

		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: <u>0049429</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Manorcare of Kankakee</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/11</u> to <u>05/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>900 West River Place</u> <u>Kankakee</u> <u>60901</u>			
Number City Zip Code			
County: <u>Kankakee</u>			
Telephone Number: <u>(815) 933-1711</u> Fax # <u>(815) 933-2065</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>11/01/81</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Garv Geise</u>			
Telephone Number: <u>(419) 252-5731</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Barry Lazarus</u>	
		(Title) <u>Vice President, Reimbursement</u>	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) <u>()</u> Fax # <u>()</u>	
		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 Kankakee# 0049429 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>107</u>	Skilled (SNF)	<u>107</u>	<u>39,162</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>107</u>	TOTALS	<u>107</u>	<u>39,162</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>17,473</u>	<u>4,268</u>	<u>12,833</u>	<u>34,574</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>17,473</u>	<u>4,268</u>	<u>12,833</u>	<u>34,574</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.28%

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 107 and days of care provided 6,610Medicare 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	245,267	16,371	1,452	263,090		263,090		263,090		1
2	Food Purchase		260,061		260,061		260,061	(324)	259,737		2
3	Housekeeping	127,820	21,897	2,408	152,125		152,125		152,125		3
4	Laundry	51,045	14,815	241	66,101		66,101		66,101		4
5	Heat and Other Utilities			148,152	148,152	1,614	149,766		149,766		5
6	Maintenance	30,210	11,842	175,309	217,361		217,361		217,361		6
7	Other (specify):* Medical Waste			614	614		614		614		7
8	TOTAL General Services	454,342	324,986	328,176	1,107,504	1,614	1,109,118	(324)	1,108,794		8
	B. Health Care and Programs										
9	Medical Director			10,992	10,992		10,992		10,992		9
10	Nursing and Medical Records	2,309,860	190,111	96,625	2,596,596	10,186	2,606,782		2,606,782		10
10a	Therapy	630,879	4,710	52,993	688,582		688,582		688,582		10a
11	Activities	101,504	2,296	1,631	105,431		105,431		105,431		11
12	Social Services	103,497	1,750		105,247		105,247		105,247		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,145,740	198,867	162,241	3,506,848	10,186	3,517,034		3,517,034		16
	C. General Administration										
17	Administrative	86,013		392,008	478,021	(155,803)	322,218		322,218		17
18	Directors Fees										18
19	Professional Services			15,988	15,988	(15,640)	348	(348)			19
20	Dues, Fees, Subscriptions & Promotions			48,303	48,303		48,303	(28,878)	19,425		20
21	Clerical & General Office Expenses	249,217	61,959	470,802	781,978	15,640	797,618	(407,193)	390,425		21
22	Employee Benefits & Payroll Taxes			716,231	716,231	21,775	738,006		738,006		22
23	Inservice Training & Education			1,084	1,084		1,084		1,084		23
24	Travel and Seminar			4,487	4,487		4,487		4,487		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			319,918	319,918		319,918		319,918		26
27	Other (specify):*							(110)	(110)		27
28	TOTAL General Administration	335,230	61,959	1,968,821	2,366,010	(134,028)	2,231,982	(436,529)	1,795,453		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,935,312	585,812	2,459,238	6,980,362	(122,228)	6,858,134	(436,853)	6,421,281		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			231,163	231,163	11,252	242,415		242,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			844,334	844,334	110,976	955,310	(850,945)	104,365			32
33	Real Estate Taxes			56,165	56,165		56,165		56,165			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,546	22,546		22,546		22,546			35
36	Other (specify):*											36
37	TOTAL Ownership			1,154,208	1,154,208	122,228	1,276,436	(850,945)	425,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			980	980		980		980			38
39	Ancillary Service Centers		227,823		227,823		227,823		227,823			39
40	Barber and Beauty Shops			12,841	12,841		12,841		12,841			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			258,223	258,223		258,223		258,223			42
43	Other (specify):* IV X-Ray & Lab		28,118	31,881	59,999		59,999		59,999			43
44	TOTAL Special Cost Centers		255,941	303,925	559,866		559,866		559,866			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,935,312	841,753	3,917,371	8,694,436		8,694,436	(1,287,798)	7,406,638			45

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

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(324)	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	(159)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(110)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(45,715)	21		18
19	Entertainment				19
20	Contributions	(50)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(348)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(359,951)	21		24
25	Fund Raising, Advertising and Promotional	(28,878)	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	(852,263)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,287,798)		\$	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)		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))	\$ (1,287,798)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Manorcare of Kankakee

Report Period Beginning:06/01/11

Ending:05/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Wage - Marketing	\$ 0	21	1
2	Employee benefits - Marketing	0	21	2
3	HCP Lease Interest	(850,945)	32	3
4	Vending Income	(1,318)	21	4
5	Misc. Income	0	21	5
6	Activity Income	0	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	(852,263)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Kankakee # 0049429 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	(324)	0	0	0	0	0	0	0	0	0	0	(324)	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	(324)	0	0	0	0	0	0	0	0	0	0	(324)	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	(348)	0	0	0	0	0	0	0	0	0	0	(348)	19
20	Fees, Subscriptions & Promotions	(28,878)	0	0	0	0	0	0	0	0	0	0	(28,878)	20
21	Clerical & General Office Expenses	(407,193)	0	0	0	0	0	0	0	0	0	0	(407,193)	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):*	(110)	0	0	0	0	0	0	0	0	0	0	(110)	27
28	TOTAL General Administration	(436,529)	0	0	0	0	0	0	0	0	0	0	(436,529)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(436,853)	0	0	0	0	0	0	0	0	0	0	(436,853)	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	0	0	0	0	0	0	0	0	0	0	0	0	30
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
Interest	(850,945)	0	0	0	0	0	0	0	0	0	0	(850,945)	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	(850,945)	0	0	0	0	0	0	0	0	0	0	(850,945)	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)	(1,287,798)	0	0	0	0	0	0	0	0	0	0	(1,287,798)	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	\$ 392,008	HCR Manor Care Services, LLC	100.00%	\$ 392,008	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	3,935,312	Heartland Employment Services, LLC	100.00%	3,935,312		4
5	V	10a	Therapy Management	12,156	Heartland Rehabilitation Services, LLC	100.00%	12,156		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			\$ 4,339,476			\$ 4,339,476	\$ *	14

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

Facility Name & ID Number

Manorcare of Kankakee

0049429

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 (SNF), L	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Kankakee# 0049429

Report Period Beginning:

06/01/11Ending: 05/31/12

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,R	\$ 775,999	\$	7,832,303	\$ 1,614	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs			7,832,303	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			7,832,303	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			7,832,303	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	485,056	352,684	7,832,303	1,009	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	7,832,303	9,177	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			7,832,303	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			7,832,303	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	71,430,003	38,287,220	7,832,303	148,587	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	7,832,303	55,452	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	7,832,303	17,380	11
12	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	7,832,303	14,786	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	2,952,374		7,832,303	6,141	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		7,832,303	15,634	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			7,832,303	0	15
16	22	Empl Bnfts - Direct to MW Div S	Accumulated Cost	474,102,184	48 NFs			7,832,303	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	4,719,938		7,832,303	9,818	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		7,832,303	1,434	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			7,832,303	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			7,832,303	0	20
21										21
22	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		7,832,303	54,799	22
23	32	Directly Assigned Interest	Not Allocated			18,851,990			56,177	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				32,615,916				24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 392,008	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			\$ 844,222	\$ 844,222		6.6543	\$ 56,177	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Home Office Pooled Interest Expense										54,799	6	
7	Interest Income / Interest Expense										(6,611)	7	
8												8	
9	TOTAL Facility Related						\$ 844,222	\$ 844,222			\$ 104,365	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 844,222	\$ 844,222			\$ 104,365	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

[illegible]

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 Kankakee

COUNTY
Kankakee

FACILITY IDPH LICENSE NUMBER
0049429

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. 16-09-31-412-001	See attached	\$ 54,232.00	\$ 54,232.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 54,232.00	\$ 54,232.00

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:	19,938	B. General Construction Type:	Exterior	Masonry	Frame	Steel, Fire Resistant	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	----------------	--------------	------------------------------	--------------------------	----------

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

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

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

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

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

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	\$ 29,077	1
2					2
3	TOTALS			\$ 29,077	3

Facility Name & ID Number Manorcare of Kankakee

0049429

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	88			1969	\$ 566,769	\$ 9,417		\$ 9,417	\$	\$ 961,537
5	9			1988	533,782					
6	10			1990	60,931					
7										
8										
	Improvement Type**									
9	Current Year Depreciation					132,058		132,058		2,200,742
10				1980	14,866					
11				1981	90,159					
12				1982	16,908					
13				1983	11,723					
14				1985	33,632					
15				1987	56,199					
16	RETIREMENTS			1987	(30,337)					
17				1988	65,707					
18				1989	92,574					
19				1990	34,128					
20				1991	13,615					
21				1992	46,361					
22	RETIREMENTS			1992	(5,120)					
23				1993	359,644					
24				1994	26,647					
25				1995	85,884					
26	CORRIDOR OVERLAY			1996	4,830					
27				1996	2,444					
28				1996	2,647					
29				1996	7,272					
30	C/R 5/31/99 AUDIT ADJ 1a - CAPITALIZED LABOR			1996	(7,272)					
31				1996	6,000					
32				1996	2,362					
33	REPLACE HEATER TANK			1996	3,921					
34				1996	26,843					
35	COUNTER TOP-N.STATN.			1996	1,104					
36				1996	2,793					

*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		1996	\$ 11,690	\$		\$	\$	\$	37
38	PLUMBING/SPRINKLER SYSTEM	1996	7,061						38
39	EMERGENCY POWER UPGRADE	1996	3,860						39
40	CARPET/WALLCOVERINGS	1996	1,730						40
41	NURSE CALL SYSTEM	1996	2,295						41
42	DECKING/LANDSCAPING	1996	6,811						42
43	CORPORATE OVERHEAD	1997	10,515						43
44	C/R 5/31/99 AUDIT ADJ 1b - CORPORATE OVERHEAD	1997	(10,515)						44
45	PLUMBING/SPRINKLER SYSTEM	1997	2,271						45
46	TILE & INSTALLATION	1997	2,911						46
47	WALLVINYL/PAINTING	1997	12,873						47
48	INSTALL CARPET	1997	1,790						48
49	FRONT ENTRY REMODEL	1997	6,068						49
50	ROOF WORK	1997	1,927						50
51	ELECTRICAL/LIGHTING	1997	10,539						51
52	REPLACE CEILING	1997	22,190						52
53	WALLVINYL/SUITE SIGNS	1997	3,465						53
54	FACILITY PLAN ALLOC.	1997	5,964						54
55	C/R 5/31/99 AUDIT ADJ 1c - FAC. PLAN ALLOC.	1997	(5,964)						55
56	HVAC/EXHAUST SYSTEM	1997	57,390						56
57	BALLUSTERS & TUBES	1997	5,000						57
58	PLUMBING	1997	1,419						58
59	PAINTING	1997	3,782						59
60	ELECTRICAL	1998	6,739						60
61	DOORS & FRAMES/WINDOWS	1998	8,286						61
62	MASONRY WORK	1998	4,000						62
63	DRYWALL/FINISHES	1998	7,000						63
64	WALLVINYL	1998	2,211						64
65	CORPORATE OVERHEAD	1998	1,651						65
66	C/R 5/31/99 AUDIT ADJ 1d - CORPORATE OVERHEAD	1998	(1,651)						66
67	FIRE ALARM INSTALL	1998	20,198						67
68	GENERAL CONTRACTOR FEES	1998	3,000						68
69	INTERIOR DEMOLITION/FLOORING & CEILING	1998	3,390						69
70	TOTAL (lines 4 thru 69)		\$ 2,346,912	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	70

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

XI. OWNERSHIP COSTS (continued)

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

1 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		\$ 2,346,912	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	1
2	CARPETING	1998	1,169						2
3	ELECTRICAL/LIGHTING	1998	149						3
4	PAINTING/WALLCOVERING	1998	552						4
5	GENERAL CONTRACTOR FEES	1998	2,507						5
6	SIGNAGE	1998	11,862						6
7	HVAC	1998	3,135						7
8	LANDSCAPING	1998	4,950						8
9	PAINTING/WALLCOVERING	1999	819						9
10	SIGNAGE	1999	1,725						10
11	SECURE CARE SYSTEM	1999	1,278						11
12	COMPRESSOR CHILLER	1999	6,505						12
13	PAGER/SPEAKER SYSTEM	1999	3,900						13
14	NEW DOOR FRAME	1999	1,581						14
15	HOT WATER COMPRESSOR	1999	45,135						15
16	CARPENTRY & ROOFING	2000	148,330						16
17	CARPETING & PADS	2000	12,448						17
18	C/R 5/31/03 AUDIT ADJ #1a - Carpet & Pads	2000	(235)						18
19	WALLCOVERING	2000	48,471						19
20	C/R 5/31/03 AUDIT ADJ #1b - Wallcoverings	2000	(272)						20
21	C/R 5/31/03 AUDIT ADJ #1c - Reclass Equipment	2000	(9,179)						21
22	DEVELOPERS COST - ARCADIA DINING	2000	38,406						22
23	C/R 5/31/03 AUDIT ADJ #1d -Dev. Cost Arcadia Dining	2000	(38,406)						23
24	BORDER	2000	134						24
25	C/R 5/31/03 AUDIT ADJ #1e - Border	2000	(8)						25
26	WALLVINYL - ARCADIA DINING	2000	819						26
27	WALLCOVERING	2000	156						27
28	PAINTING/WALLCOVERING - ARCADIA DINING	2000	3,410						28
29	CARPET	2000	188						29
30	2 A/C UNIT	2001	1,431						30
31	INSTALL SPRINKLER SYSTEM	2001	2,465						31
32	DRAPES	2001	1,520						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,641,857	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	34

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

Facility Name & ID Number Manorcare of Kankakee

0049429

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		\$ 2,641,857	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	1
2	DOORS	2001	1,056						2
3	FREIGHT ON WALLCOVERINGS	2001	205						3
4	C/R 5/31/03 AUDIT ADJ #1f - Freight on Wallcoverings	2001	(53)						4
5	VWC	2001	5,136						5
6	NEW LANDSCAPING	2001	9,200						6
7	VWC	2001	2,713						7
8	C/R 5/31/03 AUDIT ADJ #2h - VWC	2001	(160)						8
9	INTERIOR - FLOORING & VWC (Audit Adj #2g) Change Yr	2001	20,613						9
10	INTERIOR - FLOORING & VWC (Audit Adj #2g) Change Yr	2002	5,064						10
11	INTERIOR - FLOORING & VWC	2002	20,256						11
12	C/R 5/31/03 AUDIT ADJ #2e - Overhead & Interest	2002	(20,256)						12
13	INTERIOR - FLOORING & VWC	2002	69,157						13
14	C/R 5/31/03 AUDIT ADJ #2f - Interior Flooring & VWC	2002	(206)						14
15	C/R 5/31/03 AUDIT ADJ #2f - Interior Flooring & VWC	2002	(289)						15
16	WALLCOVERING AND BORDER	2002	2,400						16
17	WALL BORDER	2002	89						17
18	VWC	2002	538						18
19	WALL BORDER	2002	28						19
20	INTERIOR - FLOORING & VWC (Audit Adj #2a) Change Yr	2002	24,133						20
21	PLUMBING AND ELECTRICAL (Audit Adj #2c) Change Yr	2002	8,576						21
22	INTERIOR - FLOORING & VWC (Audit Adj #2b) Change Yr	2002	34,302						22
23	INTERIOR - FLOORING & VWC (Audit Adj #2b) Change Yr	2003	26,714						23
24	C/R 5/31/03 AUDIT ADJ #2b - Interior Flooring & VWC	2003	(450)						24
25	C/R 5/31/03 AUDIT ADJ #2b - Interior Flooring & VWC	2003	(909)						25
26	WINDOW TREATMENTS	2003	1,845						26
27	OVERHEAD & INTEREST	2003	6,809						27
28	C/R 5/31/03 AUDIT ADJ #2j - Overhead & Interest	2003	(6,809)						28
29	OVERHEAD & INTEREST	2003	450						29
30	C/R 5/31/03 AUDIT ADJ #2d - Overhead & Interest	2003	(450)						30
31	RETROADDITION \$133 disallowed per audit	2003							31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,851,559	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	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		\$ 2,851,559	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	1
2	TILE FLOORING	2003	1,946						2
3	FLOORING	2003	2,384						3
4	DOORS	2003	14,965						4
5	FENCE	2003	8,250						5
6	ceramic tile	2004	2,385						6
7	RENOVATION/ 406-01404C \$13,607 disallowed per audit	2005							7
8	PEDIMAT MATTING	2005	1,455						8
9									9
10	Entrance/Porch - add sprinkler system in canopy area	2004	3,550						10
11	Entrance/Porch - replace post & resurface floor	2005	5,940						11
12	Carpet & Cove Base	2005	3,250						12
13	Locksets, Simplex keyless	2005	3,109						13
14	HVAC System & electrical	2005	447,358						14
15	O/H & Interest - non-allowable per audit \$209,630								15
16	Wallcovering & Paint	2005	7,000						16
17	20 Amp Disconnect 200 for Chiller	2005	753						17
18	New sidewalks	2005	7,150						18
19	Ceramic Tile Walls/Floors Arcadia Shower	2006	4,100						19
20	Man door replacement	2006	1,141						20
21	Upgrade Kitchen Hood to UL300 fire system	2006	768						21
22	Privacy Fence	2006	820						22
23									23
24	Wallcovering & Rubber Cove Base	2006	7,155						24
25	Upgrade 3 Doors	2006	12,750						25
26	Upgrade Kitchen Walls	2006	3,150						26
27	New Plumbing in Hallway	2006	4,140						27
28	Show Room Renovation and Electric in Therapy Area	2006	21,850						28
29	Cabinets/Work Station in Dinning Room	2006	4,260						29
30	Fire Rated Doors (3)	2007	9,995						30
31	Drainage system	2007	8,235						31
32	Flooring	2007	59,107						32
33	Renov. - Gutter, Facia, & Soffit	2007	37,964						33
34	TOTAL (lines 1 thru 33)		\$ 3,536,489	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	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		\$ 3,536,489	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	1
2	Concrete Sidewalk	2007	9,150						2
3	Parking lot sealcoating	2007	2,036						3
4	Steel door set	2008	5,749						4
5									5
6	HOT WATER HEATER	2008	12,995						6
7	Renov. - 40 ton chiller	2008	66,710						7
8	CO2 DETECTORS	2008	5,358						8
9	ROOFING SYSTEM	2008	4,060						9
10									10
11	Fire Doors - 4 sets	2008	5,051						11
12	Roofing & Roof Trusses	2009	20,000						12
13									13
14	Seal coat parking lot	2010	3,947						14
15	Concrete pad & Storage shed 6' x 6'	2010	4,450						15
16	Concrete work - 2400 sq ft	2011	6,588						16
17	VWC, Painting, & rubber base molding	2010	5,350						17
18	Doors & Hardware	2010	18,837						18
19	Ceiling Tiles & Grid	2010	4,981						19
20	LED Wallpacks (13) & Wiring	2011	14,744						20
21	Painting, & vinyl base molding	2011	7,558						21
22	Rebuild 4 smoke & fire walls to meet UL-419	2011	14,787						22
23	VWC, Painting, & rubber base molding	2011	11,850						23
24	LED Wallpacks & Wiring	2011	2,680						24
25	Windows (14) in 100's cooridor	2011	22,400						25
26	Painting (activities room)	2011	3,285						26
27									27
28	Roof - Arcadia Addition	2011	18,908						28
29	Structural Columns (6) & Door	2011	16,900						29
30	Concrete Patio & Sidewalks	2011	18,270						30
31	Secure Care Exit Upgrades	2011	3,594						31
32	Remodel Utility Room	2011	25,360						32
33	Doors	2011	23,800						33
34	TOTAL (lines 1 thru 33)		\$ 3,895,887	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	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 12E, Carried Forward		\$ 3,895,887	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	1
2	Ductless Split Systems (5)	2011	38,990						2
3	Fan Coils (2)	2011	6,771						3
4	Flooring / Carpeting	2011	9,772						4
5	Piping for Chiller	2011	16,525						5
6	Heat Exchangers (2)	2011	6,995						6
7	Drywall (Mechanical Rm)	2011	7,466						7
8	Circuit Panel upgrade	2011	6,450						8
9	Paint, Wallcovering, Base - Renov. 31-11C	2011	44,910						9
10	Electrical Work - Renov. 31-11C	2011	1,275						10
11	Renovate Rms 174 & 176	2011	10,667						11
12	Door Smoke Gaskets (16) in Corridor	2011	11,462						12
13	Door HM	2012	7,780						13
14	Paint, Wallcovering, & Base	2012	21,533						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)		\$ 4,086,483	\$ 141,475		\$ 141,475	\$	\$ 3,162,279	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	\$ 1,445,273	\$ 89,688	\$ 89,688	\$		\$ 1,166,517	71
72	Current Year Purchases	36,524						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			11,252	11,252			74
75	TOTALS	\$ 1,481,797	\$ 89,688	\$ 100,940	\$ 11,252		\$ 1,166,517	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)	\$ 5,597,357	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 231,163	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 242,415	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,252	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,328,796	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	Various	\$ 101,124	92
93			93
94			94
95		\$ 101,124	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: \$22,546
- 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			\$	\$	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.)

12345678											
	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	4375	hrs	\$ 192,561		\$ 1,147	4,375	\$ 193,708	1	
2	Licensed Speech and Language Development Therapist	10a, 1	1827	hrs	80,401		281	1,827	80,682	2	
3	Licensed Recreational Therapist			hrs						3	
4	Licensed Physical Therapist	10a, 1	2809	hrs	123,682		3,282	2,809	126,964	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			227,823		227,823	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10	
11	Academic Education			hrs						11	
12	Other (specify): IV Therapy	43, 2					28,118		28,118	12	
13	Other (specify): X-Ray & Lab	43, 3				31,881			31,881	13	
14	TOTAL				\$ 396,644		\$ 31,881	\$ 260,651	9,011	\$ 689,176	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	\$ (36,224)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 401,488)	1,581,088		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,273		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,548,137	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	29,077		13
14	Buildings, at Historical Cost	4,086,483		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,481,797		16
17	Accumulated Depreciation (book methods)	(4,328,796)		17
18	Deferred Charges	3,378,264		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	101,124		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,747,949	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,296,086	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 125,948	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	331,256		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,829		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	228,282		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 762,315	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	844,222		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)	\$ 844,222	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,606,537	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,689,549	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,296,086	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,685,890)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,685,890)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(798,986)	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)	\$ (798,986)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	8,174,425	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 8,174,425	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,689,549	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Kankakee# 0049429Report 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	\$ 8,057,011	1
2	Discounts and Allowances for all Levels	(2,390,708)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,666,303	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,866,466	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,866,466	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	1,393	12
13	Barber and Beauty Care	15,285	13
14	Non-Patient Meals	324	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	229,777	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,011	19
20	Radiology and X-Ray	14,430	20
21	Other Medical Services	84,163	21
22	Laundry	2,248	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 362,631	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50	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)	\$ 7,895,450	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,107,504	31
32	Health Care	3,506,848	32
33	General Administration	2,366,010	33
	B. Capital Expense		
34	Ownership	1,154,208	34
	C. Ancillary Expense		
35	Special Cost Centers	301,643	35
36	Provider Participation Fee	258,223	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,694,436	40
41	Income before Income Taxes (line 30 minus line 40)**	(798,986)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (798,986)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,041,056	44
45	Private Pay - Net Inpatient Revenue	788,812	45
46	Medicare - Net Inpatient Revenue	2,033,501	46
47	Other-(specify) <u>Hospice</u>	576,233	47
48	Other-(specify) <u>Other</u>	226,701	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,666,303	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	1,097	1,177	\$ 47,606	\$ 40.45	1
2	Assistant Director of Nursing	4,713	5,056	164,715	32.58	2
3	Registered Nurses	16,718	17,935	516,616	28.80	3
4	Licensed Practical Nurses	22,631	24,278	536,959	22.12	4
5	CNAs & Orderlies	84,236	90,527	1,036,572	11.45	5
6	CNA Trainees					6
7	Licensed Therapist	9,013	9,662	425,250	44.01	7
8	Rehab/Therapy Aides	5,873	6,296	205,629	32.66	8
9	Activity Director	7,577	8,130	101,504	12.49	9
10	Activity Assistants					10
11	Social Service Workers	3,911	4,201	103,497	24.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,401	21,912	245,267	11.19	15
16	Dishwashers					16
17	Maintenance Workers	1,332	1,428	30,210	21.16	17
18	Housekeepers	11,350	12,189	127,820	10.49	18
19	Laundry	4,373	4,694	51,045	10.87	19
20	Administrator	2,080	2,080	86,013	41.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,507	12,446	249,217	20.02	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	486	526	7,392	14.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	207,298	222,537	\$ 3,935,312 *	\$ 17.68	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	10,992	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	180	9,223	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)	180	\$ 20,215		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			10, 3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

0049429

Report Period Beginning:

06/01/11

Page 21

Ending: 05/31/12

Facility Name & ID Number

Manorcare of Kankakee

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	
Katie Slench (Jun.- Oct.)		Administrator	0	\$ 26,683	Workers' Compensation Insurance		\$ 111,904	IDPH License Fee		\$ 3,980	
Kerry Donegan (Oct.- Nov.)		Administrator	0	10,000	Unemployment Compensation Insurance		66,735	Advertising: Employee Recruitment		2,185	
Janet Cantelo (Dec.- May)		Administrator	0	49,330	FICA Taxes		282,489	Health Care Worker Background Check		2,338	
					Employee Health Insurance		225,347	(Indicate # of checks performed 116)			
					Employee Meals			Patient Background Checks		144 1,440	
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		5,608	
					Disability Payments		6,703	Association Dues		12,743	
					401K		15,169	Advertising		19,719	
					Appreciation, Other Benefits		4,272	Other Licenses & Permits		290	
TOTAL (agree to Schedule V, line 17, col. 1)					Tuition Program		(2,147)	Less Non-allowable Association Dues		(9,159)	
(List each licensed administrator separately.)				\$ 86,013	SMSP Match & RSU		686	Less: Public Relations Expense		()	
B. Administrative - Other					Employee Uniforms		5,073	Non-allowable advertising		(19,719)	
Description				Amount	Home Office Allocation		21,775	Yellow page advertising		()	
Various home office services - See page 18 for breakdown				\$ 392,008				TOTAL (agree to Sch. V,		\$ 19,425	
					TOTAL (agree to Schedule V,		\$ 738,006	line 20, col. 8)			
					line 22, col.8)						
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 392,008	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)					Description		Line #	Amount	Description		Amount
C. Professional Services									Out-of-State Travel		\$
Vendor/Payee		Type		Amount							
				\$							
United Collection Bureau Inc.		Collection Services		348					In-State Travel		4,487
									Includes travel expense to the Home Office in Toledo, OH for regional meetings		
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)											
Corporate Intelligence Consultants I		Theft investigation		13,720					Seminar Expense		
		Reclassify to line 21									
MPRO		Review care of residents		1,920							
		Reclassify to line 21									
									Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$		(agree to Sch. V,		
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 15,988					line 24, col. 8)		\$ 4,487

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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 \$3584

(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. \$ 57,684 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. \$ 258,223
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. \$ 324

(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.