

		FOR BHF USE					

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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>0049569</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Manorcare of Rolling Meadows</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>425 Kirchoff Road</u> <u>Rolling Meadows</u> <u>60008</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>847-397-2400</u> Fax # <u>847-397-2414</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Barry A. Lazarus</u></td></tr><tr><td>(Title) <u>Vice President - Reimbursement</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Barry A. Lazarus</u>	(Title) <u>Vice President - Reimbursement</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>											
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	(Type or Print Name) <u>Barry A. Lazarus</u>																								
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	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>07-01-77</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Garv Geise</u> Telephone Number: <u>419-252-5731</u>																									
Email Address: _____																									

Facility Name & ID Number Manorcare of Rolling Meadows# 0049569 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>155</u>	Skilled (SNF)	<u>155</u>	<u>56,730</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	155	TOTALS	155	56,730	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,178</u>	<u>4,571</u>	<u>13,294</u>	<u>39,043</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,178	4,571	13,294	39,043	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 68.82%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/77

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

YES ☒Date 04/07/2011NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 155 and days of care provided 7,255Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐NO ☒Tax Year: 12/31Fiscal Year: 5/31

* 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	347,457	28,719	5,254	381,430		381,430		381,430		1
2	Food Purchase		263,614		263,614		263,614	(1,061)	262,553		2
3	Housekeeping	182,036	21,290	1,933	205,259		205,259		205,259		3
4	Laundry	58,312	19,953	129	78,394		78,394		78,394		4
5	Heat and Other Utilities			235,787	235,787	2,211	237,998		237,998		5
6	Maintenance	56,032	9,275	195,014	260,321		260,321		260,321		6
7	Other (specify):* Medical Waste			929	929		929		929		7
8	TOTAL General Services	643,837	342,851	439,046	1,425,734	2,211	1,427,945	(1,061)	1,426,884		8
	B. Health Care and Programs										
9	Medical Director			45,666	45,666		45,666		45,666		9
10	Nursing and Medical Records	3,074,863	186,890	87,913	3,349,666	13,952	3,363,618		3,363,618		10
10a	Therapy	889,714	4,240	118,964	1,012,918		1,012,918		1,012,918		10a
11	Activities	157,804	2,090	10,076	169,970		169,970	(546)	169,424		11
12	Social Services	145,563		148	145,711		145,711		145,711		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,267,944	193,220	262,767	4,723,931	13,952	4,737,883	(546)	4,737,337		16
	C. General Administration										
17	Administrative	85,909		459,973	545,882	(136,455)	409,427		409,427		17
18	Directors Fees										18
19	Professional Services			14,629	14,629	(2,550)	12,079	(12,079)			19
20	Dues, Fees, Subscriptions & Promotions			67,132	67,132		67,132	(40,333)	26,799		20
21	Clerical & General Office Expenses	402,181	44,248	490,635	937,064	2,550	939,614	(444,069)	495,545		21
22	Employee Benefits & Payroll Taxes			912,014	912,014	29,825	941,839		941,839		22
23	Inservice Training & Education			7,580	7,580		7,580		7,580		23
24	Travel and Seminar			2,474	2,474		2,474		2,474		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			461,208	461,208		461,208		461,208		26
27	Other (specify):*										27
28	TOTAL General Administration	488,090	44,248	2,415,645	2,947,983	(106,630)	2,841,353	(496,481)	2,344,872		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,399,871	580,319	3,117,458	9,097,648	(90,467)	9,007,181	(498,088)	8,509,093		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			379,654	379,654	15,411	395,065		395,065			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			352,603	352,603	75,056	427,659	(352,769)	74,890			32
33	Real Estate Taxes			471,102	471,102		471,102		471,102			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,459	16,459		16,459		16,459			35
36	Other (specify):*											36
37	TOTAL Ownership			1,219,818	1,219,818	90,467	1,310,285	(352,769)	957,516			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		241,847		241,847		241,847		241,847			39
40	Barber and Beauty Shops			13,571	13,571		13,571		13,571			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			309,425	309,425		309,425		309,425			42
43	Other (specify):* IV, X-ray& Lab		51,831	57,974	109,805		109,805		109,805			43
44	TOTAL Special Cost Centers		293,678	380,970	674,648		674,648		674,648			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,399,871	873,997	4,718,246	10,992,114		10,992,114	(850,857)	10,141,257			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	(1,061)	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	(153)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,079)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(396,827)	21		24
25	Fund Raising, Advertising and Promotional	(40,333)	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 page 5A	(400,404)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (850,857)		\$	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))	\$ (850,857)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Manorcare of Rolling Meadows

Report Period Beginning:

Ending:

ID#0049569

06/01/11

05/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (36,300)	21	1
2	P/R O/H Alloc- Mktg	(10,246)	21	2
3	HCP Lease Interest	(352,769)	32	3
4	Vending Income	(543)	21	4
5	Misc Income	0	21	5
6	Activity Income	(546)	11	6
7	Loss on disposal of Fixed Asset	0	36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(400,404)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Rolling Meadows # 0049569 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,061)	0	0	0	0	0	0	0	0	0	0	(1,061)	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	(1,061)	0	0	0	0	0	0	0	0	0	0	(1,061)	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	(546)	0	0	0	0	0	0	0	0	0	0	(546)	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	(546)	0	0	0	0	0	0	0	0	0	0	(546)	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	(12,079)	0	0	0	0	0	0	0	0	0	0	(12,079)	19
20	Fees, Subscriptions & Promotions	(40,333)	0	0	0	0	0	0	0	0	0	0	(40,333)	20
21	Clerical & General Office Expenses	(444,069)	0	0	0	0	0	0	0	0	0	0	(444,069)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(496,481)	0	0	0	0	0	0	0	0	0	0	(496,481)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(498,088)	0	0	0	0	0	0	0	0	0	0	(498,088)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(352,769)	0	0	0	0	0	0	0	0	0	0	(352,769)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(352,769)	0	0	0	0	0	0	0	0	0	0	(352,769)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(850,857)	0	0	0	0	0	0	0	0	0	0	(850,857)	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 Heath Care	Toledo	Nursing Staff
		See Pg 6 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	\$ 459,973	HCR Manor Care Services, LLC	100.00%	\$ 459,973	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	5,399,871	Heartland Employment Services, LLC	100.00%	5,399,871		4
5	V	10a	Therapy Management	17,607	Heartland Rehab Services, LLC	100.00%	17,607		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			\$ 5,877,451			\$ 5,877,451	\$ *	14

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

Facility Name & ID Number

Manorcare of Rolling Meadows

0049569

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 Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights West IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights IL, LLC	Palos Heights				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30								30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

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 (419-252-5000
Fax Number (419-254-5495

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & R	\$ 775,999	\$ 0	10,727,567	\$ 2,211	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	0	0	10,727,567	0	2
3	5	Utilities - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs	0	0	10,727,567	0	3
4	5	Utilities - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs	0	0	10,727,567	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & R	485,056	352,684	10,727,567	1,382	5
6	10	Nursing - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	10,727,567	12,570	6
7	10	Nursing - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs	0	0	10,727,567	0	7
8	10	Nursing - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs	0	0	10,727,567	0	8
9	17	General & Administrative - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & R	71,430,003	38,287,220	10,727,567	203,512	9
10	17	General & Administrative - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	10,727,567	75,950	10
11	17	General & Administrative - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	10,727,567	23,805	11
12	17	General & Administrative - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	10,727,567	20,252	12
13	22	Employee Benefits - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & R	2,952,374	0	10,727,567	8,412	13
14	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909	0	10,727,567	21,413	14
15	22	Employee Benefits - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs	0	0	10,727,567	0	15
16	22	Employee Benefits - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs	0	0	10,727,567	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & R	4,719,938	0	10,727,567	13,448	17
18	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966	0	10,727,567	1,963	18
19	30	Depreciation - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs	0	0	10,727,567	0	19
20	30	Depreciation - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs	0	0	10,727,567	0	20
21										21
22	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		10,727,567	75,056	22
23	32	Directly Assigned Interest	Not Allocated			18,851,990				23
24		H/O Costs allocated to Non-SNFs and Other Divisions				32,615,916				24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 459,973	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	N/A						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Pooled Interest										75,056	7	
8	Interest Income Other										(166)	8	
9	TOTAL Facility Related						\$	\$			\$ 74,890	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 74,890	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.		\$	431,338	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.)		\$	492,021	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	47,483	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	414,041	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.)		\$	9,578	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.		\$	471,102	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	419,183	8	
		2008	429,128	9	
		2009	388,048	10	
		2010	455,127	11	
		2011	468,961	12	
Line 2-2nd 1/2 2010 (\$241700.93) & 1st 1/2 2011 (\$250319.96)					
Line 4-2nd 1/2 2011 (\$218640.69) & 1st 1/2 2012 estimated (\$195400)					
Line 5-\$9578 for 2010 real estate assessment appeals (Worsek & Vihon LLP)					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Rolling Meadows COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049569

CONTACT PERSON REGARDING THIS REPORT Gary Geise

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

A. Summary of Real Estate Tax Cost

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

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>02-26-400-025-0000</u>	<u>See Attached</u>	\$ <u>468,960.65</u>	\$ <u>468,960.65</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>468,960.65</u></u>	\$ <u><u>468,960.65</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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: 38,523 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1977</u>	<u>\$ 155,000</u>	1
2					2
3	TOTALS			<u>\$ 155,000</u>	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	155			1977	\$ 1,350,315	\$ 51,357		\$ 51,357		\$ 1,589,899
5				1990	765,804					
6										
7										
8										
	Improvement Type**									
9	Building Improvements (Current Year Depreciation)					167,215		167,215		2,572,111
10				1987	72,739					
11	RETIREMENTS			1987	(44,531)					
12				1988	33,303					
13				1989	74,517					
14				1990	157,389					
15				1991	127,927					
16				1992	107,998					
17	RETIREMENTS			1992	(36,743)					
18				1993	73,889					
19				1994	71,280					
20				1995	236,489					
21	CR 5/31/99 AUDIT ADJ-CORPORATE O/H			1995	(791)					
22	HVAC/DUCTWORK			1996	3,845					
23	PLUMBING			1996	2,184					
24	CORPORATE OVERHEAD-ARCADIA/DINING			1996	7,272					
25	REMODEL ARCADIA/DINING/BEDROOM			1996	95,560					
26	PROFESSIONAL FEES-ARCADIA/DINING			1996	1,737					
27	CORNER GUARDS			1996	1,340					
28	WOODEN DOORS			1996	11,077					
29	WALLCOVERINGS			1996	5,279					
30	ELECTRICAL/LIGHTING			1996	7,005					
31	CARPETING			1996	3,300					
32	REBUILD GENERATOR			1996	1,927					
33	REPLACE SMOKE DETECTOR			1996	2,156					
34	CR 5/31/99 AUDIT ADJ-CORPORATE O/H			1996	(7,272)					
35										
36										

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

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

See Page 12A, Line 70 for total

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	INSTALL HANDRAILS	1997	\$ 8,660	\$		\$	\$	\$	37
38	WALL GUARDS	1997	2,756						38
39	REPLACE CEILING TILES	1997	12,173						39
40	REMOVE & INSTALL FIRE DOORS	1997	2,012						40
41	INSTALL CLOSET DOORS	1997	10,821						41
42	WALLCOVERINGS	1997	4,812						42
43	DECORATING	1997	10,594						43
44	CARPETING	1997	2,343						44
45	FLOORING	1997	11,254						45
46	REPAIR ELEVATOR	1997	3,430						46
47	ROOFING	1997	1,679						47
48	REMODELING-ARCADIA	1997	8,663						48
49	CONNECT WATER AND GAS LINES	1997	1,705						49
50	CORPORATE OVERHEAD-ARCADIA/DINING	1997	10,515						50
51	FACILITY PLAN ALLOC.-ARCADIA/DINING	1997	5,964						51
52	REPLACE CLOSET DOORS	1997	12,000						52
53	PROFESSIONAL FEES-ARCADIA/DINING	1997	1,396						53
54	CEILING TILES	1997	10,349						54
55	INSTALL CIRCULATING PUMPS	1997	2,250						55
56	BOILER WORK	1997	5,613						56
57	WALLPAPER	1997	482						57
58	STORAGE SHED	1997	789						58
59	REMODELING	1997	(8,489)						59
60	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1997	(10,515)						60
61	C/R 5/31/99 AUDIT ADJ. - FACILITY PLAN ALLOC	1997	(5,964)						61
62	ROOF WORK	1998	53,389						62
63	DOORS/WINDOWS	1998	10,090						63
64	PLUMBING	1998	3,838						64
65	RENOVATE PT & OT ROOMS	1998	4,500						65
66	DOOR & WINDOW CASINGS	1998	4,500						66
67	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,416						67
68	INSTALL STEEL DOORS	1998	4,224						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,315,244	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	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		\$ 3,315,244	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	1
2	ELECTRICAL	1998	754						2
3	PAINTING/WALLCOVERING	1998	36,239						3
4	PLUMBING	1998	13,534						4
5	ELECTRICAL	1998	10,004						5
6	DEVELOPERS-PT & OT ROOMS	1998	11,097						6
7	FLOORING/CEILING	1998	985						7
8	HVAC	1998	37,124						8
9	DOOR/WINDOW	1998	8,160						9
10	SIGN	1998	11,862						10
11	ROOFING	1998	92,520						11
12	MASONARY	1998	1,499						12
13	CARPENTRY	1998	1,475						13
14	FINISH STUDS	1998	26,279						14
15	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,601						15
16	CONCRETE SIDEWALK	1998	1,482						16
17	FLOORING/CEILING	1999	1,340						17
18	CARPENTRY	1999	19,278						18
19	FINISH STUDS	1999	25,000						19
20	PAINTING/WALLCOVERING	1999	750						20
21	WINDOW TREATMENTS	1999	525						21
22	ROOF WORK	1999	6,098						22
23	C/R 5/31/03 AUDIT ADJ #1-ROOF WORK	1999	(6,098)						23
24	ROOFING CONTRACT	1999	876						24
25	C/R 5/31/03 AUDIT ADJ #2-ROOFING CONTRACT	1999	(876)						25
26	DRAIN/FLASH SCUPPERS/OVERFLOW	1999	1,782						26
27	ROOFING CONTRACT	1999	6,098						27
28	C/R 5/31/03 AUDIT ADJ #3-ROOFING CONTRACT	1999	(6,098)						28
29	BUILDING IMPROVEMENTS-NURSES STATIONS	1999	4,554						29
30	BUILDING IMPROVEMENTS-NURSES STATIONS	1999	22,150						30
31	INSTALL CLOSETS	1999	2,895						31
32	25 EXIT SIGNS FOR BU	1999	4,810						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,655,943	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	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		\$ 3,655,943	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	1
2	VINYL WALLCOVERING	1999	336						2
3	WALLCOVERING	1999	226						3
4	RENOVATE NURSING STATIONS	1999	11,478						4
5	WALLCOVERING	1999	2,245						5
6	DAMPER MOTOR	1999	2,693						6
7	CHART RACK	2000	1,450						7
8	ELECTRICAL FOR A/C UNITS	2000	1,214						8
9	WALLCOVERING	2000	294						9
10	ELECTRICAL FOR A/C UNITS	2000	1,151						10
11	WORK STATIONS BOOKKEEPING & PAYROLL	2000	5,975						11
12	WORK STATIONS	2000	728						12
13	EXTERIOR LIGHTING	2000	19,956						13
14	CEILING TILE, PAINTING, CARPET	2000	900						14
15	FENCING	2000	17,820						15
16	FENCING	2000	1,980						16
17	CONCRETE, MASONRY, CARPENTRY	2000	49,335						17
18	CARPET	2000	35,925						18
19	C/R 5/31/03 AUDIT ADJ #4-CARPET	2000	(14,231)						19
20	WALLCOVERING	2000	52,636						20
21	C/R 5/31/03 AUDIT ADJ #5-WALLCOVERING	2000	(466)						21
22	ELECTRICAL	2000	34,947						22
23	C/R 5/31/03 AUDIT ADJ #6-ELECTRICAL	2000	(9,885)						23
24	INTEREST - CONST & GENERAL O/H ARCADIA	2000	74,862						24
25	C/R 5/31/03 AUDIT ADJ #15-CONST & GEN O/H	2000	(74,862)						25
26	ARCADIA RENOVATION	2000	12,075						26
27	C/R 5/31/03 AUDIT ADJ #10-ARCADIA RENOV	2000	(12,075)						27
28	ARCADIA RENO - DRAPES	2001	2,843						28
29	C/R 5/31/03 AUDIT ADJ #11-ARCADIA DRAPES	2001	(184)						29
30	ARCADIA RENO - CARPENTRY	2001	6,748						30
31	C/R 5/31/03 AUDIT ADJ #12-CARPENTRY	2001	(2,200)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,879,857	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	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		\$ 3,879,857	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	1
2	ARCAIDA RENO - CONTRACTOR	2001	50,636						2
3	C/R 5/31/03 AUDIT ADJ #13-CONTRACTOR	2001	(25,985)						3
4	ARCADIA RENO - ELECTRICAL	2001	3,560						4
5	BORDER	2001	170						5
6	KITCHEN WALLS AND FLOOR	2002	2,566						6
7	KITCHEN WALLS AND FLOOR	2002	14,796						7
8	DOORS	2002	6,445						8
9	DOORS	2002	1,868						9
10	DOORS	2002	7,740						10
11	PAINTING	2002	204						11
12	CEILING TILE	2002	517						12
13	DUCT WORK AND DAMPERS	2002	8,301						13
14	DOORS AND DRYWALL	2002	9,694						14
15	GENERAL CONSTRUCTION	2002	4,640						15
16	OVERHEAD AND INTEREST	2002	15,405						16
17	CARPENTRY	2002	85,703						17
18	C/R 5/31/03 AUDIT ADJ #7-CARPENTRY	2002	(650)						18
19	VINYL WALL COVERING	2002	10,495						19
20	C/R 5/31/03 AUDIT ADJ #8-VINYL WALL COVERING	2002	(979)						20
21	HVAC, ELECTRIC	2002	12,530						21
22	C/R 5/31/03 AUDIT ADJ #9-RECLASS HVAC, ELECTRIC	2002	(4,808)						22
23	PARKING LOT UPGRADE	2002	17,482						23
24	PARKING LOT UPGRADE	2003	1,943						24
25	METAL DOOR	2003	1,968						25
26	WALLCOVERINGS	2003	563						26
27	CARPET	2003	335						27
28	FLOORING & CARPENTRY	2003	100,275						28
29	CARPENTRY	2003	27,714						29
30	DOORS AND FRAMES	2003	24,849						30
31	SPRINKLER SYSTEM	2003	9,660						31
32	DOORS	2004	4,464						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,271,957	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	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		\$ 4,271,957	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	1
2	HERITAGE WING ROOF	2004	10,976						2
3	HERITAGE WING	2004	10,976						3
4	VWC	2004	291						4
5	VWC	2004	203						5
6	CARPET	2004	659						6
7	FREIGHT ON CARPET	2004	37						7
8	CARPET & BASE	2004	674						8
9	FREIGHT ON CARPET	2004	109						9
10	CARPET	2004	5,250						10
11	COVE BASE	2004	3,545						11
12	INSTALL CARPET	2004	4,222						12
13	INSTALL CARPET	2004	(4,222)						13
14	VWC	2005	697						14
15	PHONE LINES	2005	1,700						15
16	CABINETS	2005	6,000						16
17	MED ROOM RENOVATION	2005	2,850						17
18	door	2005	1,107						18
19	CEILING TILE	2006	10,305						19
20	vwc	2006	9,776						20
21	Renov - Doors/Frames/Drywall/ Stud/Plumbing	2006	32,276						21
22	Renov - Wall covering	2006	3,128						22
23	Renov - Interest & Gen Overhead	2006	6,615						23
24	2 Elevator door operators	2006	4,400						24
25	flooring and painting in	2006	19,120						25
26	Renov - Basic Electrical	2006	28,016						26
27	Renov - Arch & Engineering	2006	197,182						27
28	Renov - Interest & Gen Overhead	2006	62,439						28
29	ceiling & painting in lau	2006	3,245						29
30	INSTALL GENERATOR- Basic Electrical	2007	24,160						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,717,692	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	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		\$ 4,717,692	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	1
2	1306 TELEPHONE SYSTEM	2007	7,072						2
3	LIGHT FIXTURES IN CORRI	2007	3,260						3
4	electrical for steamers	2007	2,760						4
5	SOFFIT PANELS AROUND BO	2007	5,702						5
6	FLOORING	2007	3,844						6
7	METAL DOORS	2007	6,105						7
8	PRCH PR ADJ 522 023-07C	2007	(33,606)						8
9	PRCH PR ADJ 522 023-07C	2007	(8,326)						9
10	2307 INTERIOR RENOV	2007	8,326						10
11	2307 INTERIOR RENOV	2007	33,606						11
12	sprinkler heads	2008	10,500						12
13	5 door holders	2008	5,793						13
14	000000002491 SEALCOAT PARKING LOT	2008	13,216						14
15	000000002479 AUTO TRANSFER SWITCH	2008	2,295						15
16	000000002478 CEILING TILE	2008	8,554						16
17	000000002477 CO2 SYSTEM	2008	7,476						17
18	000000002483 WIRING FOR LIGHT POLES	2008	18,455						18
19	000000002490 FRENCH DOORS	2008	3,415						19
20	000000002492 2307 INT RENOV - GENL O/H, Heritage Wing	2008	31,554						20
21	000000002492 2307 INT RENOV - INT, Heritage Wing	2008	6,290						21
22	000000002492 2307 INT RENOV - FLOORING, Heritage Wing	2008	63,632						22
23	000000002492 2307 INT RENOV - WALL COVERING, Heritage	2008	8,254						23
24	000000002496 2307 INT RENOV - CARPENTRY & ELECTRICA	2008	57,268						24
25	000000002499 METAL DOORS - Arcadia Entrance	2008	5,427						25
26	000000002505 KITCHEN WASH SINK	2009	19,750						26
27									27
28	000000002534ASPHALT	2009	3,746						28
29	000000002535ENTRANCE CONCRETE PATIO	2009	6,965						29
30	000000002543ADDL COST ENTRANCE CONTRETE PATIO	2009	600						30
31	000000002523STEEL DOOR	2009	1,048						31
32	0000000025261209 NEW SECURITY SYSTEM - HM DOORS & F	2009	18,210						32
33	0000000025491209 NEW SECURITY SYSTEM - FACILITY ALA	2010	26,000						33
34	TOTAL (lines 1 thru 33)		\$ 5,064,882	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	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 12F, Carried Forward		\$ 5,064,882	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	1
2	0000000025511209 NEW SECURITY SYSTEM - UPGRADE ALAR	2010	7,552						2
3	000000002536CARPET & VCT TILE	2009	6,165						3
4	0000000025370409 ELEVATOR UPGRADE - ELEVATORS	2009	74,800						4
5	00000000253911 STEEL DOORS	2009	9,577						5
6	00000000254011 STEEL DOORS	2009	350						6
7	000000002542THERMAL DETECTION FOR FIRE	2009	6,145						7
8	0000000025461409 1ST FLOOR CORRIDOR - CEILING TILE	2009	48,078						8
9	0000000025461409 1ST FLOOR CORRIDOR - RESILIENT FLOOR	2009	61,225						9
10	0000000025461409 1ST FLOOR CORRIDOR - CARPETING	2009	6,607						10
11	0000000025461409 1ST FLOOR CORRIDOR - WALL COVERING	2009	63,459						11
12	0000000025461409 1ST FLOOR CORRIDOR - CORNER GUARDS	2009	3,307						12
13	0000000025471409 1ST FLOOR CORRIDOR - MILLWORK	2009	29,820						13
14	000000002557KITCHEN ELECTRICAL	2010	3,442						14
15									15
16	2558 LIGHT POLE 15 FEET	2010	2,419						16
17	2580 STAIRCASE RAILING	2011	6,800						17
18									18
19	000000002588 Wall covering Dining area	2011	5,787						19
20	000000002591 ARCADIA DOORS	2011	8,775						20
21	000000002602 1011 Paving East Parking Lot	2011	49,191						21
22	000000002603 HOT & COLD PIPING FOR WAS	2011	5,950						22
23	000000002609 PARKING LOT UPGRADE	2011	25,720						23
24	000000002626 DRYWALL IN O2RM, DINING R	2012	4,162						24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,494,213	\$ 218,572		\$ 218,572	\$	\$ 4,162,010	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	\$ 2,169,467	\$ 161,082	\$ 161,082	\$		\$ 1,743,913	71
72	Current Year Purchases	144,250						72
73	Fully Depreciated Assets							73
74	Home Office			15,411	15,411			74
75	TOTALS	\$ 2,313,717	\$ 161,082	\$ 176,493	\$ 15,411		\$ 1,743,913	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)	\$ 7,962,930	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 379,654	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 395,065	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,411	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,905,923	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: \$ 16,459
- Description: 02 Concentrators, wheelchairs, gerichairs, electric beds
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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	3721	hrs	\$ 148,394		\$ 748	3,721	\$ 149,142	1	
2	Licensed Speech and Language Development Therapist	10a	5125	hrs	204,400			5,125	204,400	2	
3	Licensed Recreational Therapist			hrs						3	
4	Licensed Physical Therapist	10a	9244	hrs	368,656	1,448	105,098	3,492	10,692	477,246	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			241,847		241,847		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43, 2					51,831		51,831		12
13	Other (specify): X-ray & Lab	43, 3				57,974			57,974		13
14	TOTAL				\$ 721,450	1,448	\$ 163,072	\$ 297,918	19,538	\$ 1,182,440	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	\$ (43,697)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 668,755)	1,774,532		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,741		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,735,576	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	155,000		13
14	Buildings, at Historical Cost	5,494,213		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,313,716		16
17	Accumulated Depreciation (book methods)	(5,905,923)		17
18	Deferred Charges	174,352		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			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,231,358	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,966,934	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 111,582	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	506,319		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	414,041		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	252,487		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,284,429	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,284,429	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,682,505	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,966,934	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 200,183	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 200,183	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,276,821)	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)	\$ (1,276,821)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	3,759,143	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3,759,143	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,682,505	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,572,239	1
2	Discounts and Allowances for all Levels	(2,318,417)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,253,822	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,109,038	6
7	Oxygen	(191)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,108,847	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	592	12
13	Barber and Beauty Care	14,994	13
14	Non-Patient Meals	1,061	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,068	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,210	19
20	Radiology and X-Ray		20
21	Other Medical Services	47,153	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 352,078	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Activities Income	546	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 546	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,715,293	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,425,734	31
32	Health Care	4,723,931	32
33	General Administration	2,947,983	33
	B. Capital Expense		
34	Ownership	1,219,818	34
	C. Ancillary Expense		
35	Special Cost Centers	365,223	35
36	Provider Participation Fee	309,425	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,992,114	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,276,821)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,276,821)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,674,716	44
45	Private Pay - Net Inpatient Revenue	1,413,974	45
46	Medicare - Net Inpatient Revenue	2,412,880	46
47	Other-(specify) Hospice	391,969	47
48	Other-(specify) Insurance	360,283	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,253,822	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	1,524	1,659	\$ 71,567	\$ 43.14	1
2	Assistant Director of Nursing	5,836	6,355	234,171	36.85	2
3	Registered Nurses	31,712	34,531	1,098,171	31.80	3
4	Licensed Practical Nurses	18,979	20,667	506,083	24.49	4
5	CNAs & Orderlies	79,421	86,686	1,147,153	13.23	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	18,090	19,682	784,961	39.88	7
8	Rehab/Therapy Aides	3,639	3,960	104,753	26.45	8
9	Activity Director	10,850	11,826	157,804	13.34	9
10	Activity Assistants					10
11	Social Service Workers	5,446	5,934	145,563	24.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,209	27,471	347,457	12.65	15
16	Dishwashers					16
17	Maintenance Workers	1,990	2,168	56,032	25.85	17
18	Housekeepers	14,350	15,640	182,036	11.64	18
19	Laundry	6,070	6,616	58,312	8.81	19
20	Administrator	2,080	2,080	85,909	41.30	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,526	15,878	355,635	22.40	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	1,571	1,714	17,718	10.34	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	241,293	262,867	\$ 5,353,325 *	\$ 20.37	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	45,666	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 45,666		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Manorcare of Rolling Meadows

0049569

Report Period Beginning:

06/01/11

Page 21

Ending:

05/31/12

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		
Kathryn Berg		Administrator	0	\$ 85,909	Workers' Compensation Insurance		\$ 97,898	IDPH License Fee		\$ 2,759		
					Unemployment Compensation Insurance		77,935	Advertising: Employee Recruitment		5,611		
					FICA Taxes		384,287	Health Care Worker Background Check		4,855		
					Employee Health Insurance		317,797	(Indicate # of checks performed 100)				
					Employee Meals			Patient Background Checks		56		
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		8,383		
					Tuition Program		(2,067)	Association Dues		18,458		
					Disability Payments			Advertising (Allow)		8,608		
					401K		34,850	Advertising (Non-All)		18,458		
					Appreciation, other benefits, & mkting adj		(1,579)	Less: Non-allow association dues		(13,267)		
					SMSP Company Match		333	Less: Public Relations Expense		(8,608)		
					Employee Uniforms		2,560	Non-allowable advertising		(18,458)		
					Home Office Allocation		29,825	Yellow page advertising		()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 85,909	TOTAL (agree to Schedule V, line 22, col.8)				\$ 941,839	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 26,799
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount		
Home Office Costs			\$ 459,973				\$	Out-of-State Travel		\$		
								In-State Travel		2,474		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 459,973								
C. Professional Services												
Vendor/Payee		Type	Amount									
Foote Meyers Mielke & Flowers LLC		Legal	\$ 8,887									
Porikos Rodes & Glavinskis		Legal	1,169									
United Collection Bureau Inc.		Collections	2,023									
(All above are adjusted off via page 5, Line 22, therefore no invoices are attached)												
Michigan Peer Review Organization		Consulting Fees	2,550									
(Above consultant fees are reclassified to line 21, therefore, no invoices are attached)												
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 14,629	TOTAL				\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,474

* Attach copy of IMRF notifications

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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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 \$5191

(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 \$7470

(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. \$ 61,285 Line 10, 2

(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. \$ 309,425
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. \$ 1,061

(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.