

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0049361</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Manorcare of South Holland</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>2145 East 170th Street</u> <u>South Holland</u> <u>60473</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(708) 895-3255</u> Fax # <u>(708) 895-3315</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>12/1/88</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

Facility Name & ID Number Manorcare of South Holland# 0049361 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 2/29/12

	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>200</u>	Skilled (SNF)	<u>216</u>	<u>75,632</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>200</u>	TOTALS	<u>216</u>	<u>75,632</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,289</u>	<u>4,317</u>	<u>33,679</u>	<u>56,285</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>18,289</u>	<u>4,317</u>	<u>33,679</u>	<u>56,285</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.42%

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 12/1/88

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

YES ☒Date 4/7/11NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 216 and days of care provided 25,775Medicare 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	505,881	40,745	2,953	549,579		549,579		549,579		1
2	Food Purchase		446,198		446,198		446,198	(215)	445,983		2
3	Housekeeping	283,137	38,037	1,290	322,464		322,464		322,464		3
4	Laundry	73,656	30,557	1,585	105,798		105,798		105,798		4
5	Heat and Other Utilities			227,387	227,387	3,984	231,371		231,371		5
6	Maintenance	96,415	19,012	226,354	341,781		341,781		341,781		6
7	Other (specify):* Med Waste			1,468	1,468		1,468		1,468		7
8	TOTAL General Services	959,089	574,549	461,037	1,994,675	3,984	1,998,659	(215)	1,998,444		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	5,295,762	521,362	265,430	6,082,554	25,141	6,107,695		6,107,695		10
10a	Therapy	2,591,375	24,778	78,320	2,694,473		2,694,473		2,694,473		10a
11	Activities	145,635	6,901	4,860	157,396		157,396		157,396		11
12	Social Services	206,466	309		206,775		206,775		206,775		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	8,239,238	553,350	384,610	9,177,198	25,141	9,202,339		9,202,339		16
	C. General Administration										
17	Administrative	198,894		922,007	1,120,901	(339,008)	781,893		781,893		17
18	Directors Fees										18
19	Professional Services			44,937	44,937		44,937	(44,937)			19
20	Dues, Fees, Subscriptions & Promotions			93,198	93,198		93,198	(39,337)	53,861		20
21	Clerical & General Office Expenses	656,010	116,369	582,827	1,355,206		1,355,206	(511,743)	843,463		21
22	Employee Benefits & Payroll Taxes			1,519,284	1,519,284	53,745	1,573,029		1,573,029		22
23	Inservice Training & Education			1,066	1,066		1,066		1,066		23
24	Travel and Seminar			7,718	7,718		7,718		7,718		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			628,973	628,973		628,973		628,973		26
27	Other (specify):*							(25)	(25)		27
28	TOTAL General Administration	854,904	116,369	3,800,010	4,771,283	(285,263)	4,486,020	(596,042)	3,889,978		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,053,231	1,244,268	4,645,657	15,943,156	(256,138)	15,687,018	(596,257)	15,090,761		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			630,335	630,335	27,770	658,105		658,105			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,214,771	3,214,771	228,368	3,443,139	(3,217,461)	225,678			32
33	Real Estate Taxes			1,018,484	1,018,484		1,018,484		1,018,484			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			34,241	34,241		34,241		34,241			35
36	Other (specify):*											36
37	TOTAL Ownership			4,897,831	4,897,831	256,138	5,153,969	(3,217,461)	1,936,508			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		769,992	2,010	772,002		772,002		772,002			39
40	Barber and Beauty Shops			5,594	5,594		5,594		5,594			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			328,126	328,126		328,126		328,126			42
43	Other (specify):* IV Ther/EKG/Xray/Lab		148,013	183,735	331,748		331,748		331,748			43
44	TOTAL Special Cost Centers		918,005	519,465	1,437,470		1,437,470		1,437,470			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,053,231	2,162,273	10,062,953	22,278,457		22,278,457	(3,813,718)	18,464,739			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	(215)	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	(169)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(25)	27		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	(44,937)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(457,974)	21		24
25	Fund Raising, Advertising and Promotional	(39,337)	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	(3,271,061)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,813,718)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,813,718)		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 South Holland

Report Period Beginning:

Ending:

ID#004936106/01/1105/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (41,152)	21	1
2	P/R O/H Alloc - Mktg	(10,285)	21	2
3	HCP Lease Interest	(3,217,461)	32	3
4	Vending Income	(2,163)	21	4
5	Misc. Income		21	5
6	Activity Income		11	6
7	Loss on disposal of Fixed Asset		36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(3,271,061)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of South Holland # 0049361 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	(215)	0	0	0	0	0	0	0	0	0	0	(215)	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	(215)	0	0	0	0	0	0	0	0	0	0	(215)	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	(44,937)	0	0	0	0	0	0	0	0	0	0	(44,937)	19
20	Fees, Subscriptions & Promotions	(39,337)	0	0	0	0	0	0	0	0	0	0	(39,337)	20
21	Clerical & General Office Expenses	(511,743)	0	0	0	0	0	0	0	0	0	0	(511,743)	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):*	(25)	0	0	0	0	0	0	0	0	0	0	(25)	27
28	TOTAL General Administration	(596,042)	0	0	0	0	0	0	0	0	0	0	(596,042)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(596,257)	0	0	0	0	0	0	0	0	0	0	(596,257)	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	\$ 922,005	HCR Manor Care Services, LLC	100.00%	\$ 922,005	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	10,053,231	Heartland Employment Services, LLC	100.00%	10,053,231		4
5	V	10a	Therapy Management	22,723	Heartland Rehabilitation Services, LLC	100.00%	22,723		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 10,997,959			\$ 10,997,959	\$ *	14

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

Facility Name & ID Number

Manorcare of South Holland

0049361

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 (East) IL, LLC	Palos Heights				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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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 South Holland# 0049361

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,R	\$ 775,999	\$	19,331,596	\$ 3,984	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs			19,331,596	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			19,331,596	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			19,331,596	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	485,056	352,684	19,331,596	2,490	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	19,331,596	22,651	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			19,331,596	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			19,331,596	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	71,430,003	38,287,220	19,331,596	366,739	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	19,331,596	136,866	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	19,331,596	42,898	11
12	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	19,331,596	36,494	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	2,952,374		19,331,596	15,158	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		19,331,596	38,587	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			19,331,596	0	15
16	22	Empl Bnfts - Direct to MW Div S	Accumulated Cost	474,102,184	48 NFs			19,331,596	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehal	4,719,938		19,331,596	24,233	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		19,331,596	3,537	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			19,331,596	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			19,331,596	0	20
21										21
22	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		19,331,596	135,254	22
23	32	Directly Assigned Interest	Not Allocated			18,851,990			93,114	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				32,615,916				24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 922,005	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			\$ 1,399,326	\$ 1,399,326		0.0665	\$ 93,114	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Pooled Interest Expense										135,254	7	
8	Interest Income / Interest Expense										(2,690)	8	
9	TOTAL Facility Related						\$ 1,399,326	\$ 1,399,326			\$ 225,678	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,399,326	\$ 1,399,326			\$ 225,678	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.		\$	732,834		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.)		\$	859,165		2
3. Under or (over) accrual (line 2 minus line 1).		\$	126,331		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	892,153		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.		\$	1,018,484		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	650,575	8	
		2008	700,079	9	
		2009	815,634	10	
		2010	833,565	11	
		2011	953,375	12	
Line 2: \$859,164.79 = \$385,516.11 for 2nd half of 2010 + \$458,460.68 for 1st half of 2011 + \$15,188 to adjust expense					
Line 4: \$892,153.20 = \$494,914.03 for 2nd half 2011 + \$397,239.17 for Jan - May 2012					
		FOR BHF USE ONLY			
13		FROM R. E. TAX STATEMENT FOR 2011 \$			13
14		PLUS APPEAL COST FROM LINE 5 \$			14
15		LESS REFUND FROM LINE 6 \$			15
16		AMOUNT TO USE FOR RATE CALCULATION \$			16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Manorcare of South Holland

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0049361

CONTACT PERSON REGARDING THIS REPORT

Gary Geise

TELEPHONE

(419) 252-5731

FAX #:

(419) 254-5495

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 29-25-200-006-0000	See Attached	\$ 953,374.71	\$ 953,374.71
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 953,374.71	\$ 953,374.71

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:	65,200	B. General Construction Type:	Exterior	Masonry	Frame	Steel	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	----------------	--------------	--------------	--------------------------	----------

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

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

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

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

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

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

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1988	\$ 929,902	1
2					2
3	TOTALS			\$ 929,902	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120			1988	\$ 3,317,990	\$ 184,882		\$ 184,882	\$	\$ 3,513,192	4
5	60			1991	1,912,803						5
6	10			1997	1,054,638						6
7	10			2006	1,222,040						7
8	16			2011	1,412,881						8
	Improvement Type**										
9	Current Year Depreciation					166,418		166,418		2,861,299	9
10				1988	112,623						10
11				1989	36,052						11
12				1990	6,131						12
13				1991	255,298						13
14				1992	192,798						14
15				1993	108,676						15
16				1994	85,519						16
17				1995	50,587						17
18				1996	231,349						18
19				1997	120,584						19
20				1998	237,026						20
21				1999	8,872						21
22				2000	53,921						22
23				2001	103,358						23
24	Birch Doors & Shower Floors			2002	4,644						24
25	Eletrical Work			2002	5,390						25
26	Paint, Wallcovering & Borders			2002	3,884						26
27	General Construction			2002	11,200						27
28	Floor Tile for Break Room			2002	2,794						28
29	Roofing			2003	12,928						29
30	Carpet			2003	382						30
31	Carpet/Flooring & Base			2003	18,216						31
32	Wallcovering & Border			2003	13,718						32
33	Renovation to Vending Machine Room			2003	5,794						33
34	Roofing			2003	1,010						34
35	Concrete			2003	2,050						35
36				2003	3,033						36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Construction Dept. Cost & Interest	2003	\$ 5,152	\$		\$	\$		37
38	Additional Electrical Outlets	2003	2,331						38
39	Fire Door	2004	1,463						39
40	Construction Dept. Cost & Interest	2004	985						40
41	Wallcovering & Border	2004	3,297						41
42	Doors	2004	2,284						42
43	Flooring	2004	3,807						43
44	LANDSCAPING	2004	5,300						44
45	PARKING LOT LIGHTS	2004	17,922						45
46	WALLCOVERING & BORDERS	2004	3,913						46
47	CARPET	2004	4,996						47
48	TOLI OAK FLOORING	2004	11,840						48
49	DOORS	2004	1,042						49
50	DRYWALL OVER DOORWAY & INSTALL CABINETS	2004	10,724						50
51	DOOR HARDWARE	2004	8,926						51
52	FLOORING & COVE BASE	2004	10,254						52
53	ENRTY DOORS, RAMP, & EXTEND WALL 25 FEET	2005	31,817						53
54	REGISTERS FOR BUILDING	2005	3,892						54
55	DUCT WORK FOR A/C	2005	2,080						55
56	FABRIC	2005	602						56
57	DOOR	2005	1,790						57
58	4 DOORS & LOCK SETS	2006	3,500						58
59	DOORS & LOCK SETS	2006	3,718						59
60	renov - flooring/carpeting/wallcovering	2006	41,695						60
61	renov - carpentry-subcontr	2006	14,549						61
62	renov - HM doors & frames	2006	2,456						62
63	door alarms	2006	8,525						63
64	VCT	2006	4,050						64
65	condensing unit	2006	4,175						65
66	carpet	2006	10,901						66
67	hollow door	2006	2,288						67
68	shower door	2006	724						68
69	exhaust system	2006	4,400						69
70	TOTAL (lines 4 thru 69)		\$ 10,843,587	\$ 351,300		\$ 351,300	\$	\$ 6,374,491	70

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

Facility Name & ID Number Manorcare of South Holland

0049361

Report Period Beginning:

06/01/11

Ending:

05/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,843,587	\$ 351,300		\$ 351,300	\$	\$ 6,374,491	1
2	door	2006	2,288						2
3	addition - architecture/engineering costs/permit fees	2006	404,618						3
4	addition - carpet / wallcovering	2006	33,532						4
5	addition - millwork & sprinklers	2006	36,507						5
6	ac unit	2006	5,100						6
7	1 birch door for therapy	2006	1,288						7
8	addition - general contr - site prep	2006	147,406						8
9	addition - engineering inspection	2006	4,041						9
10	paving	2006	2,650						10
11	electrical	2008	10,940						11
12	corridor electrical	2008	15,823						12
13	replacement roof	2008	163,410						13
14	wallcovering	2008	50,522						14
15	fence	2007	26,375						15
16	concrete patio & sidewalk	2007	16,296						16
17	wallcovering	2008	5,875						17
18	air handlers	2008	15,240						18
19	electronic ballast	2009	3,430						19
20	Renov - Gen overhead capital	2009	1,848						20
21	Renov - Interest on Construction	2009	94						21
22	Renov - Carpeting & pads	2009	11,240						22
23	Renov - wallcovering	2009	8,637						23
24	Renov - Gen overhead capital	2008	3,032						24
25	Renov - Paving of parking lot	2008	50,435						25
26	Renov - Interest on Construction	2008	551						26
27	Renov -Resilient Flooring	2009	12,131						27
28	Renov - Painting	2009	24,262						28
29	Renov - wallcovering	2009	968						29
30	exit steel door	2009	3,788						30
31	hand & crash rail	2009	17,378						31
32	dining room floor upgrade	2009	10,677						32
33	painting	2009	4,044						33
34	TOTAL (lines 1 thru 33)		\$ 11,938,012	\$ 351,300		\$ 351,300	\$	\$ 6,374,491	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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,938,012	\$ 351,300		\$ 351,300	\$	\$ 6,374,491	1
2	shower floor tile	2009	750						2
3	shower floor tile	2009	8,273						3
4	Dining room floor upgrade additional	2009	12,032						4
5	Carpeting	2010	4,485						5
6	Frt Carpeting	2010	731						6
7	Rear, Kitchen & Exterior HM Door	2010	8,205						7
8	Carpet Installation	2010	5,403						8
9	Additional HM Doors	2010	8,205						9
10	Hour rated door	2010	2,281						10
11	HM Doors	2010	11,450						11
12	2 smoke walls and fire damper	2011	23,640						12
13	rooftop heat exchanger	2011	4,695						13
14	2 light posts	2010	9,138						14
15	6 bollard lights in court	2010	9,058						15
16	2 halide light fixtures	2010	2,334						16
17	additional cost 2 light fixtures	2010	307						17
18	3610 Renov - General overhead capital	2011	5,776						18
19	3610 Renov - interest on constr	2011	366						19
20	3610 Renov - doors & frames	2011	78,650						20
21	Additional cost 2 smoke walls	2011	6,401						21
22	VINYL FLOORING, VWC (WOMANS BT	2011	3,924						22
23	PAINT EXTERIOR KITHEN DOORS	2011	1,467						23
24	PAINT EXTERIOR ADJUST ASSET #2	2011	4,559						24
25	EAST DRIVEWAY UPGRADE	2011	38,370						25
26	RECAULK 136 WINDOWS	2011	8,595						26
27	2 DOORS WALK IN COOLER	2011	9,250						27
28	Caulking	2011	8,595						28
29	2 water drains (front lot)	2011	3,675						29
30	CABINET SINK & COUNTERTOP	2012	3,523						30
31	4 HM DOORS	2012	5,130						31
32	FLAT ROOF OVER KITCHEN	2012	48,452						32
33	3 dry sprinkler plans	2012	14,000						33
34	TOTAL (lines 1 thru 33)		\$ 12,289,730	\$ 351,300		\$ 351,300	\$	\$ 6,374,491	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		\$ 12,289,730	\$ 351,300		\$ 351,300	\$	\$ 6,374,491	1
2	CARPETING AND PADS	2012	14,474						2
3	WALLCOVERING	2012	32,738						3
4	CORNER GUARDS	2012	4,898						4
5	FENCING/GAZEBO IN COURTYARD	2012	2,200						5
6	MILLWORK	2012	10,234						6
7	DOORS AND WINDOWS	2012	9,400						7
8	FLOORING	2012	6,002						8
9	PAINTING	2012	6,180						9
10	HVAC	2012	5,544						10
11	NURSE CALL SYSTEM	2012	7,282						11
12	FIRE PROTECTION	2012	25,920						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)		\$ 12,414,601	\$ 351,300		\$ 351,300	\$	\$ 6,374,491	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$3,338,691	\$279,035	\$279,035	\$		\$2,881,309	71
72	Current Year Purchases	566,228						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			27,770	27,770			74
75	TOTALS	\$3,904,919	\$279,035	\$306,805	\$27,770		\$2,881,309	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	Residents	1995 Goshen GHS		\$17,000	\$	\$	\$		\$17,000	76
77		Paratransit								77
78										78
79										79
80	TOTALS			\$17,000	\$	\$	\$		\$17,000	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)	\$17,266,422	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$630,335	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$658,105	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$27,770	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$9,272,800	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$29,179	92
93			93
94			94
95		\$29,179	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: \$ 34,241
- Description: 02 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	11171	hrs	\$ 470,834		\$ 1,932	11,171	\$ 472,766	1	
2	Licensed Speech and Language Development Therapist	10a	7323	hrs	308,647	(9)	(500)	1,927	7,314	310,074	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	14308	hrs	603,073	1,025	57,816	20,919	15,333	681,808	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			769,992		769,992		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Inhal Ther</u>	10a	1767		74,473			1,767	74,473		12
13	Other (specify): <u>IV Ther/EKG/Xray/La</u>	43, 2&3				183,735	148,013		331,748		13
14	TOTAL				\$ 1,457,027	1,016	\$ 241,051	\$ 942,783	35,585	\$ 2,640,861	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	\$ (264,109)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,061,169))	3,751,220		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,118		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,493,229	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	929,902		13
14	Buildings, at Historical Cost	14,193,085		14
15	Leasehold Improvements, at Historical Cost	(170,268)		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(7,223,966)		17
18	Deferred Charges	16,620,230		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	29,179		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 24,378,162	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 27,871,391	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 254,117	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	868,607		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	892,153		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	182,245		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,197,122	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,399,326		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)	\$ 1,399,326	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,596,448	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 24,274,943	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 27,871,391	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (20,534,694)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (20,534,694)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(253,040)	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)	\$ (253,040)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	45,062,677	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 45,062,677	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 24,274,943	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of South Holland# 0049361Report Period Beginning: 06/01/11Ending: 05/31/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1	2	
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 22,562,698	1	
2 Discounts and Allowances for all Levels	(8,015,713)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,546,985	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	6,412,712	6	
7 Oxygen		7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,412,712	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	2,188	12	
13 Barber and Beauty Care	6,444	13	
14 Non-Patient Meals	215	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs	830,257	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory	75,941	19	
20 Radiology and X-Ray	46,675	20	
21 Other Medical Services	104,000	21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,065,720	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***		25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28		28	
28a		28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 22,025,417	30	

	1	2	
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	1,994,675	31	
32 Health Care	9,177,198	32	
33 General Administration	4,771,283	33	
B. Capital Expense			
34 Ownership	4,897,831	34	
C. Ancillary Expense			
35 Special Cost Centers	1,109,344	35	
36 Provider Participation Fee	328,126	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,278,457	40	
41 Income before Income Taxes (line 30 minus line 40)**	(253,040)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (253,040)	43	

	1	2	
III. Net Inpatient Revenue detailed by Payer Source	Amount		
44 Medicaid - Net Inpatient Revenue	\$ 2,206,860	44	
45 Private Pay - Net Inpatient Revenue	1,067,070	45	
46 Medicare - Net Inpatient Revenue	9,262,343	46	
47 Other-(specify) <u>HOSP</u>	384,871	47	
48 Other-(specify) <u>INSURANCE</u>	1,625,841	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,546,985	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	1,972	2,136	\$ 104,171	\$ 48.77	1
2	Assistant Director of Nursing	5,075	5,497	192,188	34.96	2
3	Registered Nurses	68,726	74,441	2,526,762	33.94	3
4	Licensed Practical Nurses	30,397	32,925	861,075	26.15	4
5	CNAs & Orderlies	132,941	144,196	1,580,568	10.96	5
6	CNA Trainees					6
7	Licensed Therapist	34,569	37,441	1,578,104	42.15	7
8	Rehab/Therapy Aides	33,131	35,884	1,013,271	28.24	8
9	Activity Director	9,005	9,755	145,635	14.93	9
10	Activity Assistants					10
11	Social Service Workers	7,602	8,241	206,466	25.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,813	35,557	505,881	14.23	15
16	Dishwashers					16
17	Maintenance Workers	4,239	4,592	96,415	21.00	17
18	Housekeepers	23,722	25,713	283,137	11.01	18
19	Laundry	7,269	7,877	73,656	9.35	19
20	Administrator	2,080	2,080	134,076	64.46	20
21	Assistant Administrator	1,878	1,878	64,818	34.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,861	30,542	604,573	19.79	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	1,937	2,099	30,998	14.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	425,217	460,854	\$ 10,001,794 *	\$ 21.70	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	36,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,955	\$ 127,321	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,955	\$ 127,321		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Lenette Clark	Administrator	0	\$ 34,114
Leslie Slosser	Administrator	0	99,962
Kerry Donegan	Asst. Admin	0	1,780
Christopher Raciti	Asst. Admin	0	24,395
Patricia Stoudt	Asst. Admin	0	20,696
Susan Jones	Asst. Admin	0	17,947
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 198,894
B. Administrative - Other			
Description			Amount
Various Home Office Services		\$	922,007
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 922,007
C. Professional Services			
Vendor/Payee	Type		Amount
Foote Meyers Mielke & Flowers LLC		\$	
	Legal Fees		32,318
United Collecttion Bureau	Fees for Collections		12,619
Legal and collection fees were adjusted off on Schedule VI, Page 5, Line 22. 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.)			\$ 44,937
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	170,691
Unemployment Compensation Insurance			145,258
FICA Taxes			721,012
Employee Health Insurance			419,439
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Appreciation			1,606
401K			41,471
Oth Empl Benefits, Mktg Adj, & LT Incent			7,432
Tuition Program			2,828
SMSP Match			3,387
Employee Uniforms			6,160
Home Office Allocation			53,745
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,573,029
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	5,439
Advertising: Employee Recruitment			15,108
Health Care Worker Background Check (Indicate # of checks performed 850)			14,609
Patient Background Checks	540		5,400
Dues & Subscriptions			6,607
Association Dues			22,944
Advertising			23,091
Public Relations			
Less: Non-Allowable Association Dues			(16,246)
Less: Public Relations Expense		(	0
Non-allowable advertising			(23,091)
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 53,861
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			7,718
Includes travel expense to the Home Office in Toledo, OH for regional meetings			
Seminar Expense			
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	7,718

*** Attach copy of IMRF notifications**

****See instructions.**

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

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICHA \$6,698

(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 \$16246

(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. \$ 106,736 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. \$ 328,126
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. \$ 0

(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.