

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0049445</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Manorcare of Hinsdale</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/15</u> to <u>05/31/16</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>600 West Ogden Ave</u> <u>Hinsdale</u> <u>60521</u>																									
Number City Zip Code																									
County: <u>DuPage</u>																									
Telephone Number: <u>(630) 325-9630</u> Fax # <u>(630) 325-9648</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Martin D. Allen</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Director</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td colspan="2"></td><td>(Telephone) <u>()</u></td><td>Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Martin D. Allen</u>		Paid Preparer	(Title) <u>Director</u>		(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____				(Telephone) <u>()</u>	Fax # <u>()</u>				
Officer or Administrator of Provider	(Signed) _____				(Date) _____																				
	(Type or Print Name) <u>Martin D. Allen</u>																								
Paid Preparer	(Title) <u>Director</u>																								
	(Signed) _____			(Date) _____																					
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
		(Telephone) <u>()</u>	Fax # <u>()</u>																						
Date of Initial License for Current Owners: <u>11/01/81</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 _____	
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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>Jeff Lewandowski</u> Telephone Number: <u>(419) 252-5736</u>																									
Email Address: _____																									

Facility Name & ID Number Manorcare of Hinsdale

0049445 Report Period Beginning: 06/01/15 Ending: 05/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>202</u>	Skilled (SNF)	<u>202</u>	<u>73,932</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>202</u>	TOTALS	<u>202</u>	<u>73,932</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,952</u>	<u>6,778</u>	<u>37,720</u>	<u>56,450</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>11,952</u>	<u>6,778</u>	<u>37,720</u>	<u>56,450</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.35%

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? Yes

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/07/11 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 202 and days of care provided 27,392

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☒

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name & ID Number Manorcare of Hinsdale # 0049445 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	597,014	42,875	954	640,843		640,843		640,843			1
2	Food Purchase		411,711		411,711		411,711	(1,247)	410,464			2
3	Housekeeping	258,413	34,044	4,322	296,779		296,779		296,779			3
4	Laundry	83,913	29,836		113,749		113,749		113,749			4
5	Heat and Other Utilities			312,768	312,768	5,830	318,598		318,598			5
6	Maintenance	47,855	41,504	161,470	250,829		250,829		250,829			6
7	Other (specify):* Med Waste			1,305	1,305		1,305		1,305			7
8	TOTAL General Services	987,195	559,970	480,819	2,027,984	5,830	2,033,814	(1,247)	2,032,567			8
	B. Health Care and Programs											
9	Medical Director			45,177	45,177		45,177		45,177			9
10	Nursing and Medical Records	5,906,813	491,086	166,447	6,564,346	22,209	6,586,555		6,586,555			10
10a	Therapy	3,599,329	13,611	40,695	3,653,635		3,653,635		3,653,635			10a
11	Activities	145,661	4,889	7,377	157,927		157,927	(500)	157,427			11
12	Social Services	382,257	238		382,495		382,495		382,495			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	10,034,060	509,824	259,696	10,803,580	22,209	10,825,789	(500)	10,825,289			16
	C. General Administration											
17	Administrative	191,380		1,308,886	1,500,266	(664,109)	836,157		836,157			17
18	Directors Fees											18
19	Professional Services			93,914	93,914	(6,597)	87,317	(87,317)				19
20	Dues, Fees, Subscriptions & Promotions			108,561	108,561		108,561	(35,971)	72,590			20
21	Clerical & General Office Expenses	555,198	107,014	1,136,227	1,798,439		1,798,439	(981,875)	816,564			21
22	Employee Benefits & Payroll Taxes			1,696,248	1,696,248	87,719	1,783,967		1,783,967			22
23	Inservice Training & Education			2,773	2,773		2,773		2,773			23
24	Travel and Seminar			16,656	16,656		16,656		16,656			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,285,548	1,285,548		1,285,548		1,285,548			26
27	Other (specify):*							(4,180)	(4,180)			27
28	TOTAL General Administration	746,578	107,014	5,648,813	6,502,405	(582,987)	5,919,418	(1,109,343)	4,810,075			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,767,833	1,176,808	6,389,328	19,333,969	(554,948)	18,779,021	(1,111,090)	17,667,931			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			674,461	674,461	29,868	704,329	(103,141)	601,188			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,039,802	6,039,802	521,123	6,560,925	(6,043,614)	517,311			32
33	Real Estate Taxes			165,610	165,610		165,610		165,610			33
34	Rent-Facility & Grounds			45,216	45,216		45,216		45,216			34
35	Rent-Equipment & Vehicles			48,613	48,613		48,613		48,613			35
36	Other (specify):*											36
37	TOTAL Ownership			6,973,702	6,973,702	550,991	7,524,693	(6,146,755)	1,377,938			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,310,646	1,200	1,311,846	3,957	1,315,803		1,315,803			39
40	Barber and Beauty Shops		342	37,375	37,717		37,717		37,717			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			274,248	274,248		274,248		274,248			42
43	Other (specify):* IV X-Ray & Lab		163,619	242,196	405,815		405,815		405,815			43
44	TOTAL Special Cost Centers		1,474,607	555,019	2,029,626	3,957	2,033,583		2,033,583			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,767,833	2,651,415	13,918,049	28,337,297		28,337,297	(7,257,845)	21,079,452			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,247)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(103,141)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(387)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(245)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,180)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(5,253)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(40,630)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(958,116)	21		24
25	Fund Raising, Advertising and Promotional	(35,971)	20		25
26	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 5A	(6,108,675)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,257,845)		\$	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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (7,257,845)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ (500)	11	1
2	Misc. Income	(17,318)	21	2
3	Vending Income		21	3
4	Donations Revenue	(556)	21	4
5	Accounting/Collection Fees	(46,687)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(6,043,614)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,108,675)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Hinsdale # 0049445 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	(1,247)	0	0	0	0	0	0	0	0	0	0	(1,247)	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	(1,247)	0	0	0	0	0	0	0	0	0	0	(1,247)	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	(500)	0	0	0	0	0	0	0	0	0	0	(500)	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	(500)	0	0	0	0	0	0	0	0	0	0	(500)	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	(87,317)	0	0	0	0	0	0	0	0	0	0	(87,317)	19
20	Fees, Subscriptions & Promotions	(35,971)	0	0	0	0	0	0	0	0	0	0	(35,971)	20
21	Clerical & General Office Expenses	(981,875)	0	0	0	0	0	0	0	0	0	0	(981,875)	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):*	(4,180)	0	0	0	0	0	0	0	0	0	0	(4,180)	27
28	TOTAL General Administration	(1,109,343)	0	0	0	0	0	0	0	0	0	0	(1,109,343)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(1,111,090)	0	0	0	0	0	0	0	0	0	0	(1,111,090)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Hinsdale # 0049445 Report Period Beginning: 06/01/15 Ending: 05/31/16

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(103,141)	0	0	0	0	0	0	0	0	0	0	(103,141)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,043,614)	0	0	0	0	0	0	0	0	0	0	(6,043,614)	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	(6,146,755)	0	0	0	0	0	0	0	0	0	0	(6,146,755)	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)	(7,257,845)	0	0	0	0	0	0	0	0	0	0	(7,257,845)	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 Svcs	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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 1,308,886	HCR Manor Care Services, LLC	100.00%	\$ 1,308,886	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	11,767,833	Heartland Employment Services, LLC	100.00%	11,767,833		4
5	V	10a	Therapy Management	23,432	Heartland Rehabilitation Services, LLC	100.00%	23,432		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 13,100,151			\$ 13,100,151	\$ *	14

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

Facility Name & ID Number

Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/15

Ending:

05/31/16

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								15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/15Ending: 05/31/16

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	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	3,924,650,842	559 NFs, HHs, & Re	\$ 818,127	\$	27,968,970	\$ 5,830	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs			27,968,970	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			27,968,970	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	314,713	212,796	27,968,970	2,242	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	2,144,378	1,338,476	27,968,970	17,327	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			27,968,970	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	60,268,030	28,103,285	27,968,970	429,499	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	14,494,897	5,630,812	27,968,970	117,119	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs	3,257,281		27,968,970	98,159	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	5,205,729		27,968,970	37,099	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	6,264,775		27,968,970	50,620	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs			27,968,970	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	3,394,861		27,968,970	24,193	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	702,366		27,968,970	5,675	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			27,968,970	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,924,650,842		28,376,750		27,968,970	202,227	22
23	32	Directly Assigned Interest	Not Allocated			18,868,647			318,896	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				33,166,797				24
25	TOTALS					\$ 177,277,351	\$ 35,285,370		\$ 1,308,886	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Conv. Sub. Debentures		X	Various			\$ 4,419,968	\$ 4,223,189		0.0755	\$ 318,896	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Pooled Interest										202,227	7	
8	Interest Expense / Interest Income										(3,812)	8	
9	TOTAL Facility Related						\$ 4,419,968	\$ 4,223,189			\$ 517,311	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,419,968	\$ 4,223,189			\$ 517,311	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.)

B. Real Estate Taxes

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.

FACILITY NAME Manorcare of Hinsdale COUNTY DuPage
FACILITY IDPH LICENSE NUMBER 0049445
CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski
TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

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.

A. Square Feet: 78,479

B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

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	Facility		1981	\$ 1,358,110	1
2					2
3	TOTALS			\$ 1,358,110	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	102		1972		\$ 1,160,300	\$ 95,391		\$ 95,391	\$	\$ 3,050,877	4
5	100			1980	1,913,000						5
6	Therapy addition			2006	400,868						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					276,207		276,207		5,632,444	9
10				1984	4,367						10
11				1985	6,383						11
12				1987	14,207						12
13				1988	22,849						13
14				1989	173,344						14
15				1990	114,281						15
16				1991	240,682						16
17				1992	111,750						17
18				1993	421,420						18
19				1994	145,930						19
20				1995	182,224						20
21				1996	326,618						21
22				1997	407,293						22
23				1998	392,286						23
24				1999	128,464						24
25				1999	(11,509)						25
26				2000	138,632						26
27				2001	142,009						27
28				2002	339,762						28
29	STEEL/METAL DOORS			2003	4,336						29
30	ROOF REPAIR			2003	1,084						30
31	ARCH AND ENGINEERING COSTS			2004	553						31
32	ELECTRICAL			2004	3,776						32
33	Arch and Engineering Costs			2004	42,165						33
34	General Construction Overhead Cost & Interest			2004	55,967						34
35	Flooring			2004	9,800						35
36	Carpeting			2004	11,210						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Painting	2004	\$ 63,111	\$		\$	\$	\$	37
38	Wallcovering & Corner Guards	2004	5,782						38
39	Carpentry	2004	27,527						39
40	Electrical	2004	24,620						40
41	Roofing & Doors	2004	1,685						41
42	Fire Wall	2004	4,625						42
43	VWC & Paint	2004	2,092						43
44	Exterior Painting	2004	7,405						44
45	Flooring	2004	12,981						45
46	Air Separator	2004	9,942						46
47	Flooring	2005	113,382						47
48	Doors	2005	4,865						48
49	VWC	2005	1,474						49
50	Flooring	2005	9,070						50
51	Shower Door	2005	6,140						51
52	Painting, Wallcovering, & Base	2005	3,531						52
53	Install fire server cabinet & shelves	2005	3,700						53
54	Fire Alarm Panels	2005	10,265						54
55	Masonry Work	2005	3,875						55
56	Smoke Detectors	2005	1,160						56
57	Electrical Circuit for Smoke Detecor	2005	801						57
58	Wallcovering	2005	5,240						58
59	Electrical Work in 28 patient rooms	2005	2,284						59
60	Wallcovering	2005	1,233						60
61	Smoke Detectors	2005	2,685						61
62	Remodel Janitor Closet & Greenhouse	2005	4,800						62
63	Remodel Janitor Closet & Greenhouse	2006	4,799						63
64	Electrical Work for Elevator - Hookup shunt switch	2006	503						64
65	Phone Wiring	2006	7,231						65
66	Exhaust Fan	2006	2,272						66
67	Phone Wiring Additional Work	2006	1,605						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,254,736	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	70

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,254,736	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	1
2	Corner guards	2006	353						2
3	Engineering for conceptual site plan - parking lot, lighting, lanscap	2006	6,767						3
4	Drywall & Paint to rebuild plumbing walls in 6 resident rooms	2006	8,023						4
5	Plumbing - Replace 4 wall hydrants	2006	3,224						5
6	Overhead & Interest on HVAC Project	2006	1,344						6
7	HVAC - 35 ton roof unit & related electrical work	2006	61,639						7
8	Overhead & Interest on addition/renovation project	2006	157,013						8
9	Addition/Renov. - Architect & Engineering	2006	71,504						9
10	Addition/Renov. - Permit fees, plan reveiws, consultant misc.	2006	16,591						10
11	Addition/Renov. - Drywall canopies on 41 light fictures	2006	1,017						11
12	Addition/Renov. - Ceil Tile & Paint Grid	2006	4,365						12
13	Addition/Renov. - Flooring	2006	5,147						13
14	Addition/Renov. - Wall Covering & Corner Guards	2006	17,428						14
15	Addition/Renov. - Fire Sprinkler System	2006	84,188						15
16	Addition/Renov. - Plumbing	2006	4,895						16
17	Addition/Renov. - HVAC	2006	2,594						17
18	Addition/Renov. - Electrical	2006	11,569						18
19	Addition/Renov. - Site Preparation	2006	39,350						19
20	Addition/Renov. - Fencing	2006	1,637						20
21	Addition/Renov. - Lanscaping block, trees, plants, etc.	2006	112,980						21
22	Electrical - Parking lot lights	2006	2,413						22
23	Roof Termination Strip	2006	967						23
24	Electrical work	2006	2,215						24
25	Patio with raised seating area	2006	24,113						25
26	Concrete curbs & pavement for new parking spaces	2006	28,645						26
27	Electrical - Parking lot lights	2006	13,005						27
28	Lawn sprinler system	2006	9,800						28
29	Carpet	2007	10,314						29
30	Remodel Shower Room - Tile, Sink, Faucets, Paint	2007	15,820						30
31	Flooring in Corridors	2007	11,448						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,985,104	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,985,104	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	1
2	Electrical at nurses station	2007	2,538						2
3	Windows (9)	2007	14,245						3
4	Drainage	2007	17,001						4
5	Wallcovering	2007	15,483						5
6	Electrical for pill dispenser	2007	1,773						6
7	Elevator Upgrade	2007	4,370						7
8	Piping in laundry room	2007	1,700						8
9	Parking lot paving	2007	9,900						9
10	Curbing in Parking lot	2007	2,550						10
11	Paving	2007	8,016						11
12	Sidewalk & Railing	2007	36,550						12
13									13
14	Roofing over generator - Wate Tight Membrane	2008	16,314						14
15	Renov. - Vinyl Flooring	2008	37,310						15
16	ELEVATOR SWITCHES	2008	4,370						16
17	20 AMP CIRCUIT	2008	2,250						17
18	AC ELECTRICAL	2008	9,505						18
19	CONCRETE BOARD IN SHOWER	2008	2,680						19
20	ELECTRIC Change outlets from 2 to 4	2009	5,040						20
21	CIRCUIT BREAKER	2009	3,880						21
22	LAUNDRY CIRCUIT BREAKER	2009	5,140						22
23	225 AMP CIRCUIT BREAKER	2009	2,120						23
24	15 AMP RECEPTACLES	2008	3,360						24
25	Renov.- Front Elevator Upgrade	2009	54,708						25
26	HM Doors	2009	6,500						26
27									27
28	Renov. - Elevator Upgrade	2009	11,209						28
29	Doors (8) HM	2009	18,810						29
30	Renov. - Fire Rate Access Panels	2009	27,588						30
31	Renov. - Fire dampers & access panels	2009	78,095						31
32	Frights for Corner Guards	2009	240						32
33	Renov. - Fire Proof Acces Panels	2010	7,682						33
34	TOTAL (lines 1 thru 33)		\$ 8,396,031	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,396,031	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	1
2	Renov. - Flooring	2010	25,501						2
3	Renov. - Wallcovering & guards	2010	20,127						3
4	Radiant heaters	2010	16,131						4
5	Emergency lights (15) led wall packs	2010	16,017						5
6									6
7	Renov. - Surveys	2010	5,625						7
8	Renov. - Millwork	2010	24,495						8
9	Renov. - Gypsum, Studs, & Tile Work	2010	110,702						9
10	Wiring For Phones In Arcadia Wing	2010	4,027						10
11	Renov. - Acqustic Ceiling System & Other	2010	161,931						11
12	Renov. - Roof Replacement	2010	114,435						12
13	Renov. - Flooring	2010	108						13
14	Renov. - Flooring & Wallcovering	2010	2,700						14
15	Cabinetry and Faucet	2010	6,841						15
16	VCT Flooring & Paint	2010	5,168						16
17	Renov. - Overhead & Interest (\$19,887.59)	2010							17
18	Renov. - 40 Ton A/C Unit, Trane	2010	56,970						18
19	Renov. - Flooring, Paint, & Wallcoverings	2010	135,403						19
20	Renov. - Interior Renovations	2010	28,587						20
21	Renov. - Carpentry	2010	125,759						21
22	French Drain & new pavers around flag pole (1/2 of invoice)	2011	6,375						22
23									23
24	Upgrade main electrical breaker, switch, & wire to generator	2011	65,223						24
25	French Drain & new pavers around flag pole (1/2 of invoice)	2011	6,375						25
26	Replace hand rails in Monroe corridor	2011	6,192						26
27	Paint, wallcovering, corner guards in Monroe corridor	2011	19,585						27
28	Chiller 40 ton - Revno. 11-11C	2011	66,756						28
29	Wander System at Elevators (3)	2011	22,853						29
30	Sprinkler System Upgrade	2011	11,910						30
31	Nurse Call System - Renov. 2011	2011	41,396						31
32	Physician Paging System	2011	3,025						32
33	Boiler	2011	5,390						33
34	TOTAL (lines 1 thru 33)		\$ 9,511,638	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 9,511,638	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	1
2	Fire Wall, Doors, & Duct Dampers - Mechanical & Locker Rm	2012	36,210						2
3	Drywall, studs, & windows to enclose new OT area	2012	18,990						3
4	Exhaust system & ductwork for new OT area	2012	18,002						4
5									5
6	Electrical Panel & Wiring Upgrade	2012	4,787						6
7	Parking Lot Paving - Renov. 15-12MW	2012	54,973						7
8	Boiler, Lochinvar 1,300,000 BTU	2012	19,178						8
9	Compressor - 40 Ton	2012	2,848						9
10	Stainless Steel Corner Guards in Kitchen	2012	6,530						10
11	Install Fire Walls & Sprinklers - Renov 47-12MW as follows:	2012	30,120						11
12	1 1/2 hr. rated fire doors for second floor								12
13	Smoke wall repair by room 170								13
14	Smoke wall repair at stairwell next to room 213								14
15	Fire door repair for PT Mechanical Room								15
16	Sprinkler head extension outside room 233								16
17	Door repair for OT Storage room								17
18	HVAC - Laundry	2012	12,965						18
19	HVAC - OT Room	2013	14,980						19
20	Renovations to Lobby, Foyer, Office, 1st floor corridors, OT area, 2nd floor dining, 2nd floor corridor (elevator area) consisting of:								20
21	Carpentry, Millwork, Drywall, Handrails - Renov. 11-12MW	2013	158,004						21
22	Carpeting, Wallcovering - Renov. 11-12MW	2013	18,753						22
23	Light Fixtures - Renov. 11-12MW	2013	3,447						23
24	Water Heater	2013	4,971						24
25									25
26	Roofing on Penthouse & Mansard	2013	16,110						26
27	Compressor Replacement, RTU for 1st Flr NW Dining Area	2013	2,187						27
28	Doors & locksets - refrigeration rm, laundry & other areas.	2013	45,832						28
29	Smoke Dampers & Motors, Dinning, Lounge, Lobby, Rm 238	2014	10,755						29
30	EM Electric Upgrades to Med rm, Nurse station, Kiosk, Offices(3)	2014	6,585						30
31	Build/Repair Multiple Firestopping Walls	2014	72,800						31
32	Light fixture upgrade - whole building	2014	16,187						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,086,852	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 10,086,852	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	1
2	Drainage System Upgrades - front entrance to bldg	2014	17,658						2
3	Smoke Wall Upgrades - kitchen, deck, internet café	2014	12,857						3
4	Sprinkler System Upgrades - three exterior overhangs	2014	3,078						4
5	Sun Porch Roofing Upgrades - Bashing and Kaynar	2014	18,234						5
6	Fire Door Upgrade - Install hollow metal stairwell door by 285	2014	2,076						6
7	Gutter and Fascia Upgrades - sheet metal	2014	8,055						7
8	Sun Porch Roofing Upgrades	2014	1,633						8
9	Security - door sensors	2014	4,447						9
10	Flooring - ceramic tile	2014	2,320						10
11	Fence - 6 ft pvc fencing	2014	4,290						11
12	Engineer - generator	2013	1,000						12
13	Engineer - generator	2013	1,300						13
14	Sprinkler pipe - repair broken water main	2015	5,772						14
15	Wall Cover Freight	2015	317						15
16	Qmark Base Board Heater Upgrad - room 331 new base board heater	2014	2,757						16
17	Electric Heating Upgrades - 3rd floor resident rooms	2014	17,550						17
18	Sensor	2015	2,804						18
19	Transmitter - HVAC unit	2014	1,145						19
20	Motor - Kitchen	2014	3,041						20
21	5 Ton HVAC	2014	4,199						21
22	Generator	2013	4,924						22
23	A#3697 Parking Lot Sealing Ad	2014	675						23
24	Parking Lot Sealing Upgrades - repair hole	2014	6,867						24
25	Parking Lot Lighting	2014	32,364						25
26									26
27	Fire walls-1st flr pt rooms, MR off	2015	22,850						27
28	Window rod/caulk-front ent area	2015	3,774						28
29	Combustion motor on boiler pump	2015	3,155						29
30	Surface mount high impact door	2015	3,027						30
31	Hot water tank	2015	13,725						31
32	28 room heater in 3rd floor resident rooms	2015	17,030						32
33	Fire stop smoke wall next to room 245	2015	20,870						33
34	TOTAL (lines 1 thru 33)		\$ 10,330,646	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 10,330,646	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	1
2	Door Operator	2015	3,815						2
3	Concrete curb in front ent area to building	2015	5,845						3
4	Generator Radiator and coolant hoses	2015	15,595						4
5	Conduit wiring as needed-kitchen air unit	2015	27,400						5
6	Life safety lighting circuit for light fixtures in lobby and front office	2015	22,321						6
7	Wiring to relocate Life safety circuits -2nd floor dining closet and Med	2015	20,667						7
8	Reno 1st floor(williamsburg) & 3rd floor corridors & resident rooms:								8
9	Carpeting, Paint, Wallcovering, Corner Guards	2015	386,905						9
10	Basic/Composite Electrical	2015	170,806						10
11	HVAC	2015	2,498						11
12	Carpentry-Subcontractor/Millwork	2015	227,158						12
13	Drywall/studs, Flooring, Plumbing	2015	107,739						13
14	Exterior Sign	2015	2,458						14
15	Storage room Door	2016	4,410						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)		\$ 11,328,263	\$ 371,598		\$ 371,598	\$	\$ 8,683,321	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$4,856,347	\$199,722	\$199,722	\$		\$4,364,604	71
72	Current Year Purchases	632,518						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			29,868	29,868			74
75	TOTALS	\$5,488,865	\$199,722	\$229,590	\$29,868		\$4,364,604	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	2	
	Reference	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)	\$18,175,238	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$571,320	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$601,188	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$29,868	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$13,047,925	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Step-up Building Cost	\$3,713,060	\$103,141	\$3,566,945	86
87					87
88					88
89					89
90					90
91	TOTALS	\$3,713,060	\$103,141	\$3,566,945	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	Portion of Parking Lot			01/01/2010	45,216			5
6								6
7	TOTAL				\$ 45,216			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: \$ 45,383
- 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	Patient Transportation		\$	3,230	17
18					18
19					19
20					20
21	TOTAL		\$	3,230	21

10. Effective dates of current rental agreement:
- Beginning 02/20/2015
- Ending 02/28/2017

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

	Fiscal Year Ending	Annual Rent
12.	05/31/2017	\$ 42,750
13.	/2018	\$
14.	/2019	\$

* 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

ALLOCATION OF COSTS (d)

		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)	\$			

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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	21824	hrs	\$ 942,280		\$ 2,258	21,824	\$ 944,538	1
2	Licensed Speech and Language Development Therapist	10a	4636	hrs	200,145		1,056	4,636	201,201	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10a	23198	hrs	1,001,627		10,297	23,198	1,011,924	4
5	Physician Care			visits						5
6	Dental Care			visits						6
7	Work Related Program			hrs						7
8	Habilitation			hrs						8
9	Pharmacy	39, 2		# of prescrpts			1,310,646		1,310,646	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): IV Therapy	43, 2					163,619		163,619	12
13	Other (specify): X-Ray & Lab	43, 3				242,196			242,196	13
14	TOTAL				\$ 2,144,052	\$ 242,196	\$ 1,487,876	49,658	\$ 3,874,124	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 42,243	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,228,992)	2,947,702		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,388		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,997,333	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,358,110		13
14	Buildings, at Historical Cost	15,041,323		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,488,865		16
17	Accumulated Depreciation (book methods)	(16,614,870)		17
18	Deferred Charges	44,790,389		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) OMIT	81,250		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 50,145,067	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 53,142,400	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 399,939	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	924,045		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	152,298		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	117,316		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,593,598	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,223,189		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,223,189	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,816,787	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 47,325,613	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 53,142,400	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 47,341,669	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 47,341,669	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,170,346)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,170,346)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	2,154,290	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 2,154,290	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 47,325,613	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning: 06/01/15

Ending: 05/31/16

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 26,583,991	1
2	Discounts and Allowances for all Levels	(16,755,309)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,828,682	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,399,150	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 13,399,150	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	4,180	12
13	Barber and Beauty Care	32,907	13
14	Non-Patient Meals	1,247	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,360,774	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	177,744	19
20	Radiology and X-Ray	172,511	20
21	Other Medical Services	170,995	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,920,358	23
	D. Non-Operating Revenue		
24	Contributions	556	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 556	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activities & Misc Income	17,818	28
28a	Purchase Discount	387	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,205	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 26,166,951	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,027,984	31
32	Health Care	10,803,580	32
33	General Administration	6,502,405	33
	B. Capital Expense		
34	Ownership	6,973,702	34
	C. Ancillary Expense		
35	Special Cost Centers	1,755,378	35
36	Provider Participation Fee	274,248	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 28,337,297	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,170,346)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,170,346)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,779,043	44
45	Private Pay - Net Inpatient Revenue	2,301,830	45
46	Medicare - Net Inpatient Revenue	4,615,667	46
47	Other-(specify) <u>Hospice</u>	64,755	47
48	Other-(specify) <u>Insurance</u>	1,067,387	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,828,682	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,163	2,357	\$ 122,336	\$ 51.90	1
2	Assistant Director of Nursing	7,514	8,188	317,518	38.78	2
3	Registered Nurses	67,172	73,203	2,430,321	33.20	3
4	Licensed Practical Nurses	31,783	34,637	942,254	27.20	4
5	CNAs & Orderlies	132,630	144,885	2,034,364	14.04	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	53,798	58,634	2,531,630	43.18	7
8	Rehab/Therapy Aides	35,824	39,045	1,067,699	27.35	8
9	Activity Director	8,588	9,368	145,661	15.55	9
10	Activity Assistants					10
11	Social Service Workers	13,633	14,864	382,257	25.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,320	39,608	597,014	15.07	15
16	Dishwashers					16
17	Maintenance Workers	2,036	2,221	47,855	21.55	17
18	Housekeepers	20,296	22,142	258,413	11.67	18
19	Laundry	6,709	7,320	83,913	11.46	19
20	Administrator	2,080	2,080	132,602	63.75	20
21	Assistant Administrator	1,532	1,532	58,778	38.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,020	24,117	555,198	23.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,983	3,253	60,020	18.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	447,081	487,454	\$ 11,767,833 *	\$ 24.14	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	45,177	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)		\$ 45,177		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number		Manorcare of Hinsdale		STATE OF ILLINOIS		Report Period Beginning:		Page 21	
				# 0049445		06/01/15		Ending: 05/31/16	
XIX. SUPPORT SCHEDULES									
A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name		Function		%		Description		Amount	
Diane Lube (6/15-1/16)		Sr. Administrator		0		Workers' Compensation Insurance		\$ 105,850	
Katherine Marrero (1/16-5/16)		Administrator		0		Unemployment Compensation Insurance		127,576	
						FICA Taxes		858,312	
Cathy McBride (6/15-4/16)		Asst. Administrator		0		Employee Health Insurance		558,093	
Scott Morton (May, 2016)		Asst. Administrator		0		Employee Meals			
						Illinois Municipal Retirement Fund (IMRF)*			
						Disability Payments			
						401K		38,237	
						Appreciation, Oth Benefits & Mktg Adj		(554)	
TOTAL (agree to Schedule V, line 17, col. 1)						Tuition Program			
(List each licensed administrator separately.)				\$ 191,380		Smsp Match		1,739	
						Employee Uniforms		6,995	
						Home Office Allocation		87,719	
B. Administrative - Other						TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,783,967	
Description				Amount		E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Various Home Office Services - See Page 8 for breakdown				\$ 1,308,886		Description		Line # Amount	
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 1,308,886					
(Attach a copy of any management service agreement)									
C. Professional Services						G. Schedule of Travel and Seminar**			
Vendor/Payee		Type		Amount		Description		Amount	
Anspach Meeks Ellenberger LLP		Legal Fees		\$ 51		Out-of-State Travel		\$	
Greenberg Taurig		Legal Fees		8,729					
Littler Mendelson PC		Legal Fees		1,373					
Polsinelli Shughart PC		Legal Fees		104		In-State Travel		16,656	
SNF Global		Legal Fees		30,374		Includes travel expense to the Home Office in Toledo, OH for regional meetings			
Healthlink Inc		Collection Services		905					
Meyers & Flowers LLC		Collection Services		36,184					
National Eligibilty Solutions LLC		Collection Services		30					
Transworld Systems Inc.		Collection Services		9,567		Seminar Expense			
Legal fees were adj off on pg 5, ln 22 & Collections were adj off on pg 5a, ln 5, therefore, no invoices attached.									
Rajeev Kumar MD FACP		Palliative Care reclass line 10		2,640					
Smith-Perry Eye Center		Alibercept Injection, rclss ln 39		3,957					
TOTAL (agree to Schedule V, line 19, column 3)				\$ 93,914		TOTAL		\$	
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications

**See instructions.

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?
If YES, give association name and amount. YES
ICHA \$4,992 & ACHA \$2,876
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? YES
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. \$ 96,251 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. \$ 274,248
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. \$ 1,247
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. NO
Attach invoices and a summary of services for all architect and appraisal fees