

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0033969

Facility Name: Manorcare at South Holland

Address: 2145 East 170th Street South Holland 60473
 Number City Zip Code

County: Cook

Telephone Number: (708)895-3255 **Fax #** (708)895-3315

HFS ID Number: 520886946014

Date of Initial License for Current Owners: 12/01/88

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Gary Geise **Telephone Number:** (419)252-5731

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/05 to 05/31/06 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) <u>Barry A. Lazarus</u>	
	(Title) <u>Vice President, Reimbursement</u>	
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 at South Holland# 0033969 Report Period Beginning: 06/01/05 Ending: 05/31/06

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>190</u>	Skilled (SNF)	<u>190</u>	<u>69,350</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>190</u>	TOTALS	<u>190</u>	<u>69,350</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>15,752</u>	<u>6,670</u>	<u>39,191</u>	<u>61,613</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>15,752</u>	<u>6,670</u>	<u>39,191</u>	<u>61,613</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.84%

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

58 (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)

NoneF. 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 12/01/88

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 190 and days of care provided 31,259Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 5/31/06

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

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/05 Ending: 05/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	388,465	28,239	1,206	417,910	5,609	423,519		423,519		1
2	Food Purchase		275,746		275,746		275,746	(250)	275,496		2
3	Housekeeping	165,631	27,402	23,305	216,338		216,338		216,338		3
4	Laundry	62,037	18,821	13,890	94,748		94,748		94,748		4
5	Heat and Other Utilities			193,181	193,181	11,351	204,532		204,532		5
6	Maintenance	64,017	30,112	159,046	253,175		253,175		253,175		6
7	Other (specify):* Medical Waste			1,284	1,284		1,284		1,284		7
8	TOTAL General Services	680,150	380,320	391,912	1,452,382	16,960	1,469,342	(250)	1,469,092		8
	B. Health Care and Programs										
9	Medical Director			18,950	18,950		18,950		18,950		9
10	Nursing and Medical Records	3,847,469	433,128	74,823	4,355,420	41,866	4,397,286		4,397,286		10
10a	Therapy	1,159	22,989	1,966,693	1,990,841		1,990,841	(217,977)	1,772,864		10a
11	Activities	112,797	4,826	3,793	121,416		121,416		121,416		11
12	Social Services	143,246	81		143,327		143,327		143,327		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,104,671	461,024	2,064,259	6,629,954	41,866	6,671,820	(217,977)	6,453,843		16
	C. General Administration										
17	Administrative	116,778		787,760	904,538	(258,761)	645,777		645,777		17
18	Directors Fees										18
19	Professional Services			84,993	84,993	(21,505)	63,488	(50,052)	13,436		19
20	Dues, Fees, Subscriptions & Promotions			109,273	109,273		109,273	(58,093)	51,180		20
21	Clerical & General Office Expenses	437,870	84,494	450,960	973,324		973,324	(401,628)	571,696		21
22	Employee Benefits & Payroll Taxes			958,869	958,869	84,596	1,043,465		1,043,465		22
23	Inservice Training & Education			1,497	1,497		1,497		1,497		23
24	Travel and Seminar			10,283	10,283		10,283		10,283		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			223,180	223,180		223,180		223,180		26
27	Other (specify):* Personal Purchase							(37)	(37)		27
28	TOTAL General Administration	554,648	84,494	2,626,815	3,265,957	(195,670)	3,070,287	(509,810)	2,560,477		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,339,469	925,838	5,082,986	11,348,293	(136,844)	11,211,449	(728,037)	10,483,412		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.

Facility Name & ID Number Manorcare at South Holland #0033969 Report Period Beginning: 06/01/05 Ending: 05/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			474,031	474,031	32,033	506,064		506,064			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(370)	(370)	104,811	104,441		104,441			32
33	Real Estate Taxes			576,537	576,537		576,537		576,537			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			98,262	98,262		98,262		98,262			35
36	Other (specify):*											36
37	TOTAL Ownership			1,148,460	1,148,460	136,844	1,285,304		1,285,304			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,355	3,355		3,355		3,355			38
39	Ancillary Service Centers		851,941	103	852,044		852,044		852,044			39
40	Barber and Beauty Shops		(388)	14,143	13,755		13,755		13,755			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):* IV / X-ray & Lab		277,136	100,707	377,843		377,843		377,843			43
44	TOTAL Special Cost Centers		1,128,689	222,333	1,351,022		1,351,022		1,351,022			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,339,469	2,054,527	6,453,779	13,847,775		13,847,775	(728,037)	13,119,738			45

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

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	OHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(195)	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		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(148)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(37)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(46)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(50,052)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(398,961)	21		24
25	Fund Raising, Advertising and Promotional	(58,093)	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	(2,813)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (510,345)		\$	30

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)	(217,692)	10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (217,692)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (728,037)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Manorcare at South Holland

ID# 0033969

Report Period Beginning: 06/01/05

Ending: 05/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (2,067)	21	1
2	Misc. Income	(406)	21	2
3	Misc. Meal Income	(55)	2	3
4	Misc Therapy	(285)	10a	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(2,813)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/05

Ending:

05/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(250)	0	0	0	0	0	0	0	0	0	0	(250)	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	(250)	0	0	0	0	0	0	0	0	0	0	(250)	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	(285)	(217,692)	0	0	0	0	0	0	0	0	0	(217,977)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(285)	(217,692)	0	(217,977)	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	(50,052)	0	0	0	0	0	0	0	0	0	0	(50,052)	19
20	Fees, Subscriptions & Promotions	(58,093)	0	0	0	0	0	0	0	0	0	0	(58,093)	20
21	Clerical & General Office Expenses	(401,628)	0	0	0	0	0	0	0	0	0	0	(401,628)	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):*	(37)	0	0	0	0	0	0	0	0	0	0	(37)	27
28	TOTAL General Administration	(509,810)	0	0	0	0	0	0	0	0	0	0	(509,810)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(510,345)	(217,692)	0	(728,037)	29								

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/05 Ending:

Summary B

05/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(510,345)	(217,692)	0	(728,037)	45								

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/05

Ending:

05/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Home Office Allocation	\$ 787,760	HCR Manor Care, Inc.	100.00%	\$ 787,760	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	38,296	Heartland Management Services	100.00%	38,296		6
7	V							7
8	V	10a Therapy PT, OT, & ST	1,909,750	Heartland Rehab Services	100.00%	1,692,058	(217,692)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,735,806			\$ 2,518,114	\$ * (217,692)	14

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

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/05 Ending: 05/31/06

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 at South Holland

0033969

Report Period Beginning:

06/01/05

Ending: 05/31/06

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, Inc.
 Street Address 333 North Summit St.
 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	1	Dietary - direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	\$ 1,107,111	\$ 591,572	12,674,853	\$ 5,609	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.				0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	267,575		12,674,853	1,356	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	2,395,925		12,674,853	9,995	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	771,372	565,963	12,674,853	3,908	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	3,944,092	2,235,491	12,674,853	16,453	6
7	17	Gen & Adm - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	24,791,565	22,717,176	12,674,853	125,598	7
8	17	Gen & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	96,702,974	43,044,715	12,674,853	403,401	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	6,363,513		12,674,853	32,239	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	12,550,855		12,674,853	52,357	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.				0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	7,679,242		12,674,853	32,033	12
13										13
14	32	Interest				7,118,315			104,811	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 163,692,539	\$ 69,154,917		\$ 787,760	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X	Facility			\$ 1,399,326	\$ 1,399,326		7.4901	\$ 104,811	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income										(370)	8
9	TOTAL Facility Related						\$ 1,399,326	\$ 1,399,326			\$ 104,441	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,399,326	\$ 1,399,326			\$ 104,441	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 536,827	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.)		\$ 579,391	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 42,564	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 548,722	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.)		\$ 11,592	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 \$ 26,341 For 2002 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ (26,341)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 576,537	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	510,433	8
	2002	542,781	9
	2003	543,845	10
	2004	567,544	11
	2005	584,206	12
Line 2: \$579,391 = \$283,770 for 1st half of 2005 + \$295,621 for 2nd half of 2004			
Line 4: \$548,722 = \$248,288 for Jan - May 2006 + \$300,434 for 2nd half of 2005			
Line 5: Attached invoices 521018 & 521926 for Specific Objections filed by Worsek & Vihon			
& invoice 4075 for reseach done by Urban Real Estate Research.			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at South Holland COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033969

CONTACT PERSON REGARDING THIS REPORT Gary Geise

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>29-25-200-006-0000</u>	<u>See Attached</u>	<u>\$ 584,206.41</u>	<u>\$ 584,206.41</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 584,206.41	\$ 584,206.41

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

Facility Name & ID Number Manorcare at South Holland

0033969 Report Period Beginning:

06/01/05 Ending:

05/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,781 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1988</u>	<u>\$ 929,902</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 929,902	3

Facility Name & ID Number **Manorcare at South Holland**

0033969

Report Period Beginning:

06/01/05

Ending:

05/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1988	\$ 3,317,990	\$ 154,331		\$ 154,331	\$	\$ 2,403,902	4
5	60			1991	1,912,803						5
6	10			1997	1,054,638						6
7											7
8											8
Improvement Type**											
9	Current Year Depreciation					125,907		125,907		1,613,272	9
10				1988	112,623						10
11				1989	36,052						11
12				1990	6,131						12
13				1991	255,298						13
14				1992	192,798						14
15				1993	108,676						15
16				1994	85,519						16
17				1995	50,587						17
18				1996	231,349						18
19				1997	120,584						19
20				1998	237,026						20
21				1999	8,872						21
22				2000	53,921						22
23				2001	103,358						23
24		Birch Doors & Shower Floors		2002	4,644						24
25		Eletrical Work		2002	5,390						25
26		Paint, Wallcovering & Borders		2002	3,884						26
27		General Construction		2002	11,200						27
28		Floor Tile for Break Room		2002	2,794						28
29		Roofing		2003	12,928						29
30		Carpet		2003	382						30
31		Carpet/Flooring & Base		2003	18,216						31
32		Wallcovering & Border		2003	13,718						32
33		Renovation to Vending Machine Room		2003	5,794						33
34		Roofing		2003	1,010						34
35		Concrete		2003	2,050						35
36		Doors (2)		2003	3,033						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/05

Ending:

05/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Construction Dept. Cost & Interest	2003	\$ 5,152	\$		\$	\$	\$	37
38	Additional Electrical Outlets	2003	2,331						38
39	Fire Door	2004	1,463						39
40	Construction Dept. Cost & Interest	2004	985						40
41	Wallcovering & Border	2004	3,297						41
42	Doors	2004	2,284						42
43	Flooring	2004	3,807						43
44	LANDSCAPING	2004	5,300						44
45	PARKING LOT LIGHTS	2004	17,922						45
46	WALLCOVERING & BORDERS	2004	3,913						46
47	CARPET	2004	4,996						47
48	TOLI OAK FLOORING	2004	11,840						48
49	DOORS	2004	1,042						49
50	DRYWALL OVER DOORWAY & INSTALL CABINETS	2004	10,724						50
51	DOOR HARDWARE	2004	8,926						51
52	FLOORING & COVE BASE	2004	10,254						52
53	ENRTY DOORS, RAMP, & EXTEND WALL 25 FEET	2005	31,817						53
54	REGISTERS FOR BUILDING	2005	3,892						54
55	DUCT WORK FOR A/C	2005	2,080						55
56	FABRIC	2005	602						56
57	DOOR	2005	1,790						57
58	4 DOORS & LOCK SETS	2006	3,500						58
59	DOORS & LOCK SETS	2006	3,718						59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,114,903	\$ 280,238		\$ 280,238	\$	\$ 4,017,174	70

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

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/05 Ending: 05/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,336,025	\$ 193,793	\$ 193,793	\$		\$ 1,421,590	71
72	Current Year Purchases	199,198						72
73	Fully Depreciated Assets							73
74	Home Office Depr			32,033	32,033			74
75	TOTALS	\$ 2,535,223	\$ 193,793	\$ 225,826	\$ 32,033		\$ 1,421,590	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residents	1995 Goshen GCH	1995	\$ 17,000	\$	\$	\$		\$ 17,000	76
77		Paratransit								77
78										78
79										79
80	TOTALS			\$ 17,000	\$	\$	\$		\$ 17,000	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,597,028	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 474,031	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 506,064	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,033	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,455,764	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 98,262 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elec. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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)	\$			

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	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	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	35 hrs	\$ 1,159	16,449	\$ 700,740	\$ 2,439	16,484	\$ 704,338	1
2	Licensed Speech and Language Development Therapist	10a	hrs		4,314	183,759	203	4,314	183,962	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		20,079	855,377	20,347	20,079	875,724	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				851,941		851,941	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): IV / X-ray & Lab	43, 3				100,707			100,707	13
14	TOTAL			\$ 1,159	40,842	\$ 1,840,583	\$ 874,930	40,877	\$ 2,716,672	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.

Facility Name & ID Number Manorcare at South Holland# 0033969Report Period Beginning: 06/01/05

Ending:

05/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/06

(last day of reporting year)

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	\$ (36,947)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (611,971))	4,051,896		3
4	Supply Inventory (priced at <u>03/31/06</u>)	46,538		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,898		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,066,385	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	929,902		13
14	Buildings, at Historical Cost	8,114,903		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,552,223		16
17	Accumulated Depreciation (book methods)	(5,455,764)		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):			22
23	Other(specify): <u>Construction In Progress</u>	2,094,069		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,235,333	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,301,718	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 178,596	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	348,445		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	548,722		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	345,660		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,421,423	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	(4,087)		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (4,087)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,417,336	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 10,884,382	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,301,718	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,605,136	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,605,136	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	4,385,754	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)	\$ 4,385,754	17
B. Transfers (Itemize):			
18	Change in Interdivision	(2,106,508)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,106,508)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,884,382	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning: 06/01/05

Ending: 05/31/06

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,480,400	1
2	Discounts and Allowances for all Levels	(905,789)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,574,611	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,658,218	6
7	Oxygen	247	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,658,465	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,664	12
13	Barber and Beauty Care	14,205	13
14	Non-Patient Meals	195	14
15	Telephone, Television and Radio	(22)	15
16	Rental of Facility Space		16
17	Sale of Drugs	835,821	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	94,496	19
20	Radiology and X-Ray	50,022	20
21	Other Medical Services		21
22	Laundry	823	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 998,204	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	Misc. Income	1,974	28
28a	Late Charges	275	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,249	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,233,529	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,452,382	31
32	Health Care	6,629,954	32
33	General Administration	3,265,957	33
B. Capital Expense			
34	Ownership	1,148,460	34
C. Ancillary Expense			
35	Special Cost Centers	1,246,997	35
36	Provider Participation Fee	104,025	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,847,775	40
41	Income before Income Taxes (line 30 minus line 40)**	4,385,754	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,385,754	43

* 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.

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	1,923	2,074	\$ 77,375	\$ 37.31	1
2	Assistant Director of Nursing	3,873	4,178	127,893	30.61	2
3	Registered Nurses	37,989	40,980	1,155,042	28.19	3
4	Licensed Practical Nurses	47,392	51,123	1,115,639	21.82	4
5	CNAs & Orderlies	123,044	132,897	1,318,091	9.92	5
6	CNA Trainees					6
7	Licensed Therapist	35	35	1,159	33.11	7
8	Rehab/Therapy Aides					8
9	Activity Director	7,982	8,634	112,797	13.06	9
10	Activity Assistants					10
11	Social Service Workers	7,541	8,210	143,246	17.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,888	33,444	388,465	11.62	15
16	Dishwashers					16
17	Maintenance Workers	3,392	3,665	64,017	17.47	17
18	Housekeepers	16,701	18,065	165,631	9.17	18
19	Laundry	7,323	7,917	62,037	7.84	19
20	Administrator	2,080	2,080	85,163	40.94	20
21	Assistant Administrator	1,265	1,265	31,615	24.99	21
22	Other Administrative	22,270	24,352	437,870	17.98	22
23	Office Manager					23
24	Clerical					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	4,145	4,488	53,429	11.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	317,843	343,407	\$ 5,339,469 *	\$ 15.55	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	18,950	9,3	36
37	Medical Records Consultant			10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,700	10,3	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) <u>Physician Care</u>	Monthly	12,000	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,650		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	49	\$ 2,727	10,3	50
51	Licensed Practical Nurses	36	1,516	10,3	51
52	Certified Nurse Assistants/Aides	764	32,182	10,3	52
53	TOTAL (lines 50 - 52)	849	\$ 36,425		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Tim Irwin (June 05 - April 06)	Administrator	0	\$ 85,163	Workers' Compensation Insurance	\$ 58,268	IDPH License Fee	\$ 5,077	
Bonnie Breese (May 06)	Interim Administrator	0	0	Unemployment Compensation Insurance	96,249	Advertising: Employee Recruitment	23,181	
Scott Hochstadt (Dec 05 -	Asst. Administrator	0	31,615	FICA Taxes	393,087	Health Care Worker Background Check		
				Employee Health Insurance	357,638	(Indicate # of checks performed <u>706</u>)	10,954	
Bonnie Breese's costs are included on Line 19 below				Employee Meals		Dues & Subscriptions	3,387	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues	10,742	
				Employee Appreciation	15,451	Advertising	43,180	
				401K	23,950	Public Relations	11,460	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 116,778	Other Employee Benefits	2,111			
(List each licensed administrator separately.)				Tuition Program	5,536	Less Non-allowable association Dues	(2,161)	
				SMSP Match	2,670	Less: Public Relations Expense	(11,460)	
				Employee Uniforms	3,909	Non-allowable advertising	(43,180)	
				Home Office Allocation	84,596	Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V,	\$ 51,180	
						line 20, col. 8)		
Description			Amount	E. Schedule of Non-Cash Compensation Paid		G. Schedule of Travel and Seminar**		
Management Fees			\$ 787,760	to Owners or Employees		Description	Amount	
				Description	Line #	Amount		
						\$		
							Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 787,760					
(Attach a copy of any management service agreement)							In-State Travel	10,283
							Includes travel expense to the Home	
							Office in Toledo, OH for regional meetings	
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount					
Foote, Meyers, Mielke & Flowers, LI	Legal Fees		\$ 48,473				Entertainment Expense	()
Physicians Dredit Bureau	Fees for Collections		1,579				(agree to Sch. V,	
Carol L Walters	Wound Care Consultant		21,505				line 24, col. 8)	
	Reclass to Line 10						TOTAL	\$ 10,283
Tobin, Merritt & Assoc.	Purch Svc Int Administrator		13,436					
	(Bonnie Breese)							
Legal fees were adjusted off on Schedule VI, Page 5, Line 22.								
Therefore, no legal invoices are attached.								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 84,993	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at South Holland

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 \$10742
- (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 \$2161
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 92,887 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? No
If YES, give effective date of lease. _____
- (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. \$ 104,025
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. \$ 195
- (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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.