lines 1 thru 33)		\$ 11,288,053	\$ 522,900		\$ 522,900	\$	\$ 5,918,049	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,288,053	\$ 522,900		\$ 522,900	\$	\$ 5,918,049	1
2	1809 INTERIOR RENOVATION - Wall Covering	2010	44,154						2
3	HM Doors	2010	10,350						3
4	0910 HERITAGE RENOVATION - Lobby Finishes	2010	76,149						4
5	0910 HERITAGE RENOVATION - Carpeting & Pads	2010	8,725						5
6	0910 HERITAGE RENOVATION - Wall Covering	2010	8,753						6
7	0910 HERITAGE RENOVATION - Corner Guards	2010	2,827						7
8	0910 HERITAGE RENOVATION - Millwork	2010	15,549						8
9	0910 HERITAGE RENOVATION - Basic Electrical	2010	8,612						9
10	SMOKE DETECTOR SYSTEM	2011	10,890						10
11	1211 C-WING RES BTHRM HEATERS	2011	18,560						11
12	HM DOORS	2011	19,050						12
13	DRAINAGE SYSTEM (COURTYARD)	2011	28,203						13
14	300 FT OF SEWER PIPING	2011	27,190						14
15	concrete walk sections	2011	14,426						15
16	CABINETS (NOURISHMENT RM)	2011	3,969						16
17	ELECTRIC HEATERS	2011	14,233						17
18	208 volt 30 amp circuit (steam	2011	2,153						18
19	RENOV - GEN OVERHEAD & INTEREST	2011	79,909						19
20	RENOV - RESILIENT FLOORING	2011	109,165						20
21	RENOV - CARPETING	2011	21,188						21
22	RENOV - WALLCOVERING	2011	85,740						22
23	RENOV - BASIC ELECTRICAL	2011	25,016						23
24	SHOWER RENOVATIONS	2011	4,857						24
25	PLANTER BOXES, ADDL CONCRETE FOR COURTYARD	2011	3,375						25
26	SPRINKLER PIPING	2012	15,836						26
27	DOUBLE DOORS @ STORAGE SHED	2012	2,915						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,949,847	\$ 522,900		\$ 522,900	\$	\$ 5,918,049	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	\$ 3,479,945	\$ 263,174	\$ 263,174	\$		\$ 2,836,530	71
72	Current Year Purchases	296,123						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			30,025	30,025			74
75	TOTALS	\$ 3,776,068	\$ 263,174	\$ 293,199	\$ 30,025		\$ 2,836,530	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,579,543	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 786,074	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 816,099	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,025	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,754,579	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 20,927	92
93			93
94			94
95		\$ 20,927	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?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 41,545
- Description: 02 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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	13642	hrs	\$ 558,978	2,529	\$ 153,276	\$ 1,167	16,171	\$ 713,421	1
2	Licensed Speech and Language Development Therapist	10a	3260	hrs	133,595	24	1,446		3,284	135,041	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	19288	hrs	790,325	8,226	498,481	12,222	27,514	1,301,028	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				955,802		955,802	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>PS Inhal Therapist</u>	10a				2,196	133,098		2,196	133,098	12
13	Other (specify): <u>IV Ther/EKG/Xray/La</u>	43, 2 & 3					242,548	208,204		450,752	13
14	TOTAL				\$ 1,482,898	12,975	\$ 1,028,849	\$ 1,177,395	49,165	\$ 3,689,142	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (4,982)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (801,714))	3,903,215		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,812		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,904,045	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	853,628		13
14	Buildings, at Historical Cost	11,949,847		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,776,068		16
17	Accumulated Depreciation (book methods)	(8,754,579)		17
18	Deferred Charges	14,580,372		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	20,927		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,426,263	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 26,330,308	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 453,467	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	910,618		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	603,030		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	301,733		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,268,848	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	241,832		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 241,832	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,510,680	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 23,819,628	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 26,330,308	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (13,895,967)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (13,895,967)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	307,568	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)	\$ 307,568	17
	B. Transfers (Itemize):		
18	Change in Interdivision	37,408,027	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 37,408,027	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 23,819,628	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Elk Grove Village# 0049387Report Period Beginning: 06/01/11Ending: 05/31/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 22,916,203	1
2	Discounts and Allowances for all Levels	(8,199,442)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,716,761	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,601,661	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,601,661	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	926	12
13	Barber and Beauty Care	31,174	13
14	Non-Patient Meals	2,972	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,041,215	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	130,524	19
20	Radiology and X-Ray	70,385	20
21	Other Medical Services	155,177	21
22	Laundry	3,317	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,435,690	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 22,754,112	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,123,285	31
32	Health Care	9,850,673	32
33	General Administration	4,526,921	33
	B. Capital Expense		
34	Ownership	4,172,131	34
	C. Ancillary Expense		
35	Special Cost Centers	1,432,160	35
36	Provider Participation Fee	341,374	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,446,544	40
41	Income before Income Taxes (line 30 minus line 40)**	307,568	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 307,568	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,721,592	44
45	Private Pay - Net Inpatient Revenue	1,245,428	45
46	Medicare - Net Inpatient Revenue	9,461,472	46
47	Other-(specify) <u>Hospice</u>	132,460	47
48	Other-(specify) <u>Insurance</u>	1,155,809	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,716,761	49

* 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	1,993	2,154	\$ 99,174	\$ 46.04	1
2	Assistant Director of Nursing	6,489	7,011	260,368	37.14	2
3	Registered Nurses	72,979	78,854	2,770,541	35.14	3
4	Licensed Practical Nurses	19,363	20,921	523,872	25.04	4
5	CNAs & Orderlies	139,204	150,755	1,937,486	12.85	5
6	CNA Trainees					6
7	Licensed Therapist	36,190	39,033	1,599,400	40.98	7
8	Rehab/Therapy Aides	17,614	18,997	421,069	22.17	8
9	Activity Director	10,499	11,357	163,666	14.41	9
10	Activity Assistants					10
11	Social Service Workers	13,996	15,131	392,161	25.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,286	39,241	548,349	13.97	15
16	Dishwashers					16
17	Maintenance Workers	3,627	3,923	103,429	26.36	17
18	Housekeepers	19,368	20,946	255,185	12.18	18
19	Laundry	6,207	6,710	70,348	10.48	19
20	Administrator	2,080	2,080	136,824	65.78	20
21	Assistant Administrator	1,024	1,024	44,961	43.91	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,970	27,254	587,427	21.55	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	2,864	3,095	51,605	16.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	414,753	448,486	\$ 9,965,865 *	\$ 22.22	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	30,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,000		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Brian Gross	Administrator	0	\$ 136,824	Workers' Compensation Insurance		\$ 33,456	IDPH License Fee	\$ 5,412	
Jennifer Miller	Asst. Admin.	0	44,961	Unemployment Compensation Insurance		130,942	Advertising: Employee Recruitment	28,395	
				FICA Taxes		710,835	Health Care Worker Background Check		
				Employee Health Insurance		411,011	(Indicate # of checks performed 478)	8,730	
				Employee Meals			Patient Background Checks 853	8,531	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	10,270	
				Employee Appreciation			Association Dues	22,627	
				401K		76,433	Advertising	47,121	
				Oth Empl Bfts, Mktg Adj, LT Incent, Dis Pymts		20,176	Public Relations		
				Tuition Program		18,351	Less: Non-Allowable Association Dues	(16,264)	
				SMSP Match		5,739	Less: Public Relations Expense (	0)	
				Employee Uniforms		4,220	Non-allowable advertising	(47,121)	
				Home Office Allocation		58,109	Yellow page advertising (		
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		\$ 1,469,272	TOTAL (agree to Sch. V,		
(List each licensed administrator separately.)			\$ 181,785	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			\$ 912,276			\$	Out-of-State Travel	\$	
							In-State Travel	5,761	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 912,276				Includes travel expense to the Home		
(Attach a copy of any management service agreement)							Office in Toledo, OH for regional meetings		
C. Professional Services									
Vendor/Payee	Type		Amount				Seminar Expense		
Foote Meyers Mielke Flowers LLC	Legal Fees		\$ 11,233						
Little Mendelson PC	Legal Fees		34,802						
Lexis Nexis	Legal Fees		2,325						
United Collection Bureau	Fees for Collections		2,413						
Legal and collection fees were adjusted off on Schedule VI, Page 5, Line 22.									
Therefore, no invoices are attached.									
MPRO	H/R Consulting		4,650						
CAIRS	H/R Consulting		7,473						
Consulting fees reclassified to Line 21.									
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense (		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 62,896				(agree to Sch. V,		
							line 24, col. 8)		
							TOTAL	\$ 5,761	

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. ICHA \$6,363

(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 \$16264

(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. \$ 115,290 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. \$ 341,374
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. \$ 2,972

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

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

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

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