

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 0027482

Facility Name: Manorcare at Hinsdale

Address: 600 West Ogden Avenue Hinsdale 60521
 Number City Zip Code

County: DuPage

Telephone Number: (630) 325-9630 **Fax #** (630) 325-9648

HFS ID Number: 520886946017

Date of Initial License for Current Owners: 11/01/81

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 06/01/06 to 05/31/07 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 Hinsdale

0027482 Report Period Beginning: 06/01/06 Ending: 05/31/07

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 08/24/06

	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>192</u>	Skilled (SNF)	<u>200</u>	<u>72,326</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>192</u>	TOTALS	<u>200</u>	<u>72,326</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>5,146</u>	<u>25,876</u>	<u>37,055</u>	<u>68,077</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>5,146</u>	<u>25,876</u>	<u>37,055</u>	<u>68,077</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.13%

D. How many bed-hold days during this year were paid by the Department? 459 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/81 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 198 and days of care provided 30,953

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 5/31/07

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

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/06 Ending: 05/31/07

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	551,835	46,037	421	598,293	7,001	605,294		605,294		1
2	Food Purchase		370,363		370,363		370,363	(445)	369,918		2
3	Housekeeping	248,332	39,241	1,954	289,527		289,527		289,527		3
4	Laundry	108,417	21,534	910	130,861		130,861		130,861		4
5	Heat and Other Utilities			266,497	266,497	13,337	279,834		279,834		5
6	Maintenance	85,553	44,539	166,260	296,352		296,352		296,352		6
7	Other (specify):* Medical Waste			917	917		917		917		7
8	TOTAL General Services	994,137	521,714	436,959	1,952,810	20,338	1,973,148	(445)	1,972,703		8
	B. Health Care and Programs										
9	Medical Director			58,900	58,900		58,900		58,900		9
10	Nursing and Medical Records	5,305,816	424,702	61,255	5,791,773	10,573	5,802,346		5,802,346		10
10a	Therapy	771,582	31,977	1,619,198	2,422,757		2,422,757	(44,695)	2,378,062		10a
11	Activities	147,126	4,851		151,977		151,977		151,977		11
12	Social Services	176,011	2,199		178,210		178,210		178,210		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,400,535	463,729	1,739,353	8,603,617	10,573	8,614,190	(44,695)	8,569,495		16
	C. General Administration										
17	Administrative	215,823		1,018,181	1,234,004	(371,213)	862,791		862,791		17
18	Directors Fees										18
19	Professional Services			42,164	42,164	(2,871)	39,293	(39,293)			19
20	Dues, Fees, Subscriptions & Promotions			112,096	112,096		112,096	(73,845)	38,251		20
21	Clerical & General Office Expenses	404,374	97,711	171,644	673,729		673,729	(116,182)	557,547		21
22	Employee Benefits & Payroll Taxes			1,342,682	1,342,682	98,341	1,441,023		1,441,023		22
23	Inservice Training & Education			5,733	5,733		5,733		5,733		23
24	Travel and Seminar			15,711	15,711		15,711		15,711		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			209,783	209,783		209,783		209,783		26
27	Other (specify):* Pers Purch - Admin			283	283		283	(6,122)	(5,839)		27
28	TOTAL General Administration	620,197	97,711	2,918,277	3,636,185	(275,743)	3,360,442	(235,442)	3,125,000		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,014,869	1,083,154	5,094,589	14,192,612	(244,832)	13,947,780	(280,582)	13,667,198		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 Hinsdale #0027482 Report Period Beginning: 06/01/06 Ending: 05/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	D. Ownership										
30	Depreciation			761,594	761,594	33,590	795,184	(103,140)	692,044		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			6,570	6,570	211,242	217,812		217,812		32
33	Real Estate Taxes			143,255	143,255		143,255		143,255		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			147,044	147,044		147,044		147,044		35
36	Other (specify):*										36
37	TOTAL Ownership			1,058,463	1,058,463	244,832	1,303,295	(103,140)	1,200,155		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		1,133,892	5,035	1,138,927		1,138,927		1,138,927		39
40	Barber and Beauty Shops			51,052	51,052		51,052		51,052		40
41	Coffee and Gift Shops	27,855			27,855		27,855		27,855		41
42	Provider Participation Fee			104,016	104,016		104,016		104,016		42
43	Other (specify):* IV Therpay/X-Ray/Lab		144,533	181,773	326,306		326,306		326,306		43
44	TOTAL Special Cost Centers	27,855	1,278,425	341,876	1,648,156		1,648,156		1,648,156		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,042,724	2,361,579	6,494,928	16,899,231		16,899,231	(383,722)	16,515,509		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 Hinsdale

0027482

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(445)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(39,244)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(103,140)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(3,823)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(697)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(6,122)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(22,666)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(39,293)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,170)	21		24
25	Fund Raising, Advertising and Promotional	(73,845)	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	(1,582)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (339,027)		\$	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)	(44,695)	10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (44,695)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (383,722)		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 Hinsdale

ID# 0027482
 Report Period Beginning: 06/01/06
 Ending: 05/31/07

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vrning Income	\$ (2,204)	21	1
2	Miscellaneous Income	622	21	2
3				3
4				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	(1,582)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Hinsdale

0027482

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	(445)	0	0	0	0	0	0	0	0	0	0	(445)	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	(445)	0	0	0	0	0	0	0	0	0	0	(445)	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	(44,695)	(44,695)	0	0	0	0	0	0	0	0	0	(89,390)	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	(44,695)	(44,695)	0	(89,390)	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	(39,293)	0	0	0	0	0	0	0	0	0	0	(39,293)	19
20	Fees, Subscriptions & Promotions	(73,845)	0	0	0	0	0	0	0	0	0	0	(73,845)	20
21	Clerical & General Office Expenses	(116,182)	0	0	0	0	0	0	0	0	0	0	(116,182)	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):*	(6,122)	0	0	0	0	0	0	0	0	0	0	(6,122)	27
28	TOTAL General Administration	(235,442)	0	0	0	0	0	0	0	0	0	0	(235,442)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(280,582)	(44,695)	0	(325,277)	29								

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Hinsdale

0027482

Report Period Beginning:

06/01/06 Ending:

Summary B

05/31/07

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	(103,140)	0	0	0	0	0	0	0	0	0	0	(103,140)	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	(103,140)	0	0	0	0	0	0	0	0	0	0	(103,140)	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)	(383,722)	(44,695)	0	(428,417)	45								

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	\$ 1,018,181	HCR Manor Care, Inc.	100.00%	\$ 1,018,181	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	71,311	Heartland Management Services	100.00%	71,311		6
7	V							7
8	V	10a Therapy PT, OT, & ST	1,489,806	Heartland Rehab Services	100.00%	1,445,111	(44,695)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,579,298			\$ 2,534,603	\$ * (44,695)	14

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

Facility Name & ID Number

Manorcare at Hinsdale

#

0027482

Report Period Beginning:

06/01/06

Ending:

05/31/07

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 Hinsdale

0027482

Report Period Beginning:

06/01/06

Ending: 05/31/07

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	2,604,994,312	369 Nurs. Fac.	\$ 0	\$ 0	15,903,935	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	1,156,548	625,878	15,903,935	5,690	2
3	5	Utilities - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	500,452	0	15,903,935	3,055	3
4	5	Utilities - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	2,089,736	0	15,903,935	10,282	4
5	10	Nursing - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	0	0	15,903,935	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	1,831,963	1,296,078	15,903,935	9,013	6
7	17	Gen & Admin - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	41,206,110	0	15,903,935	251,570	7
8	17	Gen & Admin - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	80,368,229	42,462,992	15,903,935	395,398	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	8,458,198	0	15,903,935	51,639	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	9,492,678	0	15,903,935	46,702	10
11	30	Depreciation - Direct	Accumulated Cost	2,604,994,312	369 Nurs. Fac.	0	0	15,903,935	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,232,621,368	369 Nurs. Fac.	6,827,559	0	15,903,935	33,590	12
13										13
14										14
15	32	Interest				4,662,634			211,242	15
16		Non-Nursing Home Allocations				22,389,200				16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 178,983,307	\$ 44,384,948		\$ 1,018,181	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		3	4	5	6		8	9	10						
		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	Facility			\$ 4,305,633	\$ 4,305,633		4.9062	\$ 211,242	1					
2	National City Bank		X	To fund fixed asset additions		4/2003	114,335	114,335		6.2448	7,140	2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8	Interest Income / Expense Other										(570)	8					
9	TOTAL Facility Related						\$ 4,419,968	\$ 4,419,968			\$ 217,812	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 4,419,968	\$ 4,419,968			\$ 217,812	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Hinsdale COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0027482

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 2006 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 2006.

(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>09-02-212-001</u>	<u>See Attached</u>	\$ <u>125,032.88</u>	\$ <u>125,032.88</u>
2. <u>09-02-212-006</u>	<u>See Attached</u>	\$ <u>12,148.48</u>	\$ <u>12,148.48</u>
3. <u>09-02-404-001</u>	<u>See Attached</u>	\$ <u>3,529.36</u>	\$ <u>3,529.36</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>140,710.72</u>	\$ <u>140,710.72</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Hinsdale

0027482 Report Period Beginning:

06/01/06 Ending:

05/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,479 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1981</u>	<u>\$ 1,358,110</u>	1
2					2
3	TOTALS			\$ 1,358,110	3

Facility Name & ID Number Manorcare at Hinsdale

0027482

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	100		1972		\$ 1,160,300	\$ 93,720		\$ 93,720		\$ 2,192,386	4
5	100			1980	1,913,000						5
6				2006	400,868						6
7											7
8											8
Improvement Type**											
9	Current Year Depreciation					362,773		362,773		3,342,096	9
10				1984	4,367						10
11				1985	6,383						11
12				1987	14,207						12
13				1988	22,849						13
14				1989	173,344						14
15				1990	114,281						15
16				1991	240,682						16
17				1992	111,750						17
18				1993	421,420						18
19				1994	145,930						19
20				1995	182,224						20
21				1996	326,618						21
22				1997	407,293						22
23				1998	392,286						23
24				1999	128,464						24
25				1999	(11,509)						25
26				2000	138,632						26
27				2001	142,009						27
28				2002	339,762						28
29		STEEL/METAL DOORS		2003	4,336						29
30		ROOF REPAIR		2003	1,084						30
31		ARCH AND ENGINEERING COSTS		2004	553						31
32		ELECTRICAL		2004	3,776						32
33		Arch and Engineering Costs		2004	42,165						33
34		General Construction Overhead Cost & Interest		2004	55,967						34
35		Flooring		2004	9,800						35
36		Carpeting		2004	11,210						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Hinsdale

0027482

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	Painting	2004	\$ 63,111	\$		\$	\$	\$	37
38	Wallcovering & Corner Guards	2004	5,782						38
39	Carpentry	2004	27,527						39
40	Electrical	2004	24,620						40
41	Roofing & Doors	2004	1,685						41
42	Fire Wall	2004	4,625						42
43	VWC & Paint	2004	2,092						43
44	Exterior Painting	2004	7,405						44
45	Flooring	2004	12,981						45
46	Air Separator	2004	9,942						46
47	Flooring	2005	113,382						47
48	Doors	2005	4,865						48
49	VWC	2005	1,474						49
50	Flooring	2005	9,070						50
51	Shower Door	2005	6,140						51
52	Painting, Wallcovering, & Base	2005	3,531						52
53	Install fire server cabinet & shelves	2005	3,700						53
54	Fire Alarm Panels	2005	10,265						54
55	Masonry Work	2005	3,875						55
56	Smoke Detectors	2005	1,160						56
57	Electrical Circuit for Smoke Detecor	2005	801						57
58	Wallcovering	2005	5,240						58
59	Electrical Work in 28 patient rooms	2005	2,284						59
60	Wallcovering	2005	1,233						60
61	Smoke Detectors	2005	2,685						61
62	Remodel Janitor Closet & Greenhouse	2005	4,800						62
63	Remodel Janitor Closet & Greenhouse	2006	4,799						63
64	Electrical Work for Elevator - Hookup shunt switch	2006	503						64
65	Phone Wiring	2006	7,231						65
66	Exhaust Fan	2006	2,272						66
67	Phone Wiring Additional Work	2006	1,605						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,254,736	\$ 456,493		\$ 456,493	\$	\$ 5,534,482	70

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

Facility Name & ID Number Manorcare at Hinsdale

0027482

Report Period Beginning:

06/01/06

Ending:

05/31/07

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	
1	Totals from Page 12A, Carried Forward		\$ 7,254,736	\$ 456,493		\$ 456,493	\$	\$ 5,534,482	1
2	Corner guards	2006	353						2
3	Engineering for conceptual site plan - parking lot, lighting, landscaping	2006	6,767						3
4	Drywall & Paint to rebuild plumbing walls in 6 resident rooms	2006	8,023						4
5	Plumbing - Replace 4 wall hydrants	2006	3,224						5
6	Overhead & Interest on HVAC Project	2006	1,344						6
7	HVAC - 35 ton roof unit & related electrical work	2006	61,639						7
8	Overhead & Interest on addition/renovation project	2006	157,013						8
9	Addition/Renov. - Architect & Engineering	2006	71,504						9
10	Addition/Renov. - Permit fees, plan reviews, consultant misc.	2006	16,591						10
11	Addition/Renov. - Drywall canopies on 41 light fixtures	2006	1,017						11
12	Addition/Renov. - Ceil Tile & Paint Grid	2006	4,365						12
13	Addition/Renov. - Flooring	2006	5,147						13
14	Addition/Renov. - Wall Covering & Corner Guards	2006	17,428						14
15	Addition/Renov. - Fire Sprinkler System	2006	84,188						15
16	Addition/Renov. - Plumbing	2006	4,895						16
17	Addition/Renov. - HVAC	2006	2,594						17
18	Addition/Renov. - Electrical	2006	11,569						18
19	Addition/Renov. - Site Preparation	2006	39,350						19
20	Addition/Renov. - Fencing	2006	1,637						20
21	Addition/Renov. - Landscaping block, trees, plants, etc.	2006	112,980						21
22	Electrical - Parking lot lights	2006	2,413						22
23	Roof Termination Strip	2006	967						23
24	Electrical work	2006	2,215						24
25	Patio with raised seating area	2006	24,113						25
26	Concrete curbs & pavement for new parking spaces	2006	28,645						26
27	Electrical - Parking lot lights	2006	13,005						27
28	Lawn sprinler system	2006	9,800						28
29	Carpet	2007	10,314						29
30	Remodel Shower Room - Tile, Sink, Faucets, Paint	2007	15,820						30
31	Flooring in Corridors	2007	11,448						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,985,104	\$ 456,493		\$ 456,493	\$	\$ 5,534,482	34

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

Facility Name & ID Number Manorcare at Hinsdale # 0027482 Report Period Beginning: 06/01/06 Ending: 05/31/07

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	\$ 2,630,459	\$ 201,961	\$ 201,961	\$		\$ 1,784,773	71
72	Current Year Purchases	218,881						72
73	Fully Depreciated Assets							73
74				33,590	33,590			74
75	TOTALS	\$ 2,849,340	\$ 201,961	\$ 235,551	\$ 33,590		\$ 1,784,773	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 12,192,554	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 658,454	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 692,044	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 33,590	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 7,319,255	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	STEP-UP BUILDING	\$ 3,713,060	\$ 103,140	\$ 2,638,679	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,713,060	\$ 103,140	\$ 2,638,679	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.

Facility Name & ID Number Manorcare at Hinsdale

0027482

Report Period Beginning: 06/01/06

Ending: 05/31/07

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 146,324

Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. 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	<u>Patient Transportation</u>		\$ _____	\$ <u>720</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>720</u>	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	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8	
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
1	Licensed Occupational Therapist	10a	4911 hrs	\$ 184,917	11,386	\$ 608,026	\$ 9,183	16,297	\$ 802,126	1			
2	Licensed Speech and Language Development Therapist	10a	1256 hrs	47,326	2,453	130,965	527	3,709	178,818	2			
3	Licensed Recreational Therapist		hrs							3			
4	Licensed Physical Therapist	10a	5379 hrs	205,109	15,022	802,170	22,267	20,401	1,029,546	4			
5	Physician Care		visits							5			
6	Dental Care		visits							6			
7	Work Related Program		hrs							7			
8	Habilitation		hrs							8			
9	Pharmacy	39,2	# of prescrpts				1,133,892		1,133,892	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10			
11	Academic Education		hrs							11			
12	Exceptional Care Program									12			
13	Other (specify): PS-Dentist/X-Ray/Lab	43, 3				186,808	144,533		331,341	13			
14	TOTAL			\$ 437,352	28,861	\$ 1,727,969	\$ 1,310,402	40,407	\$ 3,475,723	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 Hinsdale# 0027482Report Period Beginning: 06/01/06

Ending:

05/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/07

(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	\$ 39,186	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (120,523))	3,519,408		3
4	Supply Inventory (priced at <u>3/31/07</u>)	73,787		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,127		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,637,508	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,358,110		13
14	Buildings, at Historical Cost	11,698,164		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,849,340		16
17	Accumulated Depreciation (book methods)	(9,957,934)		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>	40,855		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,988,535	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,626,043	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 128,874	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	815,926		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	130,157		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>	253,715		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,328,672	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	114,335		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	221,071		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 335,406	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,664,078	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 7,961,965	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,626,043	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,895,523	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,895,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,811,932	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)	\$ 5,811,932	17
	B. Transfers (Itemize):		
18	Changes in Interdivision	(5,745,490)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (5,745,490)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,961,965	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Hinsdale

0027482

Report Period Beginning: 06/01/06

Ending: 05/31/07

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	\$ 16,407,851	1
2	Discounts and Allowances for all Levels	(1,653,766)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,754,085	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,303,062	6
7	Oxygen	99,403	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,402,465	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	8,326	12
13	Barber and Beauty Care	58,126	13
14	Non-Patient Meals	445	14
15	Telephone, Television and Radio	39,244	15
16	Rental of Facility Space	15	16
17	Sale of Drugs	1,200,338	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	144,862	19
20	Radiology and X-Ray	71,477	20
21	Other Medical Services	14,821	21
22	Laundry	18,778	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,556,432	23
D. Non-Operating Revenue			
24	Contributions	2,550	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,550	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income & Purchase Discount	(4,445)	28
28a	Late Charges	76	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,369)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 22,711,163	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,952,810	31
32	Health Care	8,603,617	32
33	General Administration	3,636,185	33
B. Capital Expense			
34	Ownership	1,058,463	34
C. Ancillary Expense			
35	Special Cost Centers	1,544,140	35
36	Provider Participation Fee	104,016	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,899,231	40
41	Income before Income Taxes (line 30 minus line 40)**	5,811,932	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,811,932	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 Hinsdale

0027482

Report Period Beginning:

06/01/06

Ending:

05/31/07

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,029	2,197	\$ 83,534	\$ 38.02	1
2	Assistant Director of Nursing	2,038	2,207	79,572	36.05	2
3	Registered Nurses	52,665	57,033	1,740,750	30.52	3
4	Licensed Practical Nurses	49,120	53,194	1,277,153	24.01	4
5	CNAs & Orderlies	148,891	161,502	2,097,894	12.99	5
6	CNA Trainees					6
7	Licensed Therapist	11,533	12,573	494,005	39.29	7
8	Rehab/Therapy Aides	9,654	10,525	248,133	23.58	8
9	Activity Director	12,295	13,344	147,126	11.03	9
10	Activity Assistants					10
11	Social Service Workers	7,719	8,380	176,011	21.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,102	45,687	551,835	12.08	15
16	Dishwashers					16
17	Maintenance Workers	3,985	4,327	85,553	19.77	17
18	Housekeepers	23,328	25,328	248,332	9.80	18
19	Laundry	11,184	12,140	108,417	8.93	19
20	Administrator	2,080	2,080	142,382	68.45	20
21	Assistant Administrator	1,804	1,804	73,441	40.71	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,735	21,417	404,374	18.88	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	3,424	3,717	56,357	15.16	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,935	2,101	27,855	13.26	33
34	TOTAL (lines 1 - 33)	404,521	439,556	\$ 8,042,724 *	\$ 18.30	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	58,900	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	11,357	10, 3	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)		\$ 70,257		49

C. CONTRACT NURSES

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICHA \$4,639
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes \$3757
- (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. \$ 114,152 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. \$ 104,016
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. \$ 445
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.