

		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: 0049411

Facility Name: Manorcare of Libertyville

Address: 1500 South Milwaukee Avenue Libertyville 60048
Number City Zip Code

County: Lake

Telephone Number: (708) 816-3200 Fax # (708) 816-8981

HFS ID Number:

Date of Initial License for Current Owners: 02/02/88

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 Libertyville# 0049411 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>150</u>	Skilled (SNF)	<u>150</u>	<u>54,900</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>150</u>	TOTALS	<u>150</u>	<u>54,900</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>16,600</u>	<u>2,358</u>	<u>22,313</u>	<u>41,271</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>16,600</u>	<u>2,358</u>	<u>22,313</u>	<u>41,271</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.17%

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 02/23/88

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 150 and days of care provided 16,659Medicare Intermediary Novitas Solutions

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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	367,365	35,359	55,485	458,209		458,209		458,209			1
2	Food Purchase		339,738		339,738		339,738	(513)	339,225			2
3	Housekeeping	161,308	26,032	2,432	189,772		189,772		189,772			3
4	Laundry	49,698	33,508	141	83,347		83,347		83,347			4
5	Heat and Other Utilities			204,458	204,458	2,762	207,220		207,220			5
6	Maintenance	53,936	16,449	149,947	220,332		220,332		220,332			6
7	Other (specify):* Med Waste			4,980	4,980		4,980		4,980			7
8	TOTAL General Services	632,307	451,086	417,443	1,500,836	2,762	1,503,598	(513)	1,503,085			8
	B. Health Care and Programs											
9	Medical Director			26,150	26,150		26,150		26,150			9
10	Nursing and Medical Records	3,449,461	371,979	345,020	4,166,460	17,428	4,183,888		4,183,888			10
10a	Therapy	1,689,545	17,291	364,162	2,070,998		2,070,998		2,070,998			10a
11	Activities	91,833	(273)	5,543	97,103		97,103		97,103			11
12	Social Services	205,416			205,416		205,416		205,416			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,436,255	388,997	740,875	6,566,127	17,428	6,583,555		6,583,555			16
	C. General Administration											
17	Administrative	104,563		833,774	938,337	(429,644)	508,693		508,693			17
18	Directors Fees											18
19	Professional Services			29,761	29,761	(2,944)	26,817	(26,817)				19
20	Dues, Fees, Subscriptions & Promotions			117,148	117,148		117,148	(64,985)	52,163			20
21	Clerical & General Office Expenses	550,681	83,667	731,739	1,366,087	2,944	1,369,031	(594,475)	774,556			21
22	Employee Benefits & Payroll Taxes			1,018,146	1,018,146	37,256	1,055,402		1,055,402			22
23	Inservice Training & Education			2,769	2,769		2,769		2,769			23
24	Travel and Seminar			22,539	22,539		22,539		22,539			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			458,399	458,399		458,399		458,399			26
27	Other (specify):*							(32)	(32)			27
28	TOTAL General Administration	655,244	83,667	3,214,275	3,953,186	(392,388)	3,560,798	(686,309)	2,874,489			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,723,806	923,750	4,372,593	12,020,149	(372,198)	11,647,951	(686,822)	10,961,129			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			451,800	451,800	19,250	471,050		471,050			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,392,894	1,392,894	352,948	1,745,842	(1,396,938)	348,904			32
33	Real Estate Taxes			147,405	147,405		147,405		147,405			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			90,478	90,478		90,478		90,478			35
36	Other (specify):*											36
37	TOTAL Ownership			2,082,577	2,082,577	372,198	2,454,775	(1,396,938)	1,057,837			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		754,856		754,856		754,856		754,856			39
40	Barber and Beauty Shops			16,750	16,750		16,750		16,750			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,148	257,148		257,148		257,148			42
43	Other (specify):* IV Ther/Xray/Lab		82,731	138,772	221,503		221,503		221,503			43
44	TOTAL Special Cost Centers		837,587	412,670	1,250,257		1,250,257		1,250,257			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,723,806	1,761,337	6,867,840	15,352,983		15,352,983	(2,083,760)	13,269,223			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- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(513)	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	(96)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(32)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,860)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,817)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(576,994)	21		24
25	Fund Raising, Advertising and Promotional	(64,985)	20		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached 5a	(1,411,463)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,083,760)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,083,760)		37

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

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

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

Manorcare of Libertyville

Report Period Beginning:

Ending:

ID#0049411

06/01/11

05/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (10,881)	21	1
2	P/R O/H Alloc - Mktg	(2,617)	21	2
3	HCP Lease Interest	(1,396,938)	32	3
4	Vending Income	(1,026)	21	4
5	Misc. Income	(1)	21	5
6	Activity Income		11	6
7	Loss on disposal of Fixed Asset		36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,411,463)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Libertyville # 0049411 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	(513)	0	0	0	0	0	0	0	0	0	0	(513)	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	(513)	0	0	0	0	0	0	0	0	0	0	(513)	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	(26,817)	0	0	0	0	0	0	0	0	0	0	(26,817)	19
20	Fees, Subscriptions & Promotions	(64,985)	0	0	0	0	0	0	0	0	0	0	(64,985)	20
21	Clerical & General Office Expenses	(594,475)	0	0	0	0	0	0	0	0	0	0	(594,475)	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):*	(32)	0	0	0	0	0	0	0	0	0	0	(32)	27
28	TOTAL General Administration	(686,309)	0	0	0	0	0	0	0	0	0	0	(686,309)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(686,822)	0	0	0	0	0	0	0	0	0	0	(686,822)	29

Summary B

05/31/12

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care 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	\$ 833,774	HCR Manor Care Services, LLC	100.00%	\$ 833,774	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,723,806	Heartland Employment Services, LLC	100.00%	6,723,806		4
5	V	10a	Therapy Management	17,042	Heartland Rehabilitation Services, LLC	100.00%	17,042		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			\$ 7,574,622			\$ 7,574,622	\$ *	14

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

Facility Name & ID Number

Manorcare of Libertyville

0049411

Report Period Beginning:

06/01/11

Ending:

05/31/12

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Geneva IL, LLC	Geneva				1
2			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				2
3			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				3
4			Arden Courts of Northbrook IL, LLC	Northbrook				4
5			Arden Courts of Palos Heights IL, LLC	Palos Heights				5
6								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 Libertyville # 0049411 Report Period Beginning: 06/01/11 Ending: 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	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,Reha	\$ 775,999	\$	13,400,541	\$ 2,762	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs			13,400,541	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			13,400,541	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			13,400,541	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	485,056	352,684	13,400,541	1,726	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	13,400,541	15,702	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			13,400,541	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			13,400,541	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	71,430,003	38,287,220	13,400,541	254,221	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	13,400,541	94,875	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	13,400,541	29,736	11
12	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	13,400,541	25,298	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	2,952,374		13,400,541	10,508	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		13,400,541	26,748	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			13,400,541	0	15
16	22	Empl Bnfts - Direct to MW Div S	Accumulated Cost	474,102,184	48 NFs			13,400,541	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	4,719,938		13,400,541	16,798	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		13,400,541	2,452	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			13,400,541	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			13,400,541	0	20
21										21
22	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		13,400,541	93,757	22
23	32	Directly Assigned Interest				18,851,990			259,191	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				32,615,916				24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 833,774	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			\$ 3,895,128	\$ 3,895,128		0.0665	\$ 259,191	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Pooled Interest										93,757	7	
8	Interest Expense / Interest Income										(4,044)	8	
9	TOTAL Facility Related						\$ 3,895,128	\$ 3,895,128			\$ 348,904	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,895,128	\$ 3,895,128			\$ 348,904	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.	\$	123,229	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.)	\$	139,011	2		
3. Under or (over) accrual (line 2 minus line 1).	\$	15,781	3		
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	131,624	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.	\$	147,405	7		
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	114,392	8		
	2008	119,948	9		
	2009	124,666	10		
	2010	134,432	11		
	2011	143,590	12		
Line 2: \$139,010.78 = \$67,215.99 for 2nd half 2010 + \$71,794.79 for 1st half 2011					
Line 4: \$131,623.97 = \$71,794.80 for 2nd half 2011 + \$59,859.17 for Jan - May 2012					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Manorcare of Libertyville
COUNTY
Lake

FACILITY IDPH LICENSE NUMBER
0049411

CONTACT PERSON REGARDING THIS REPORT
Gary Geise

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	11-28-401-003	See Attached	\$ 143,589.60	\$ 143,589.60
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 143,589.60	\$ 143,589.60

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:	41,805	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		1988	\$ 476,076	1
2					2
3	TOTALS			\$ 476,076	3

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	150			1988	\$ 4,592,131	\$ 117,248		\$ 117,248	\$	2,749,288	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					155,667		155,667		2,527,618	9
10				1988	68,073						10
11				1989	52,434						11
12				1990	30,247						12
13				1991	67,316						13
14				1992	175,480						14
15	RETIREMENTS			1992	(10,437)						15
16				1993	55,746						16
17				1994	135,262						17
18				1995	66,532						18
19	FLOOR VINYL/TILE & INSTALLATION			1996	31,353						19
20	CAPITALIZED LABOR-NURSES STATION RENOV			1996	7,272						20
21	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR			1996	(7,272)						21
22	WALL VINYL/SIGNS			1996	5,576						22
23	CARPET			1996	4,210						23
24	INNER CAMERA MONITOR			1996	4,177						24
25	SIDING			1996	2,205						25
26	REPAIR LOOSE BRICKS			1996	2,183						26
27	NURSES STATION RENOVATION			1996	11,271						27
28	DOOR RELEASE			1996	2,071						28
29	REMODELING			1996	1,129						29
30	WATER HEATER			1996	5,313						30
31	CARPER/INSTALLATION			1996	2,991						31
32	FLOORING/TILE			1996	23,312						32
33	DOOR FRAME/GUARDS			1996	4,941						33
34	KITCHEN CEILING TILE			1996	3,638						34
35	WALLCOVERING			1996	4,964						35
36				1996	3,055						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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CABINETRY	1996	\$ 5,880	\$		\$	\$	\$	37
38	REBUILD NURSES STATION	1996	8,500						38
39	INSTALL SWING DOORS	1996	8,826						39
40	INSTALL BALLUSTER POSTS	1996	2,500						40
41	FLOOR COVING	1996	7,791						41
42	BRICK PIER/CONCRETE SIDEWALK	1996	3,880						42
43	INSTALL BOULDER EDGE	1996	4,830						43
44	NURSES STATION RENOVATIONS	1996	1,506						44
45	WALL VINYL	1997	18,304						45
46	CARPETING	1997	1,624						46
47	DECORATING	1997	45,045						47
48	BRICK PIER	1997	1,500						48
49	EXTERIOR ENTRY DOORS	1997	3,317						49
50	PAINTING	1997	7,449						50
51	INSTALL CONDENSING COILS	1997	2,583						51
52	LANDSCAPE	1997	59,118						52
53	CURBING/ASPHALT	1997	30,000						53
54	ROOFING	1997	1,536						54
55	CORPORATE OVERHEAD-PARKING LOT	1997	10,516						55
56	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)						56
57	PARKING LOT WORK	1997	25,000						57
58	FACILITY PLAN ALLOC	1997	5,964						58
59	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)						59
60	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)						60
61	ELEVATOR REPAIRS	1997	5,018						61
62	SECURITY SYSTEM	1997	16,954						62
63	NEW EXHAUSTERS	1997	6,310						63
64	BUILD & INSTALL CABINETS	1997	6,512						64
65	CARPET	1997	5,148						65
66	LANDSCAPE	1997	25,279						66
67	CURB/ASPHALT	1997	45,210						67
68	INSTALL CEDAR FENCE	1997	2,750						68
69	DRUM SLUDGE REMOVAL	1997	2,563						69
70	TOTAL (lines 4 thru 69)		\$ 5,700,105	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	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		\$ 5,700,105	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	1
2	INSTALL OIL TANK	1997	11,780						2
3	FLOORING/CEILING	1998	1,115						3
4	CARPETING	1998	2,574						4
5	ARCHITECT/PROFESSIONAL FEES-ADMIN OFFICE	1998	3,685						5
6	PAINTING/WALLPAPER	1998	10,125						6
7	RENOVATE ADMIN OFFICE	1998	2,533						7
8	ENERGY AUDITS	1998	1,875						8
9	GENERAL CONTRACTOR FEES-ADMIN OFFICE	1998	4,165						9
10	CORPORATE OVERHEAD-ADMIN OFFICE	1998	1,651						10
11	C/R 5/31/99 AUDIT ADJ - MONTHLY CAP BUDGET	1998	(1,651)						11
12	INSTALL FENCE/GAZEBO	1998	2,153						12
13	PAINTING/WALLCOVERING	1998	5,821						13
14	PLUMBING	1998	5,250						14
15	ELECTRICAL	1998	8,883						15
16	DEVELOPERS-ADMIN OFFICE	1998	5,555						16
17	SIGN	1998	11,862						17
18	ROOFING	1998	5,520						18
19	MASONARY	1998	4,766						19
20	CARPENTRY	1998	3,137						20
21	PAINTING/WALLCOVERING	1999	6,873						21
22	ELECTRICAL	1999	6,590						22
23	FLOORING/CEILING	1999	8,230						23
24	CARPENTRY	1999	12,373						24
25	MILLWORK	1999	540						25
26	FINISH STUDS	1999	20,000						26
27	PAVING	1999	35,325						27
28	CARPET FOR BUILDING	1999	11,611						28
29	WINDOW TREATMENTS	1999	10,291						29
30	KNOBLOCKS, CYPHER	1999	1,448						30
31	CARPET, CREDIT	1999	(13,990)						31
32	SALES TAX, CARPET	1999	71						32
33	CARPET	1999	148						33
34	TOTAL (lines 1 thru 33)		\$ 5,890,414	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	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 12B, Carried Forward		\$ 5,890,414	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	1
2	DOOR FRAME FOR BOILER ROOM	1999	2,550						2
3	ELECTRICAL CIRCUITS, HEATER	1999	5,937						3
4	PTAC UNITS	1999	2,920						4
5	DOOR, HARDWARE, & STAIN	2000	1,025						5
6	ADDTL COST GARAGE	2000	1,671						6
7	SECURE CARE SYS 2ND FL STAIRWELL	2000	3,147						7
8	DOOR - SOUTH CORRIDOR EXIT	2000	2,440						8
9	PANIC DEVICE - EXTERIOR DOOR	2000	760						9
10	2 A/C UNITS	2000	1,156						10
11	GARAGE	2000	21,256						11
12	LANDSCAPING	2000	2,675						12
13	LANDSCAPING - ARBORIVITAE	2000	3,784						13
14	GARAGE	2000	19,209						14
15	GARAGE	2000	5,556						15
16	BOILER	2001	4,525						16
17	FIRE WALL IN ATTIC	2001	7,422						17
18	A/C UNIT	2001	597						18
19	4 A/C UNITS	2001	2,680						19
20	WORKCOUNTER & CABINETS	2001	2,219						20
21	GATES	2001	4,760						21
22	ELECTRICAL CIRCUITS	2001	1,279						22
23	ARCADIA CORRIDORS & LOUNGE (See Line 32)	2001	132,623						23
24	ARCADIA CORRIDORS & LOUNGE	2001	5,666						24
25	ARCADIA CORRIDORS & LOUNGE (See Line 32)	2001	124,865						25
26	ARCADIA CORRIDORS & LOUNGE	2001	20,483						26
27	ARCADIA CORRIDORS & LOUNGE	2001	181,656						27
28	CARPENTRY, DOORS, ELECT.	2001	52,344						28
29	VWC, CORNER GUARDS	2001	10,041						29
30	Per 7/06 Cap. Rate Audit Adjustments	2001	(122,832)						30
31	Invoice #13216 Per 7/06 Cap Rate Audit Adj.	2002	21,952						31
32	Invoice #13233 Pre 7/16 Cap Rate Audit Adj.	2002	24,155						32
33	Per 7/06 Cap Rate Audit Adj. Move (See Lines 2 & 3)	2003	(46,107)						33
34	TOTAL (lines 1 thru 33)		\$ 6,392,829	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	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		\$ 6,392,829	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	1
2	DINING ROOM & BREAKROOM	2003	21,720						2
3	RETROACTIVE ADDITION	2003	(588)						3
4	ARCH&ENGINEER COSTS, PLANS REVIEWS	2003	16,667						4
5	GENERAL OVERHEAD & INTEREST	2003	33,439						5
6	GENERAL OH & INT Pr 7/06 Cap Rate Audit Adj.	2003	(33,439)						6
7	CARPETING & PADS, WALLCOVERINGS	2003	74,310						7
8	CARPENTRY & MILLWORK	2003	5,750						8
9	HVAC & ELECTRICAL WORK	2003	30,572						9
10	HM DOORS & FRAMES	2003	3,662						10
11	WARDROBES	2004	11,000						11
12	FLOORING	2004	761						12
13	GENERAL OVERHEAD & INTEREST (See Line 18)	2004	32,935						13
14	Gen OH & Int Per 7/06 Cap Rate Audit Adj.	2004	(32,935)						14
15	SOWER ROOM RENOVATION	2004	3,000						15
16	Building décor/3 yrs Ta (See Line 21)	2004	21						16
17	Building décor/3 yrs Ta Per Cap Rate Audit Adj.	2004	(21)						17
18	VWC	2004	252						18
19	SECOND FLOORING	2004	13,500						19
20	FRP FIRE WALL	2004	2,941						20
21	WINDOWS	2004	18,532						21
22	PAINTING EXTERIOR	2004	13,667						22
23	SHOWER ROOM RENOVATION	2004	3,800						23
24	ADD'L FLOORING	2004	1,238						24
25	SHOWER ROOM RENOVATION RE	2004	690						25
26	VWC	2004	83						26
27	INSTALL CARPET	2004	4,364						27
28	Per 7/06 Cap Rate Audit Adj.	2004	43,112						28
29	Per 7/06 Cap Rate Audit Adj.	2004	5,300						29
30	INSTALL VCT FLOORING	2005	3,436						30
31	Renov -Lobby Finishes	2005	1,680						31
32	Renov -Custom Casework (See Line 29)	2005	16,000						32
33	Renov -Carpeting & Pads & Guards & WC	2005	26,679						33
34	TOTAL (lines 1 thru 33)		\$ 6,714,957	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	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		\$ 6,714,957	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	1
2	Renov -General Overhead & Interest (See Line 19)	2005	6,015						2
3	Stainles Steel Flashing	2005	20,000						3
4	Linen&Bathroom doors	2005	2,482						4
5	Renov -Roof Covering	2005	101,050						5
6	Renov -General Overhead (See Line 30)	2005	4,327						6
7	Renov -Interest on Construction (See Line 30)	2005	546						7
8	VWC	2005	4,168						8
9	Stainless steel flashing	2005	15,440						9
10	Bathroom Exhaust fans	2005	4,426						10
11	Carpet	2005	1,648						11
12	Renov -Drywall/Studs	2005	1,430						12
13	Renov -Resilient Flooring	2005	16,153						13
14	Renov -General Overhead & Interest (See Line 31)	2005	866						14
15	Adj. out OH & Int Per 7/06 Cap Rate Audit Adjs.	2005	(6,015)						15
16	To 2004 Per 7/06 Cap Rate Audit Adjs.	2005	(28,179)						16
17	Adj. out OH & Int Per 7/06 Cap Rate Audit Adjs.	2005	(5,670)						17
18	RENOVATION/ 440 018 04C (See Line 21)	2005	25,904						18
19	RENOVATION/ 440 018 04C (See Line 20)	2005	27,234						19
20	RENOVATION/ 440 018 04C (See Line 20)	2005	945						20
21	FLOORING	2005	1,636						21
22	INSTALL DOORS	2005	6,480						22
23	2 LIGHT FIXTURES	2005	1,650						23
24	INSTALL SMOKE WALL & SIDE	2005	10,129						24
25	Per 7/06 Cap Rate Audit Adjs.	2005	(5,000)						25
26	Per 7/06 Cap Rate Audit Adjs.	2005	(4,873)						26
27	Per 7/06 Cap Rate Audit Adjs.	2005	(866)						27
28	Per 7/06 Cap Rate Audit Adjs.	2005	(20,234)						28
29	KVA TRANSFORMER	2006	2,838						29
30	21 doors	2006	37,670						30
31	sheet vinyl & ceramic flo	2006	4,074						31
32	metsl doors	2006	3,317						32
33	electrical	2006	827						33
34	TOTAL (lines 1 thru 33)		\$ 6,945,375	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	34

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

Facility Name & ID Number Manorcare of Libertyville

0049411

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 12E, Carried Forward		\$ 6,945,375	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	1
2	DOORS ON KITCHEN	2007	14,124						2
3	DOORS ON 3RD & 2ND FLOOR	2007	5,940						3
4	Renov - Carpentry	2007	29,850						4
5	Renov - Doors/Frames/Drywall/Studs/Plumbing	2007	14,674						5
6	Renov - Resilient Flooring	2007	79,144						6
7	Renov - Carpeting & ads	2007	19,746						7
8	Renov - Fire Sprinkler	2007	3,752						8
9	Renov - Basic Electric	2007	21,558						9
10	Renov - Interest on Construction	2007	1,493						10
11	Renov - General Overhead	2007	20,811						11
12	Fire Rated Doors	2007	22,384						12
13	000000001811 Concrete Sidewalk	2008	2,862						13
14	000000001815 Seal Parking Lot	2008	8,031						14
15	000000001821 Asphalt	2008	1,706						15
16	000000001809 Fire Proofing	2008	8,820						16
17	000000001810 Kitchen Make Air	2008	4,903						17
18	000000001812 30 amp 277 volt Circuit	2008	5,238						18
19	000000001813 0208 Door Alarm System	2008	1,382						19
20	000000001834 Ceramic Tile in 4 Showers	2008	22,440						20
21	000000001835 Elevator Switches	2008	4,757						21
22	000000001839 Added Sprinklers	2009	9,700						22
23	000000001840 2208 Water Heaters	2009	7,056						23
24	000000001841 2208 Water Heaters	2009	48,816						24
25	000000001844 0908 Rms & Bthrms Gen Overhead & Interest	2009	41,216						25
26	000000001846 0908 Rms & Bthrms Carpentry & Milwork	2009	137,855						26
27	000000001847 0908 Rms & Bthrms Ceiling tile, flooring VWC	2009	26,975						27
28	1847 0908 Rms & Bathrms VWC	2009	396						28
29	1864 Door	2009	2,076						29
30	1866 Adj Asset #1847 VWC	2009	(30)						30
31	1870 Steel Railing & Gate	2010	2,250						31
32	1883 25 Smoke Detectors	2010	11,770						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,527,068	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	34

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

Facility Name & ID Number Manorcare of Libertyville

0049411

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 12F, Carried Forward		\$ 7,527,068	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	1
2	CONCRETE RAMP	2011	16,704						2
3	KITCHEN CEILING	2011	12,322						3
4	REMODEL KITCHEN POT & PAN WASH	2011	36,617						4
5	100 GALLON WATER HEATER	2011	7,832						5
6	RENOV - ARCH & ENGINEER COSTS	2012	151,874						6
7	RENOV - LEGAL FEES	2012	15,348						7
8	RENOV - REPRODUCTIONS	2012	216						8
9	RENOV - GENERAL OVERHEAD & INTEREST	2012	156,725						9
10	RENOV - PLAN REVIEWS	2012	10,800						10
11	RENOV - CARPENTRY	2012	11,960						11
12	RENOV - MILLWORK	2012	78,250						12
13	RENOV - ROOFING	2012	81,509						13
14	RENOV - HM DOORS & FRAMES	2012	110,354						14
15	RENOV - DRYWALL & STUDS	2012	213,277						15
16	RENOV - ACCOUSTICAL CEILING TILE	2012	70,837						16
17	RENOV - RESILIENT FLOORING	2012	20,295						17
18	RENOV - PAINTING	2012	64,368						18
19	RENOV - WALLCOVERING	2012	14,883						19
20	RENOV - PLUMBING	2012	74,511						20
21	RENOV - HVAC	2012	96,332						21
22	RENOV - BASIC ELECTRICAL	2012	314,076						22
23	RENOV - MASONRY	2012	50,230						23
24	RENOV - METALS	2012	36,219						24
25	RENOV - CONCRETE	2012	54,119						25
26	RENOV - RESILIENT FLOORING	2012	352						26
27	RENOV - CARPETING AND PADS	2012	26,902						27
28	RENOV - WALLCOVERING	2012	29,316						28
29	RENOV - SOIL & CONCRETE TESTING	2012	12,107						29
30	RENOV - WATER & SEWER FEES	2012	13,775						30
31	RENOV - PERMIT FEES	2012	28,724						31
32	RENOV - SITE PREP/GRADING	2012	292,886						32
33	prep sink	2012	17,416						33
34	TOTAL (lines 1 thru 33)		\$ 9,648,205	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	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 12G, Carried Forward		\$ 9,648,205	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	1
2	RENOV- DRYWALL & STUDS FOR MECHANICAL ROOM UPGR	2012	44,749						2
3	ENLARGE O2 ROOM	2012	21,080						3
4	PAINTING ON 1ST, 2ND & 3RD	2012	4,364						4
5	OVN MAIL CHGS RE: ADDITION	2012	48						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)		\$ 9,718,445	\$ 272,915		\$ 272,915	\$	\$ 5,276,906	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,156,337	\$ 178,885	\$ 178,885	\$		\$ 1,823,051	71
72	Current Year Purchases	431,916						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			19,250	19,250			74
75	TOTALS	\$ 2,588,253	\$ 178,885	\$ 198,135	\$ 19,250		\$ 1,823,051	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)	\$ 12,782,774	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 451,800	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 471,050	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,250	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,099,957	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		\$	92
93			93
94			94
95		\$	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: \$ 90,478
- 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.)

	Service	Schedule V Line & Column Reference	2		3	4	5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	10492	hrs	\$ 415,721	904	\$ 53,152	\$	11,396	\$ 468,873	1
2	Licensed Speech and Language Development Therapist	10a	1814	hrs	71,886				1,814	71,886	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	17357	hrs	687,717	2,682	157,722		20,039	845,439	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				754,856		754,856	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Inhal Therapist</u>	10a				2,295	134,972		2,295	134,972	12
13	Other (specify): <u>IV Ther/Xray/Lab</u>	43, 2 & 3					138,772	82,731		221,503	13
14	TOTAL				\$ 1,175,324	5,881	\$ 484,618	\$ 837,587	35,544	\$ 2,497,529	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	\$ (41,713)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,032,403))	2,755,458		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,589		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,718,334	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	476,076		13
14	Buildings, at Historical Cost	9,718,445		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,588,253		16
17	Accumulated Depreciation (book methods)	(7,099,957)		17
18	Deferred Charges	681,254		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,364,071	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,082,405	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 163,979	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	592,808		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	131,624		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	329,194		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,217,605	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,895,128		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)	\$ 3,895,128	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,112,733	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,969,672	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,082,405	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (19,591,853)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (19,591,853)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(186,446)	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)	\$ (186,446)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	23,747,971	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 23,747,971	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,969,672	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Libertyville# 0049411Report 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	\$ 15,199,640	1
2	Discounts and Allowances for all Levels	(5,977,802)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,221,838	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,848,061	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,848,061	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	1,058	12
13	Barber and Beauty Care	19,864	13
14	Non-Patient Meals	513	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	829,710	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,292	19
20	Radiology and X-Ray	58,921	20
21	Other Medical Services	127,279	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,096,637	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	Miscellaneous Income	1	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,166,537	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,500,836	31
32	Health Care	6,566,127	32
33	General Administration	3,953,186	33
	B. Capital Expense		
34	Ownership	2,082,577	34
	C. Ancillary Expense		
35	Special Cost Centers	993,109	35
36	Provider Participation Fee	257,148	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,352,983	40
41	Income before Income Taxes (line 30 minus line 40)**	(186,446)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (186,446)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,904,606	44
45	Private Pay - Net Inpatient Revenue	737,362	45
46	Medicare - Net Inpatient Revenue	5,316,082	46
47	Other-(specify) <u>Hospice</u>	102,480	47
48	Other-(specify) <u>Insurance</u>	1,161,308	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,221,838	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	2,022	2,195	\$ 109,050	\$ 49.68	1
2	Assistant Director of Nursing	5,057	5,491	210,322	38.30	2
3	Registered Nurses	37,930	41,182	1,380,097	33.51	3
4	Licensed Practical Nurses	22,729	24,678	575,164	23.31	4
5	CNAs & Orderlies	87,883	95,621	1,146,238	11.99	5
6	CNA Trainees					6
7	Licensed Therapist	29,663	32,212	1,276,328	39.62	7
8	Rehab/Therapy Aides	13,696	14,873	413,217	27.78	8
9	Activity Director	5,146	5,592	91,833	16.42	9
10	Activity Assistants					10
11	Social Service Workers	8,233	8,946	205,416	22.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,855	25,932	367,365	14.17	15
16	Dishwashers					16
17	Maintenance Workers	2,307	2,507	53,936	21.51	17
18	Housekeepers	11,997	13,040	161,308	12.37	18
19	Laundry	4,371	4,750	49,698	10.46	19
20	Administrator	2,080	2,080	104,563	50.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,475	22,310	537,183	24.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,843	2,002	28,590	14.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	279,287	303,411	\$ 6,710,308 *	\$ 22.12	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	26,150	9, 3	36
37	Medical Records Consultant	Monthly	3,855	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,005		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	147	\$ 10,275	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	147	\$ 10,275		53

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

** See instructions.

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

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

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2)

Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

ICHA \$5,024

(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 \$12837

(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.

\$ 63,773

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.

\$ 257,148

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.

\$ 513

(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.