

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0049411

Facility Name: Manorcare of Libertyville

Address: 1500 S Milwaukee Ave Libertyville 60048
Number City Zip Code

County: Lake

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

HFS ID Number:

Date of Initial License for Current Owners: 02/02/1988

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501(c)(3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: A. Dean Shipman Telephone Number: (419) 254-7841
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2019 to 05/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Martin D. Allen
(Title) Director

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Manorcare of Libertyville

0049411 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>150</u>	Skilled (SNF)	<u>150</u>	<u>54,900</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,900</u>	7

B. Census-For the entire report period.

	1	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>21,223</u>	<u>2,087</u>	<u>18,601</u>	<u>41,911</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>21,223</u>	<u>2,087</u>	<u>18,601</u>	<u>41,911</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.34%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 02/23/1988

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/25/2018 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 150 and days of care provided 11,351

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 Libertyville # 0049411 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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	435,721	35,117	25	470,863		470,863		470,863			1
2	Food Purchase		293,381		293,381		293,381	(1,747)	291,634			2
3	Housekeeping	248,036	24,893	112	273,041		273,041		273,041			3
4	Laundry	54,753	19,266		74,019		74,019		74,019			4
5	Heat and Other Utilities			186,387	186,387	3,455	189,842		189,842			5
6	Maintenance	62,920	34,208	128,268	225,396		225,396		225,396			6
7	Other (specify):* Security & Waste			3,267	3,267		3,267		3,267			7
8	TOTAL General Services	801,430	406,865	318,059	1,526,354	3,455	1,529,809	(1,747)	1,528,062			8
	B. Health Care and Programs											
9	Medical Director			58,455	58,455		58,455		58,455			9
10	Nursing and Medical Records	4,296,412	308,426	124,783	4,729,621	160	4,729,781		4,729,781			10
10a	Therapy	1,590,678	18,787	44,984	1,654,449		1,654,449		1,654,449			10a
11	Activities	62,162	2,416	4,055	68,633		68,633		68,633			11
12	Social Services	133,031	632	15,918	149,581		149,581		149,581			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,082,283	330,261	248,195	6,660,739	160	6,660,899		6,660,899			16
	C. General Administration											
17	Administrative	144,638		470,172	614,810	(83,923)	530,887		530,887			17
18	Directors Fees											18
19	Professional Services			61,582	61,582	(1,073)	60,509	(60,509)				19
20	Dues, Fees, Subscriptions & Promotions			100,556	100,556		100,556	(19,626)	80,930			20
21	Clerical & General Office Expenses	446,994	79,284	783,101	1,309,379	1,073	1,310,452	(700,325)	610,127			21
22	Employee Benefits & Payroll Taxes			1,180,833	1,180,833	59,754	1,240,587		1,240,587			22
23	Inservice Training & Education			3,851	3,851		3,851		3,851			23
24	Travel and Seminar			14,010	14,010		14,010		14,010			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			603,038	603,038		603,038		603,038			26
27	Other (specify):*											27
28	TOTAL General Administration	591,632	79,284	3,217,143	3,888,059	(24,169)	3,863,890	(780,460)	3,083,430			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,475,345	816,410	3,783,397	12,075,152	(20,554)	12,054,598	(782,207)	11,272,391			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			355,234	355,234	24,556	379,790		379,790			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(4,302)	(4,302)	(4,002)	(8,304)		(8,304)			32
33	Real Estate Taxes			225,551	225,551		225,551		225,551			33
34	Rent-Facility & Grounds			1,216,063	1,216,063		1,216,063	(1,216,063)				34
35	Rent-Equipment & Vehicles			49,054	49,054		49,054		49,054			35
36	Other (specify):*											36
37	TOTAL Ownership			1,841,600	1,841,600	20,554	1,862,154	(1,216,063)	646,091			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			227	227		227		227			38
39	Ancillary Service Centers		475,254		475,254		475,254		475,254			39
40	Barber and Beauty Shops			3,027	3,027		3,027		3,027			40
41	Coffee and Gift Shops	26,906			26,906		26,906		26,906			41
42	Provider Participation Fee			246,081	246,081		246,081		246,081			42
43	Other (specify):* IV Therapy		62,591	202,713	265,304		265,304		265,304			43
44	TOTAL Special Cost Centers	26,906	537,845	452,048	1,016,799		1,016,799		1,016,799			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,502,251	1,354,255	6,077,045	14,933,551		14,933,551	(1,998,270)	12,935,281			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,747)	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		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(211)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,809)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(45,590)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(682,644)	21		24
25	Fund Raising, Advertising and Promotional	(19,626)	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	(1,231,571)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,998,270)		\$	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	2	
		Amount	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))	\$ (1,998,270)		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	2	3	4	
		Yes	No	Amount	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	Exeptional 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	\$	11	1
2	Misc. Income		21	2
3	Vending Income	(589)	21	3
4	Donations Revenue		21	4
5	Accounting/Collection Fees	(14,919)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest		32	8
9	WT Rent Expense	(1,216,063)	34	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,231,571)		49

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 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	\$ 470,172	HCR Manor Care Services, LLC	0.00%	\$ 470,172	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	7,502,252	Heartland Employment Services, LLC	0.00%	7,502,252		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 7,972,424			\$ 7,972,424	\$ *	14

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

Facility Name & ID Number

Manorcare of Libertyville

0049411

Report Period Beginning:

06/01/2019

Ending:

05/31/2020

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 Galesburg IL, LLC	Galesburg				1
2			Heartland of Henry IL, LLC	Henry				2
3			Heartland of Macomb IL, LLC	Macomb				3
4			Heartland of Moline IL, LLC	Moline				4
5			Manor Care at Arlington Heights	Arlington Heights				5
6			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				6
7			Manor Care of Hinsdale IL, LLC	Hinsdale				7
8			Manor Care of Homewood IL, LLC	Homewood				8
9			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				9
10			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				10
11			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				11
12			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				12
13			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Arden Courts of Geneva IL, LLC	Geneva				14
15			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				15
16			Arden Courts of Northbrook IL, LLC	Northbrook				16
17			Arden Courts of Palos Heights IL, LLC	Palos Heights				17
18			Arden Courts of South Holland IL, LLC	South Holland				18
19								19
20								20
21								21
22								22
23								23
24	Martin D. Allen	BOD						24
25	Lynne Davis	BOD						25
26	Kathryn S. Hoops	BOD						26
27	Thomas Kile	BOD						27
28	Patricia McCormick	BOD						28
29	Rami Ubaydi	BOD						29
30								30

Facility Name & ID Number Manorcare of Libertyville # 0049411 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Libertyville# 0049411

Report Period Beginning:

06/01/2019Ending: 5/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

HCR Manor Care Services LLC

Street Address

333 North Summit Street

City / State / Zip Code

Toledo, OH 43604-2617

Phone Number

(419) 252-5500

Fax Number

(419) 254-5495

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities - Pooled	Accumulated Cost	485 NFs, HHs, & Re	\$ 709,073	\$ 0	12,846,970	\$ 3,455	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	305 NFs		0	12,846,970	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	54 NFs		0	12,846,970	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	485 NFs, HHs, & Re	32,137	0	12,846,970	157	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	305 NFs	454	0	12,846,970	3	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	54 NFs		0	12,846,970	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	485 NFs, HHs, & Re	57,708,481	23,053	12,846,970	281,173	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	305 NFs	7,841,321	0	12,846,970	47,698	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	54 NFs	2,818,405	0	12,846,970	57,378	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	485 NFs, HHs, & Re	5,631,859	35,913,957	12,846,970	27,440	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	305 NFs	5,312,192	1,179,502	12,846,970	32,314	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	54 NFs		0	12,846,970	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	485 NFs, HHs, & Re	4,013,110	0	12,846,970	19,553	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	305 NFs	822,456	0	12,846,970	5,003	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	54 NFs		0	12,846,970	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		(782,905)		12,846,970	(3,815)	22
23	32	Directly Assigned Interest	Not Allocated		(8,038)			(187)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions			34,182,124				24
25	TOTALS				\$ 118,280,668	\$ 37,116,512		\$ 470,172	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	Not applicable			\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Home Office Pooled Interest Expense											(4,002)	6	
7	Interest Income / Interest Expense											(4,302)	7	
8													8	
9	TOTAL Facility Related						\$					\$ (8,304)	9	
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	14	
15	TOTALS (line 9+line14)						\$					\$ (8,304)	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 2019 report.				\$	197,125	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.)				\$	218,753	2
3. Under or (over) accrual (line 2 minus line 1).				\$	21,628	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	203,923	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.				\$	225,551	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	198,595	8		
		2016	201,123	9		
		2017	208,845	10		
		2018	215,046	11		
		2019	222,461	12		
Line 2: \$0 = \$107,522.79 for 2nd half 2018+ \$111,230.64 for 1st half 2019						
Line 4: = \$111,230.64 for 2nd half 2019 + estimate \$92,692.20 for 1st half 2020						

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019 \$	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.

FACILITY NAME Manorcare of Libertyville COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0049411

CONTACT PERSON REGARDING THIS REPORT A. Dean Shipman

TELEPHONE (419) 254-7841 FAX #: (419) 254-5495

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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: 41,805

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

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

NONE

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	276,603	1988	\$ 476,076	1
2					2
3	TOTALS	276,603		\$ 476,076	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	150			1988	\$ 4,592,131	\$ 117,249		\$ 117,249	\$	\$ 3,687,276
5										
6										
7										
8										
	Improvement Type**									
9	Current Year Depreciation					153,903		153,903		3,911,760
10				1988	68,073					
11				1989	52,434					
12				1990	30,247					
13				1991	67,316					
14				1992	175,480					
15	RETIREMENTS			1992	(10,437)					
16				1993	55,746					
17				1994	135,262					
18				1995	66,532					
19				1996	156,102					
20				1997	322,999					
21				1998	79,019					
22				1999	110,917					
23				2000	62,680					
24				2001	428,328					
25				2002	46,107					
26				2003	105,986					
27				2004	122,241					
28	INSTALL VCT FLOORING			2005	3,436					
29	Renov -Lobby Finishes			2005	1,680					
30	Renov -Custom Casework (See 7/06 Audit Adj's)			2005	16,000					
31	Renov -Carpeting & Pads & Guards & WC			2005	26,679					
32	Renov -General Overhead & Interest (See 7/06 Audit Adj's)			2005	6,015					
33	Stainles Steel Flashing			2005	20,000					
34	Linen&Bathroom doors			2005	2,482					
35	Renov -Roof Covering			2005	101,050					
36	Renov -General Overhead (See 7/06 Audit Adj's)			2005	4,327					

*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 Libertyville

0049411

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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	Renov -Interest on Construction (See 7/06 Audit Adj's)	2005	\$ 546	\$		\$	\$	\$	37
38	VWC	2005	4,168						38
39	Stainless steel flashing	2005	15,440						39
40	Bathroom Exhaust fans	2005	4,426						40
41	Carpet	2005	1,648						41
42	Renov -Drywall/Studs	2005	1,430						42
43	Renov -Resilient Flooring	2005	16,153						43
44	Renov -General Overhead & Interest (See 7/06 Audit Adj's)	2005	866						44
45	Adj. out OH & Int Per 7/06 Cap Rate Audit Adjs.	2005	(6,015)						45
46	To 2004 Per 7/06 Cap Rate Audit Adjs.	2005	(28,179)						46
47	Adj. out OH & Int Per 7/06 Cap Rate Audit Adjs.	2005	(5,670)						47
48	RENOVATION/ 440 018 04C (See 7/06 Audit Adj's)	2005	25,904						48
49	RENOVATION/ 440 018 04C (See 7/06 Audit Adj's)	2005	27,234						49
50	RENOVATION/ 440 018 04C (See 7/06 Audit Adj's)	2005	945						50
51	FLOORING	2005	1,636						51
52	INSTALL DOORS	2005	6,480						52
53	2 LIGHT FIXTURES	2005	1,650						53
54	INSTALL SMOKE WALL & SIDE	2005	10,129						54
55	Per 7/06 Cap Rate Audit Adjs.	2005	(5,000)						55
56	Per 7/06 Cap Rate Audit Adjs.	2005	(4,873)						56
57	Per 7/06 Cap Rate Audit Adjs.	2005	(866)						57
58	Per 7/06 Cap Rate Audit Adjs.	2005	(20,234)						58
59	KVA TRANSFORMER	2006	2,838						59
60	21 doors	2006	37,670						60
61	sheet vinyl & ceramic flooring	2006	4,074						61
62									62
63	metals doors	2006	3,316						63
64	electrical	2006	827						64
65	DOORS ON KITCHEN	2007	14,124						65
66	DOORS ON 3RD & 2ND FLOOR	2007	5,940						66
67	Renov - Carpentry	2007	29,850						67
68	Renov - Doors/Frames/Drywall/Studs/Plumbing	2007	14,674						68
69	Renov - Resilient Flooring (change from 07 to 06 per 7/19 audit)	2006	79,143						69
70	TOTAL (lines 4 thru 69)		\$ 7,089,106	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	70

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

Facility Name & ID Number Manorcare of Libertyville

0049411

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 7,089,106	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	1
2	Renov - Carpeting & ads	2007	19,746						2
3	Renov - Fire Sprinkler	2007	3,752						3
4	Renov - Basic Electric	2007	21,558						4
5	Renov - 'Interest on Construction	2007	1,493						5
6	Adj. out Int Per 7/19 Cap Rate Audit Adjs.	2007	(1,493)						6
7	Renov - General Overhead	2007	20,811						7
8	Adj. out OH Per 7/19 Cap Rate Audit Adjs.	2007	(20,811)						8
9	Fire Rated Doors	2007	22,384						9
10									10
11	000000001811 Concrete Sidewalk	2008	2,862						11
12	000000001815 Seal Parking Lot	2008	8,031						12
13	000000001821 Asphalt	2008	1,706						13
14	000000001809 Fire Proofing	2008	8,820						14
15	000000001810 Kitchen Make Air	2008	4,903						15
16	000000001812 30 amp 277 volt Circuit	2008	5,238						16
17	000000001813 0208 Door Alarm System	2008	1,381						17
18	Adj. out less than min for cap Per 7/19 Cap Rate Audit Adjs.	2008	(1,381)						18
19	000000001834 Ceramic Tile in 4 Showers	2008	22,440						19
20	000000001835 Elevator Switches	2008	4,757						20
21									21
22	000000001839 Added Sprinklers	2009	9,700						22
23	000000001840 2208 Water Heaters	2009	7,056						23
24	Adj. out no invoice Per 7/19 Cap Rate Audit Adjs.	2009	(7,056)						24
25	000000001841 2208 Water Heaters (changed from 09 to 08 per 7/19)	2008	48,816						25
26	000000001844 0908 Rms & Bthrms Gen Overhead & Interest	2009	41,216						26
27	Adj. out OH and Int Per 7/19 Cap Rate Audit Adjs.	2009	(41,216)						27
28	000000001846 0908 Rms & Bthrms Carpentry & Milwork	2009	137,855						28
29	000000001847 0908 Rms & Bthrms Ceiling tile, flooring VWC	2009	26,975						29
30	1847 0908 Rms & Bathrms VWC	2009	396						30
31	1864 Door	2009	2,076						31
32	1866 Adj Asset #1847 VWC	2009	(30)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,441,091	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	34

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

Facility Name & ID Number Manorcare of Libertyville

0049411

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 7,441,091	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	1
2	1870 Steel Railing & Gate	2010	2,250						2
3	Adj. out less than min for cap Per 7/19 Cap Rate Audit Adjs.	2010	(2,250)						3
4	1883 25 Smoke Detectors	2010	11,770						4
5									5
6	CONCRETE RAMP	2011	16,704						6
7	KITCHEN CEILING	2011	12,322						7
8	REMODEL KITCHEN POT & PAN WASH AREA	2011	36,617						8
9	100 GALLON WATER HEATER	2011	7,832						9
10									10
11	ADDITION - ARCH & ENGINEER COSTS	2012	151,873						11
12	ADDITION - LEGAL FEES	2012	15,348						12
13	ADDITION - REPRODUCTIONS	2012	216						13
14	ADDITION - GENERAL OVERHEAD & INTEREST	2012	156,725						14
15	Adj. out OH and Int Per 7/19 Cap Rate Audit Adjs.	2012	(156,725)						15
16	ADDITION - PLAN REVIEWS	2012	10,800						16
17	ADDITION - CARPENTRY	2012	11,960						17
18	ADDITION - MILLWORK	2012	78,250						18
19	ADDITION - ROOFING	2012	81,509						19
20	ADDITION - HM DOORS & FRAMES	2012	110,354						20
21	ADDITION - DRYWALL & STUDS	2012	213,277						21
22	ADDITION - ACCOUSTICAL CEILING TILE	2012	70,837						22
23	ADDITION - RESILIENT FLOORING	2012	20,295						23
24	ADDITION - PAINTING	2012	64,368						24
25	ADDITION - WALLCOVERING	2012	14,883						25
26	ADDITION - PLUMBING	2012	74,511						26
27	ADDITION - HVAC	2012	96,332						27
28	ADDITION - BASIC ELECTRICAL	2012	314,076						28
29	ADDITION - MASONRY	2012	50,230						29
30	ADDITION - METALS	2012	36,219						30
31	ADDITION- CONCRETE	2012	54,119						31
32	ADDITION - RESILIENT FLOORING	2012	352						32
33	ADDITION- CARPETING AND PADS	2012	26,902						33
34	TOTAL (lines 1 thru 33)		\$ 9,023,047	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	34

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

Facility Name & ID Number Manorcare of Libertyville

0049411

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 9,023,047	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	1
2	ADDITION - WALLCOVERING	2012	29,316						2
3	ADDITION- SOIL & CONCRETE TESTING	2012	12,107						3
4	ADDITION - WATER & SEWER FEES	2012	13,775						4
5	ADDITION - PERMIT FEES	2012	28,724						5
6	ADDITION - SITE PREP/GRADING	2012	292,886						6
7	prep sink in kitchen	2012	17,416						7
8	RENOV- DRYWALL /STUDS - MECH RM UPGRADES	2012	44,749						8
9	Adj. out OH and Int Per 7/19 Cap Rate Audit Adjs.	2012	(4,949)						9
10	ENLARGE O2 STORAGE ROOM TO 6X9	2012	21,080						10
11	PAINTING ON 1ST, 2ND & 3RD FLOORS	2012	4,364						11
12	OVERNIGHT MAIL CHGS RE: ADDITION PLANS	2012	48						12
13	ELEVATOR DOOR OPERATORS	2012	9,925						13
14	ADDITIONAL FOR LIBERTYVILLE ADDITION								14
15	PAINTING	2012	422						15
16	Adj. out related to appeal Cap Rate Audit Adjs.	2012	(422)						16
17	ACCOUTICAL CEILING TILES	2012	7,957						17
18	Adj. out related to appeal Cap Rate Audit Adjs.	2012	(7,957)						18
19	MILLWORK/WOOD DOORS/HVAC	2012	37,332						19
20	Adj. out Int Per 7/19 Cap Rate Audit Adjs.	2012	(37,332)						20
21	PLUMBING	2012	8,052						21
22	Adj. out related to appeal Cap Rate Audit Adjs.	2012	(8,052)						22
23	BRICK AND MASONRY	2012	1,674						23
24	Adj. out related to appeal Cap Rate Audit Adjs.	2012	(1,674)						24
25	LOUNGE WALL UPDATES- LARGE & SMALL LOUNGES	2012	3,091						25
26	RESTROOM WALL UPDATES 2 ea 2nd & 3rd flrs	2012	6,389						26
27	PARKING LOT-front handicapped & dumpster areas	2012	23,662						27
28	FIRE LINKS	2012	16,290						28
29	ELEVATOR DOOR OPERATORS	2012	9,925						29
30	Elevator Controllers	2012	42,577						30
31	Adj. out Int Per 7/19 Cap Rate Audit Adjs.	2012	(177)						31
32	GARAGE ROOF	2012	2,880						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,597,125	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	34

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

Facility Name & ID Number Manorcare of Libertyville

0049411

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 9,597,125	\$ 271,152		\$ 271,152		\$ 7,599,036	1
2	double door install	2013	2,890						2
3	KITCHEN FLOORING	2013	4,034						3
4	SEWER DRAIN- reroute 2nd/3rd flr plbg f/ 1st flr baths	2013	7,661						4
5	ELEVATOR WIRING	2013	6,745						5
6	ELECTRICAL UPDATE - 2ND FLR main elec rm	2013	11,858						6
7	Life Safety Corrections-intrusion alert system	2013	54,000						7
8	Adj. out OH and Int Per 7/19 Cap Rate Audit Adjs.	2013	(5,617)						8
9	Electrical for EZ path devices for TV cabling	2013	3,775						9
10	Landscaping refunds on dead plantings	2013	(3,030)						10
11	Elec Transformer for 1st floor storage room	2013	22,178						11
12	front office cabinetry	2013	4,215						12
13									13
14	paving- south entrance drive	2014	3,690						14
15	Upper Siding & Fascia	2014	60,335						15
16	Adj. out OH and Int Per 7/19 Cap Rate Audit Adjs.	2014	(11,575)						16
17	DOOR, 4000 LE/SL SERIES AUTOMATED	2014	3,083						17
18	A#2025 AUTOMATED DOORS ADDL	2014	1,171						18
19	GEN ELEC UPGRADES	2014	6,758						19
20	Plumbing Equip repairs 2nd flr -main mixing valve	2014	5,000						20
21	K-tag corrections: ext exit signs @ dining rm & internet café patio	2014	5,052						21
22									22
23	fire rated ceiling in main elec rm & firestop 2nd flr stairwell	2015	17,075						23
24	MASONRY	2015	1,415						24
25	Adj. out less than min for cap Per 7/19 Cap Rate Audit Adjs.	2015	(1,415)						25
26									26
27	steel door, frame, hinges & closer on garage. Fire hatch								27
28	in ceiling of Maint Ofc.	2015	4,880						28
29	trees: spruce (6), maples (2), & linden (1) on property	2015	4,360						29
30	fire wall system extending wall to underside of deck around boiler rm								30
31	& E stairwell	2015	9,850						31
32	steel door, frame, hinges & closer on N Stairwell exit	2015	5,120						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,820,633	\$ 271,152		\$ 271,152		\$ 7,599,036	34

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

Facility Name & ID Number Manorcare of Libertyville

0049411

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 9,820,633	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	1
2	<u>make-up air vent & limestone cap S side of bldg. Main flr. -water damage</u>								2
3	<u>from rain, snow, & 2nd flr PTAC unit directly above</u>	2015	4,365						3
4	<u>100 gal water heater in forst floor boiler room</u>	2015	9,249						4
5	<u>PTAC -12,000 BTU (2) units & 9,000 BTU (1) unit -lounges</u>	2015	3,309						5
6	<u>p-trap, 4" in kitchen</u>	2015	5,410						6
7									7
8	<u>Fire dampers - Replace 9 dampers</u>	2016	2,365						8
9	<u>Fire dampers - 180 Fusible links</u>	2016	14,200						9
10	<u>Blower Shaft and 2 bearings on 1st Floor McQuay Air Handler</u>	2016	3,200						10
11									11
12	<u>Flooring Kitchen</u>	2017	5,046						12
13	<u>Kitchen drain lines in floor</u>	2017	11,613						13
14	<u>AC, mini split unit -Elevator Eq Rm</u>	2017	5,300						14
15	<u>roofing</u>	2017	6,460						15
16	<u>plumbing @ rotted P traps & floor drain-Kitchen</u>	2017	4,355						16
17	<u>flooring in kitchen</u>	2017	10,799						17
18	<u>mixing valve</u>	2017	2,761						18
19	<u>pump for elevators</u>	2017	4,050						19
20	<u>firestopping -1st flr stairwell & by rm 118</u>	2017	6,542						20
21	<u>carpeting & FRT -1st & 2nd floor corridors</u>	2017	6,847						21
22	<u>carpeting-1st flr nurse station & lounge</u>	2017	5,764						22
23	<u>AC Economizer control - kitchen Air Handler</u>	2017	3,975						23
24	<u>doors, HM @ front entrance</u>	2018	21,355						24
25	<u>Trees (23): Maple (4), Honey Locust (8), linden(6), Hackberry (4)-</u>	2017	12,120						25
26	<u>Fence</u>	2017	5,700						26
27	<u>Patio, 200 sf, concrete off 1st floor dining room</u>	2017	4,275						27
28	<u>asphalt - east driveway</u>	2017	3,000						28
29	<u>pole lights for parking lot (3)</u>	2017	29,823						29
30									30
31	<u>PTAC Units in residen rooms (6)</u>	2018	4,303						31
32	<u>Electrical Components for fire alarm system and and Replace seve</u>	2018	6,833						32
33	<u>Adj. out less than min for cap Per 7/19 Cap Rate Audit Adjs.</u>	2018	(2,283)						33
34	TOTAL (lines 1 thru 33)		\$ 10,021,369	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	34

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

Facility Name & ID Number Manorcare of Libertyville

0049411

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 10,021,369	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	1
2	Condensor motors and capacitors (2 each) and impeller for boiler	2018	4,832						2
3	Materials for Elevator Repair	2018	9,450						3
4	Exit door replacement from service hall to exterior	2018	5,324						4
5	Heat pumps for PTAC units in resident rooms	2019	3,393						5
6	Architectural Drawings for Dialysis space changes	2019	15,813						6
7	Adj. out architect fees to be included with completed project Per 7/19	2019	(15,813)						7
8	Material for gutters and exterior drainage	2019	9,016						8
9									9
10	Architect Renderings for Dialysis Conversion of Activity Room	2020	3,363						10
11	Wall Covering in Administrator office and family meeting room	2020	3,670						11
12	Carpet installation for second floor corridors and nurse station	2020	4,756						12
13	Tile for secon floor corridors and nurse station	2020	4,841						13
14	Tile for secon floor corridors and nurse station	2020	7,020						14
15	Tile for secon floor corridors and nurse station	2020	8,163						15
16	Backflow device	2020	10,936						16
17	Asphalt Paving for parking lot	2020	12,063						17
18	Install new open site and drain line for garbadge disposal in kitchen	2020	13,536						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)		\$ 10,121,732	\$ 271,152		\$ 271,152	\$	\$ 7,599,036	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	\$ 3,179,750	\$ 84,081	\$ 84,081	\$		\$ 2,941,173	71
72	Current Year Purchases	49,516						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			24,556	24,556			74
75	TOTALS	\$ 3,229,266	\$ 84,081	\$ 108,637	\$ 24,556		\$ 2,941,173	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	13,827,072
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	355,233
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	379,789
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	24,556
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	10,540,209

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$
93		
94		
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:	N/A			\$			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?
16. Rental Amount for movable equipment: \$49,054 Description: 02 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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

* 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	9439 hrs	\$ 400,686	328	\$ 20,526	\$ 3,215	9,767	\$ 424,427	1
2	Licensed Speech and Language Development Therapist	10a	3239 hrs	137,498			2,126	3,239	139,624	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	10738 hrs	455,823			13,446	10,738	469,269	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				475,254		475,254	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Inhal Therapy</u>	10a, 3	1174	49,840	88	5,516		1,262	55,356	12
13	Other (specify): <u>X-Ray & Lab I IV</u>	43, 2 & 3				202,713	62,591		265,304	13
14	TOTAL			\$ 1,043,847	416	\$ 228,755	\$ 556,632	25,006	\$ 1,829,234	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	\$ 4,662	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 821,035)	1,104,729		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,985		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,115,376	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	476,076		13
14	Buildings, at Historical Cost	10,121,730		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,229,266		16
17	Accumulated Depreciation (book methods)	(10,540,209)		17
18	Deferred Charges			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	225,759		22
23	Other(specify): CIP	62,691		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,575,313	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,690,689	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 206,514	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	552,366		30
31	Accrued Taxes Payable (excluding real estate taxes)	757		31
32	Accrued Real Estate Taxes(Sch.IX-B)	203,923		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	173,791		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,137,351	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,137,351	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,553,338	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,690,689	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,928,208	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,928,208	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	225,978	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)	\$ 225,978	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(600,848)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (600,848)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,553,338	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Libertyville

0049411

Report Period Beginning: 06/01/2019

Ending: 05/31/2020

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	\$ 15,148,829	1
2	Discounts and Allowances for all Levels	(7,415,350)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,733,479	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,006,499	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,006,499	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	589	12
13	Barber and Beauty Care	3,339	13
14	Non-Patient Meals	1,747	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,054,376	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	302,444	19
20	Radiology and X-Ray	84,915	20
21	Other Medical Services	72,248	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,519,658	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	<u>Purchase Discount</u>	899,893	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 899,893	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,159,529	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,526,354	31
32	Health Care	6,660,739	32
33	General Administration	3,888,059	33
	B. Capital Expense		
34	Ownership	1,841,600	34
	C. Ancillary Expense		
35	Special Cost Centers	770,718	35
36	Provider Participation Fee	246,081	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,933,551	40
41	Income before Income Taxes (line 30 minus line 40)**	225,978	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 225,978	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,826,561	44
45	Private Pay - Net Inpatient Revenue	602,166	45
46	Medicare - Net Inpatient Revenue	2,412,179	46
47	Other-(specify) <u>Hospice</u>	358,227	47
48	Other-(specify) <u>Insurance</u>	534,346	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,733,479	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	1,715	1,830	\$ 110,595	\$ 60.43	1
2	Assistant Director of Nursing	3,516	3,751	157,269	41.93	2
3	Registered Nurses	46,390	49,495	1,770,103	35.76	3
4	Licensed Practical Nurses	21,321	22,748	662,083	29.11	4
5	CNAs & Orderlies	81,813	87,406	1,560,233	17.85	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	27,708	29,526	1,253,376	42.45	7
8	Rehab/Therapy Aides	11,173	11,906	337,302	28.33	8
9	Activity Director	3,334	3,556	62,162	17.48	9
10	Activity Assistants					10
11	Social Service Workers	5,408	5,764	133,031	23.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,438	25,000	435,721	17.43	15
16	Dishwashers					16
17	Maintenance Workers	2,341	2,472	62,920	25.45	17
18	Housekeepers	15,714	16,777	248,036	14.78	18
19	Laundry	4,017	4,288	54,753	12.77	19
20	Administrator	2,080	2,080	144,638	69.54	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,962	19,228	446,994	23.25	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	1,751	1,869	36,129	19.33	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	2,061	2,199	26,906	12.24	33
34	TOTAL (lines 1 - 33)	271,742	289,895	\$ 7,502,251 *	\$ 25.88	34

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

** See instructions.

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	58,455	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)		\$ 58,455		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2	\$ 125	10, 3	50
51	Licensed Practical Nurses			10, 3	51
52	Certified Nurse Assistants/Aides			10, 3	52
53	TOTAL (lines 50 - 52)	2	\$ 125		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA \$4,817 & AHCA \$2,245
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,847 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. 7/28/18
- (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. \$ 246,081
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. \$ 1,747
- (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?
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) 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.