

		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: 0049445

Facility Name: Manorcare of Hinsdale

Address: 600 West Ogden Avenue Hinsdale 60521
Number City Zip Code

County: DuPage

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

HFS ID Number:

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

Type of Ownership:

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

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 Hinsdale# 0049445 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>202</u>	Skilled (SNF)	<u>202</u>	<u>73,932</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>202</u>	TOTALS	<u>202</u>	<u>73,932</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,422</u>	<u>9,299</u>	<u>46,511</u>	<u>61,232</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,422</u>	<u>9,299</u>	<u>46,511</u>	<u>61,232</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.82%

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 11/01/81

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 202 and days of care provided 37,149Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐NO ☒Tax Year: 12/31Fiscal Year: 05/31

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
	A. General Services										
1	Dietary	620,411	50,004	3,199	673,614		673,614		673,614		1
2	Food Purchase		522,779		522,779		522,779	(11,005)	511,774		2
3	Housekeeping	291,220	33,609	1,821	326,650		326,650		326,650		3
4	Laundry	83,307	36,157	121	119,585		119,585		119,585		4
5	Heat and Other Utilities			354,438	354,438	5,408	359,846		359,846		5
6	Maintenance	64,264	33,346	209,326	306,936		306,936		306,936		6
7	Other (specify):* Medical Waste			1,382	1,382		1,382		1,382		7
8	TOTAL General Services	1,059,202	675,895	570,287	2,305,384	5,408	2,310,792	(11,005)	2,299,787		8
	B. Health Care and Programs										
9	Medical Director			63,053	63,053		63,053		63,053		9
10	Nursing and Medical Records	6,008,925	701,050	300,221	7,010,196	34,129	7,044,325		7,044,325		10
10a	Therapy	3,520,309	14,986	325,007	3,860,302		3,860,302		3,860,302		10a
11	Activities	203,637	3,729	6,256	213,622		213,622	(260)	213,362		11
12	Social Services	424,669	412		425,081		425,081		425,081		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	10,157,540	720,177	694,537	11,572,254	34,129	11,606,383	(260)	11,606,123		16
	C. General Administration										
17	Administrative	184,923		1,419,275	1,604,198	(627,900)	976,298		976,298		17
18	Directors Fees										18
19	Professional Services			66,167	66,167	(830)	65,337	(65,337)			19
20	Dues, Fees, Subscriptions & Promotions			139,781	139,781		139,781	(62,370)	77,411		20
21	Clerical & General Office Expenses	564,866	166,753	644,834	1,376,453	830	1,377,283	(502,528)	874,755		21
22	Employee Benefits & Payroll Taxes			1,770,284	1,770,284	72,955	1,843,239		1,843,239		22
23	Inservice Training & Education			5,133	5,133		5,133		5,133		23
24	Travel and Seminar			26,234	26,234		26,234		26,234		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			650,032	650,032		650,032		650,032		26
27	Other (specify):*							(190)	(190)		27
28	TOTAL General Administration	749,789	166,753	4,721,740	5,638,282	(554,945)	5,083,337	(630,425)	4,452,912		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,966,531	1,562,825	5,986,564	19,515,920	(515,408)	19,000,512	(641,690)	18,358,822		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			787,221	787,221	37,696	824,917	(103,140)	721,777			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,721,932	5,721,932	477,712	6,199,644	(5,732,550)	467,094			32
33	Real Estate Taxes			157,083	157,083		157,083		157,083			33
34	Rent-Facility & Grounds			22,399	22,399		22,399		22,399			34
35	Rent-Equipment & Vehicles			75,012	75,012		75,012		75,012			35
36	Other (specify):*											36
37	TOTAL Ownership			6,763,647	6,763,647	515,408	7,279,055	(5,835,690)	1,443,365			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,401,723	850	1,402,573		1,402,573		1,402,573			39
40	Barber and Beauty Shops			39,573	39,573		39,573		39,573			40
41	Coffee and Gift Shops	12,663			12,663		12,663		12,663			41
42	Provider Participation Fee			283,884	283,884		283,884		283,884			42
43	Other (specify):* IV X-Ray & Lab		319,935	216,174	536,109		536,109		536,109			43
44	TOTAL Special Cost Centers	12,663	1,721,658	540,481	2,274,802		2,274,802		2,274,802			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,979,194	3,284,483	13,290,692	28,554,369		28,554,369	(6,477,380)	22,076,989			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,005)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(103,140)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(393)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(190)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(22,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(65,337)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(397,608)	21		24
25	Fund Raising, Advertising and Promotional	(62,370)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,814,837)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,477,380)		\$	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	2	
		Amount	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)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (6,477,380)		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	2	3	4	
		Yes	No	Amount	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

Manorcare of Hinsdale

Report Period Beginning:06/01/11

Ending:05/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wage - Marketing	\$ (65,435)	21	1
2	Employee benefits - Marketing	(16,562)	21	2
3	HCP Lease Interest	(5,732,550)	32	3
4	Vending Income	0	21	4
5	Misc. Income	(30)	21	5
6	Activity Income	(260)	11	6
7	Loss on Disposal of Fixed Assets	0	36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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	(5,814,837)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Hinsdale # 0049445 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	(11,005)	0	0	0	0	0	0	0	0	0	0	(11,005)	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	(11,005)	0	0	0	0	0	0	0	0	0	0	(11,005)	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	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	(65,337)	0	0	0	0	0	0	0	0	0	0	(65,337)	19
20	Fees, Subscriptions & Promotions	(62,370)	0	0	0	0	0	0	0	0	0	0	(62,370)	20
21	Clerical & General Office Expenses	(502,528)	0	0	0	0	0	0	0	0	0	0	(502,528)	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):*	(190)	0	0	0	0	0	0	0	0	0	0	(190)	27
28	TOTAL General Administration	(630,425)	0	0	0	0	0	0	0	0	0	0	(630,425)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(641,690)	0	0	0	0	0	0	0	0	0	0	(641,690)	29

Summary B

05/31/12

												SUMMARY	
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
Depreciation	(103,140)	0	0	0	0	0	0	0	0	0	0	(103,140)	30
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
Interest	(5,732,550)	0	0	0	0	0	0	0	0	0	0	(5,732,550)	32
Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
TOTAL Ownership	(5,835,690)	0	0	0	0	0	0	0	0	0	0	(5,835,690)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(6,477,380)	0	0	0	0	0	0	0	0	0	0	(6,477,380)	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	\$ 1,419,275	HCR Manor Care Services, LLC	100.00%	\$ 1,419,275	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	11,979,194	Heartland Employment Services, LLC	100.00%	11,979,194		4
5	V	10a	Therapy Management	22,934	Heartland Rehabilitation Services, LLC	100.00%	22,934		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 13,421,403			\$ 13,421,403	\$ *	14

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

Facility Name & ID Number

Manorcare of Hinsdale

0049445

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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

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 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,R	\$ 775,999	\$	26,241,194	\$ 5,408	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs			26,241,194	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			26,241,194	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			26,241,194	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	485,056	352,684	26,241,194	3,381	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	26,241,194	30,748	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			26,241,194	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			26,241,194	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	71,430,003	38,287,220	26,241,194	497,820	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	26,241,194	185,786	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	26,241,194	58,230	11
12	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	26,241,194	49,539	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	2,952,374		26,241,194	20,576	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		26,241,194	52,379	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			26,241,194	0	15
16	22	Empl Bnfts - Direct to MW Div S	Accumulated Cost	474,102,184	48 NFs			26,241,194	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	4,719,938		26,241,194	32,895	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		26,241,194	4,801	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			26,241,194	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			26,241,194	0	20
21										21
22	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		26,241,194	183,597	22
23	32	Directly Assigned Interest	Not Allocated			18,851,990			294,115	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				32,615,916				24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 1,419,275	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Conv. Sub. Debentures		X	Various			\$ 4,419,968	\$ 4,419,968		6.6542	\$ 294,115	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Home Office Pooled Interest Expense										183,597	6	
7	Interest Income / Interest Expense										(10,618)	7	
8												8	
9	TOTAL Facility Related						\$ 4,419,968	\$ 4,419,968			\$ 467,094	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,419,968	\$ 4,419,968			\$ 467,094	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.	\$	139,792	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.)	\$	154,118	2
3. Under or (over) accrual (line 2 minus line 1).	\$	14,326	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	142,757	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.	\$	157,083	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2007	134,320	8
	2008	141,026	9
	2009	145,678	10
	2010	152,500	11
	2011	155,735	12
Line 2: \$154,118 = \$76,250 for the 2nd half of 2010 + \$77,868 for the 1st half of 2011.			
Line 4: \$142,757 = \$77,868 for the 2nd half 2011 + \$64,889 estimate for Jan-May 2012.			

	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

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 Hinsdale

COUNTY
DuPage

FACILITY IDPH LICENSE NUMBER
0049445

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)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	09-02-404-001	See attached	\$ 2,271.40	\$ 2,271.40
2.	09-02-212-006	See attached	\$ 14,486.42	\$ 14,486.42
3.	09-02-212-001	See attached	\$ 138,977.34	\$ 138,977.34
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 155,735.16	\$ 155,735.16

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 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:	78,479	B. General Construction Type:	Exterior	Masonry	Frame	Steel	Number of Stories	3
------------------------	---------------	--------------------------------------	-----------------	----------------	--------------	--------------	--------------------------	----------

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ **4. Dates Incurred:** _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	102		1972		\$ 1,160,300	\$ 95,391		\$ 95,391	\$	2,669,313	4
5	100			1980	1,913,000						5
6	Therapy addition			2006	400,868						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					230,919		230,919		4,678,255	9
10				1984	4,367						10
11				1985	6,383						11
12				1987	14,207						12
13				1988	22,849						13
14				1989	173,344						14
15				1990	114,281						15
16				1991	240,682						16
17				1992	111,750						17
18				1993	421,420						18
19				1994	145,930						19
20				1995	182,224						20
21				1996	326,618						21
22				1997	407,293						22
23				1998	392,286						23
24				1999	128,464						24
25				1999	(11,509)						25
26				2000	138,632						26
27				2001	142,009						27
28				2002	339,762						28
29	STEEL/METAL DOORS			2003	4,336						29
30	ROOF REPAIR			2003	1,084						30
31	ARCH AND ENGINEERING COSTS			2004	553						31
32	ELECTRICAL			2004	3,776						32
33	Arch and Engineering Costs			2004	42,165						33
34	General Construction Overhead Cost & Interest			2004	55,967						34
35	Flooring			2004	9,800						35
36	Carpeting			2004	11,210						36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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	Painting	2004	\$ 63,111	\$		\$	\$	\$	37
38	Wallcovering & Corner Guards	2004	5,782						38
39	Carpentry	2004	27,527						39
40	Electrical	2004	24,620						40
41	Roofing & Doors	2004	1,685						41
42	Fire Wall	2004	4,625						42
43	VWC & Paint	2004	2,092						43
44	Exterior Painting	2004	7,405						44
45	Flooring	2004	12,981						45
46	Air Separator	2004	9,942						46
47	Flooring	2005	113,382						47
48	Doors	2005	4,865						48
49	VWC	2005	1,474						49
50	Flooring	2005	9,070						50
51	Shower Door	2005	6,140						51
52	Painting, Wallcovering, & Base	2005	3,531						52
53	Install fire server cabinet & shelves	2005	3,700						53
54	Fire Alarm Panels	2005	10,265						54
55	Masonry Work	2005	3,875						55
56	Smoke Detectors	2005	1,160						56
57	Electrical Circuit for Smoke Detecor	2005	801						57
58	Wallcovering	2005	5,240						58
59	Electrical Work in 28 patient rooms	2005	2,284						59
60	Wallcovering	2005	1,233						60
61	Smoke Detectors	2005	2,685						61
62	Remodel Janitor Closet & Greenhouse	2005	4,800						62
63	Remodel Janitor Closet & Greenhouse	2006	4,799						63
64	Electrical Work for Elevator - Hookup shunt switch	2006	503						64
65	Phone Wiring	2006	7,231						65
66	Exhaust Fan	2006	2,272						66
67	Phone Wiring Additional Work	2006	1,605						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,254,736	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	70

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

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 12A, Carried Forward		\$ 7,254,736	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	1
2	Corner guards	2006	353						2
3	Engineering for conceptual site plan - parking lot, lighting, landscap	2006	6,767						3
4	Drywall & Paint to rebuild plumbing walls in 6 resident rooms	2006	8,023						4
5	Plumbing - Replace 4 wall hydrants	2006	3,224						5
6	Overhead & Interest on HVAC Project	2006	1,344						6
7	HVAC - 35 ton roof unit & related electrical work	2006	61,639						7
8	Overhead & Interest on addition/renovation project	2006	157,013						8
9	Addition/Renov. - Architect & Engineering	2006	71,504						9
10	Addition/Renov. - Permit fees, plan reveiws, consultant misc.	2006	16,591						10
11	Addition/Renov. - Drywall canopies on 41 light fictures	2006	1,017						11
12	Addition/Renov. - Ceil Tile & Paint Grid	2006	4,365						12
13	Addition/Renov. - Flooring	2006	5,147						13
14	Addition/Renov. - Wall Covering & Corner Guards	2006	17,428						14
15	Addition/Renov. - Fire Sprinkler System	2006	84,188						15
16	Addition/Renov. - Plumbing	2006	4,895						16
17	Addition/Renov. - HVAC	2006	2,594						17
18	Addition/Renov. - Electrical	2006	11,569						18
19	Addition/Renov. - Site Preparation	2006	39,350						19
20	Addition/Renov. - Fencing	2006	1,637						20
21	Addition/Renov. - Landscaping block, trees, plants, etc.	2006	112,980						21
22	Electrical - Parking lot lights	2006	2,413						22
23	Roof Termination Strip	2006	967						23
24	Electrical work	2006	2,215						24
25	Patio with raised seating area	2006	24,113						25
26	Concrete curbs & pavement for new parking spaces	2006	28,645						26
27	Electrical - Parking lot lights	2006	13,005						27
28	Lawn sprinler system	2006	9,800						28
29	Carpet	2007	10,314						29
30	Remodel Shower Room - Tile, Sink, Faucets, Paint	2007	15,820						30
31	Flooring in Corridors	2007	11,448						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,985,104	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

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		\$ 7,985,104	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	1
2	Electrical at nurses station	2007	2,538						2
3	Windows (9)	2007	14,245						3
4	Drainage	2007	17,001						4
5	Wallcovering	2007	15,483						5
6	Electrical for pill dispenser	2007	1,773						6
7	Elevator Upgrade	2007	4,370						7
8	Piping in laundry room	2007	1,700						8
9	Parking lot paving	2007	9,900						9
10	Curbing in Parking lot	2007	2,550						10
11	Paving	2007	8,016						11
12	Sidewalk & Railing	2007	36,550						12
13									13
14	Roofing over generator - Wate Tight Membrane	2008	16,314						14
15	Renov. - Vinyl Flooring	2008	37,310						15
16	ELEVATOR SWITCHES	2008	4,370						16
17	20 AMP CIRCUIT	2008	2,250						17
18	AC ELECTRICAL	2008	9,505						18
19	CONCRETE BOARD IN SHOWER	2008	2,680						19
20	ELECTRIC Change outlets from 2 to 4	2009	5,040						20
21	CIRCUIT BREAKER	2009	3,880						21
22	LAUNDRY CIRCUIT BREAKER	2009	5,140						22
23	225 AMP CIRCUIT BREAKER	2009	2,120						23
24	15 AMP RECEPTACLES	2008	3,360						24
25	Renov.- Front Elevator Upgrade	2009	54,708						25
26	HM Doors	2009	6,500						26
27									27
28	Renov. - Elevator Upgrade	2009	11,209						28
29	Doors (8) HM	2009	18,810						29
30	Renov. - Fire Rate Access Panels	2009	27,588						30
31	Renov. - Fire dampers & access panels	2009	78,095						31
32	Frights for Corner Guards	2009	240						32
33	Renov. - Fire Proof Acces Panels	2010	7,682						33
34	TOTAL (lines 1 thru 33)		\$ 8,396,031	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

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	
1	Totals from Page 12C, Carried Forward		\$ 8,396,031	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	1
2	Renov. - Flooring	2010	25,501						2
3	Renov. - Wallcovering & guards	2010	20,127						3
4	Radiant heaters	2010	16,131						4
5	Emergency lights (15) led wall packs	2010	16,017						5
6									6
7	Renov. - Surveys	2010	5,625						7
8	Renov. - Millwork	2010	24,495						8
9	Renov. - Gypsum, Studs, & Tile Work	2010	110,702						9
10	Wiring For Phones In Arcadia Wing	2010	4,027						10
11	Renov. - Acoustic Ceiling System & Other	2010	161,931						11
12	Renov. - Roof Replacement	2010	114,435						12
13	Renov. - Flooring	2010	108						13
14	Renov. - Flooring & Wallcovering	2010	2,700						14
15	Cabinetry and Faucet	2010	6,841						15
16	VCT Flooring & Paint	2010	5,168						16
17	Renov. - Overhead & Interest (\$19,887.59)	2010							17
18	Renov. - 40 Ton A/C Unit, Trane	2010	56,970						18
19	Renov. - Flooring, Paint, & Wallcoverings	2010	135,403						19
20	Renov. - Interior Renovations	2010	28,587						20
21	Renov. - Carpentry	2010	125,759						21
22	French Drain & pavers around F	2011	6,375						22
23									23
24	Electrical Upgrade - Renov. 12-11C	2011	65,223						24
25	Landscaping	2011	6,375						25
26	Hand Rails - Renov. 09-11C	2011	6,192						26
27	Paint, Wallcovering, Corners - Renov. 09-11C	2011	19,585						27
28	Chiller 40 ton - Revno. 11-11C	2011	66,756						28
29	Wander System at Elevators (3)	2011	22,853						29
30	Sprinkler System Upgrade	2011	11,910						30
31	Nurse Call System - Renov. 2011	2011	41,396						31
32	Physician Paging System	2011	3,025						32
33	Boiler	2011	5,390						33
34	TOTAL (lines 1 thru 33)		\$ 9,511,638	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	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 12D, Carried Forward		\$ 9,511,638	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	1
2	Fire Walls, Hatch, Doors, & Dampers - Renov. 46-11	2012	36,210						2
3	Wall To Enclose OT	2012	18,990						3
4	Exhaust System	2012	18,002						4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,584,840	\$ 326,310		\$ 326,310	\$	\$ 7,347,568	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	\$4,353,432	\$357,771	\$357,771	\$		\$3,226,702	71
72	Current Year Purchases	114,494						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			37,696	37,696			74
75	TOTALS	\$4,467,926	\$357,771	\$395,467	\$37,696		\$3,226,702	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)	\$15,410,876	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$684,081	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$721,777	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$37,696	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$10,574,270	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Step-up Building Cost 1981	\$3,713,060	\$103,140	\$3,154,382	86
87					87
88					88
89					89
90					90
91	TOTALS	\$3,713,060	\$103,140	\$3,154,382	91

G. Construction-in-Progress

	Description	Cost	
92	Various	\$61,038	92
93			93
94			94
95		\$61,038	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Portion of Parking Lot			01/01/2010	22,399	4		5
6								6
7	TOTAL				\$ 22,399			7

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 70,925
- Description: O2 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	Patient Transportation		\$	\$ 4,087	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,087	21

10. Effective dates of current rental agreement:

Beginning 01/01/2010

Ending 12/31/2013

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

	Fiscal Year Ending	Annual Rent
12.	5/31/2013	\$ 22,399
13.	5/31/2014	\$ 13,066
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, 1	19026	hrs	\$ 838,400	5,293	\$ 298,502	\$ 4,630	24,319	\$ 1,141,532	1
2	Licensed Speech and Language Development Therapist	10a, 1	5740	hrs	252,959	10	580		5,750	253,539	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	24998	hrs	1,101,618	14	781	10,356	25,012	1,112,755	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				1,401,723		1,401,723	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43, 2						319,935		319,935	12
13	Other (specify): X-Ray & Lab	43, 3					216,174			216,174	13
14	TOTAL				\$ 2,192,977	5,317	\$ 516,037	\$ 1,736,644	55,081	\$ 4,445,658	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	\$ (49,279)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 895,385)	4,602,138		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,151		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,566,010	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,358,110		13
14	Buildings, at Historical Cost	13,297,900		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,467,926		16
17	Accumulated Depreciation (book methods)	(13,728,652)		17
18	Deferred Charges	44,790,389		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	61,038		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 50,246,711	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 54,812,721	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 408,463	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	883,638		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	142,757		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	280,163		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,715,021	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,419,968		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)	\$ 4,419,968	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,134,989	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 48,677,732	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 54,812,721	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (13,173,427)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (13,173,427)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,113,109	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)	\$ 2,113,109	17
	B. Transfers (Itemize):		
18	Change in Interdivision	59,738,050	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 59,738,050	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 48,677,732	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Hinsdale# 0049445Report 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	\$ 30,787,932	1
2	Discounts and Allowances for all Levels	(11,318,956)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,468,976	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,353,552	6
7	Oxygen	1,140	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 9,354,692	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	120	12
13	Barber and Beauty Care	31,629	13
14	Non-Patient Meals	11,005	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,505,003	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	106,162	19
20	Radiology and X-Ray	84,298	20
21	Other Medical Services	104,974	21
22	Laundry	329	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,843,520	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	Activity Income	260	28
28a	Misc. Income	30	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 290	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 30,667,478	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,305,384	31
32	Health Care	11,572,254	32
33	General Administration	5,638,282	33
	B. Capital Expense		
34	Ownership	6,763,647	34
	C. Ancillary Expense		
35	Special Cost Centers	1,990,918	35
36	Provider Participation Fee	283,884	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,554,369	40
41	Income before Income Taxes (line 30 minus line 40)**	2,113,109	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,113,109	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 639,780	44
45	Private Pay - Net Inpatient Revenue	2,581,090	45
46	Medicare - Net Inpatient Revenue	13,371,260	46
47	Other-(specify) <u>Hospice</u>	53,393	47
48	Other-(specify) <u>Other</u>	2,823,453	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 19,468,976	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
2	Assistant Director of Nursing	8,176	8,893	323,933	36.43	2
3	Registered Nurses	57,619	62,676	2,068,835	33.01	3
4	Licensed Practical Nurses	52,750	57,380	1,473,572	25.68	4
5	CNAs & Orderlies	141,825	154,634	2,079,024	13.44	5
6	CNA Trainees					6
7	Licensed Therapist	52,063	56,652	2,496,446	44.07	7
8	Rehab/Therapy Aides	35,782	38,936	1,023,863	26.30	8
9	Activity Director	10,873	11,836	203,637	17.20	9
10	Activity Assistants					10
11	Social Service Workers	14,993	16,324	424,669	26.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,928	43,490	620,411	14.27	15
16	Dishwashers					16
17	Maintenance Workers	2,294	2,497	64,264	25.74	17
18	Housekeepers	22,059	24,022	291,220	12.12	18
19	Laundry	7,505	8,176	83,307	10.19	19
20	Administrator	2,080	2,080	129,958	62.48	20
21	Assistant Administrator	1,928	1,928	54,965	28.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,580	22,664	482,869	21.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,327	3,623	63,561	17.54	31
32	Other Health Care(specify)					32
33	Other(specify)	989	1,077	12,663	11.76	33
34	TOTAL (lines 1 - 33)	474,771	516,888	\$ 11,897,197 *	\$ 23.02	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	63,053	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	324	17,318	10, 1	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	324	\$ 80,371		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10, 3	50
51	Licensed Practical Nurses			10, 3	51
52	Certified Nurse Assistants/Aides	2,437	34,118	10, 3	52
53	TOTAL (lines 50 - 52)	2,437	\$ 34,118		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	
Diane Lube		Administrator	0	\$ 129,958	Workers' Compensation Insurance		\$ 116,713	IDPH License Fee		\$ 0	
Katherine Marrero		Asst. Admin	0	54,965	Unemployment Compensation Insurance		159,779	Advertising: Employee Recruitment		23,715	
					FICA Taxes		862,963	Health Care Worker Background Check		8,898	
					Employee Health Insurance		528,590	(Indicate # of checks performed 570)			
					Employee Meals			Patient Background Checks		1427	
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		19,768	
					Disability Payments			Association Dues		23,118	
					401K		71,050	Advertising		45,978	
					Appreciation, Other Benefits & Marketing Adjust		8,124	Other Licenses & Permits		4,034	
					Tuition Program		(136)	Less Non-allowable Association Dues		(16,392)	
					SMSP Match & RSU		15,762	Less: Public Relations Expense		()	
					Employee Uniforms		7,439	Non-allowable advertising		(45,978)	
					Home Office Allocation		72,955	Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 184,923	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,843,239	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 77,411
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 - See page 18 for breakdown				\$ 1,419,275			\$	Out-of-State Travel		\$	
								In-State Travel		26,234	
								Includes travel expense to the Home Office in Toledo, OH for regional meetings			
								Seminar Expense			
								Entertainment Expense		()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 1,419,275	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 26,234
C. Professional Services											
Vendor/Payee		Type		Amount							
Elvidge Kelley Attorney at Law		Legal Fees		\$ 1,750							
Foote Meyers Mielde, Flowers, LLC		Legal Fees		45,697							
Littler Mendelson PC		Legal Fees		15,577							
United Collection Bureau Inc.		Collection Services		2,313							
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)											
MPRO		Review resident care issues Reclassify to line 21		830							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 66,167							

*** 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.
IHCA \$6726

(3)
Did the nursing home make political contributions or payments to a political action organization?
Yes

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

(4)
Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
No

If YES, what is the capacity?

(5)
Have you properly capitalized all major repairs and equipment purchases?
Yes

What was the average life used for new equipment added during this period?
5-10 Years

(6)
Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.
\$
101,309
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.
\$
283,884

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.
\$
11,005

(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.