

Facility Name & ID Number Manorcare at South Holland

0033969 Report Period Beginning: 06/01/07 Ending: 05/31/08

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 9/1/07

	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>200</u>	<u>73,200</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>200</u>	<u>73,200</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>17,251</u>	<u>6,055</u>	<u>37,484</u>	<u>60,790</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>17,251</u>	<u>6,055</u>	<u>37,484</u>	<u>60,790</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.05%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 200 and days of care provided 31,349

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 Fiscal Year: 5/31

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

Facility Name & ID Number Manorcare at South Holland # 0033969 Report Period Beginning: 06/01/07 Ending: 05/31/08

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	442,616	35,927	3,463	482,006	5,256	487,262		487,262		1
2	Food Purchase		305,607		305,607		305,607	(440)	305,167		2
3	Housekeeping		27,649	208,113	235,762		235,762		235,762		3
4	Laundry		25,643	134,492	160,135		160,135		160,135		4
5	Heat and Other Utilities			275,885	275,885	12,054	287,939		287,939		5
6	Maintenance	66,781	36,639	238,479	341,899		341,899		341,899		6
7	Other (specify):* Medical Waste			1,675	1,675		1,675		1,675		7
8	TOTAL General Services	509,397	431,465	862,107	1,802,969	17,310	1,820,279	(440)	1,819,839		8
	B. Health Care and Programs										
9	Medical Director			23,000	23,000		23,000		23,000		9
10	Nursing and Medical Records	4,610,621	552,652	251,134	5,414,407	9,743	5,424,150		5,424,150		10
10a	Therapy	1,677,727	35,235	188,805	1,901,767		1,901,767		1,901,767		10a
11	Activities	72,318	8,016	4,067	84,401		84,401		84,401		11
12	Social Services	209,990	46		210,036		210,036		210,036		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,570,656	595,949	467,006	7,633,611	9,743	7,643,354		7,643,354		16
	C. General Administration										
17	Administrative	139,526		934,246	1,073,772	(230,558)	843,214		843,214		17
18	Directors Fees										18
19	Professional Services			131,457	131,457		131,457	(86,391)	45,066		19
20	Dues, Fees, Subscriptions & Promotions			104,827	104,827		104,827	(26,330)	78,497		20
21	Clerical & General Office Expenses	652,465	81,729	517,842	1,252,036		1,252,036	(136,547)	1,115,489		21
22	Employee Benefits & Payroll Taxes			1,247,908	1,247,908	123,231	1,371,139	918	1,372,057		22
23	Inservice Training & Education			5,166	5,166		5,166		5,166		23
24	Travel and Seminar			24,293	24,293		24,293		24,293		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			291,869	291,869		291,869		291,869		26
27	Other (specify):*							(3)	(3)		27
28	TOTAL General Administration	791,991	81,729	3,257,608	4,131,328	(107,327)	4,024,001	(248,353)	3,775,648		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,872,044	1,109,143	4,586,721	13,567,908	(80,274)	13,487,634	(248,793)	13,238,841		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: 06/01/07 Ending: 05/31/08

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			623,545	623,545	37,131	660,676	660,676			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(5,398)	(5,398)	43,143	37,745	37,745			32
33	Real Estate Taxes			659,325	659,325		659,325	20,207	679,532		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			82,208	82,208		82,208	82,208			35
36	Other (specify):*										36
37	TOTAL Ownership			1,359,680	1,359,680	80,274	1,439,954	20,207	1,460,161		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			379	379		379	379			38
39	Ancillary Service Centers		1,180,049		1,180,049		1,180,049	1,180,049			39
40	Barber and Beauty Shops			7,533	7,533		7,533	7,533			40
41	Coffee and Gift Shops	28,081			28,081		28,081	28,081			41
42	Provider Participation Fee			109,035	109,035		109,035	109,035			42
43	Other (specify):* IV Ther/Xray/Lab		285,054	159,170	444,224		444,224	444,224			43
44	TOTAL Special Cost Centers	28,081	1,465,103	276,117	1,769,301		1,769,301	1,769,301			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,900,125	2,574,246	6,222,518	16,696,889		16,696,889	(228,586)	16,468,303		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: 06/01/07

Ending: 05/31/08

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	(440)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(285)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(121)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(59)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(86,391)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(133,973)	21		24
25	Fund Raising, Advertising and Promotional	(26,330)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	20,207	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,191)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (228,586)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (228,586)		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: 06/01/07

Ending: 05/31/08

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Vending Income	\$ (2,109)	21
2	Employee Benefits Adj	918	22
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	(1,191)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/07

Ending:

05/31/08

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	(440)	0	0	0	0	0	0	0	0	0	0	(440)	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	(440)	0	0	0	0	0	0	0	0	0	0	(440)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(86,391)	0	0	0	0	0	0	0	0	0	0	(86,391)	19
20	Fees, Subscriptions & Promotions	(26,330)	0	0	0	0	0	0	0	0	0	0	(26,330)	20
21	Clerical & General Office Expenses	(136,547)	0	0	0	0	0	0	0	0	0	0	(136,547)	21
22	Employee Benefits & Payroll Taxes	918	0	0	0	0	0	0	0	0	0	0	918	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):*	(3)	0	0	0	0	0	0	0	0	0	0	(3)	27
28	TOTAL General Administration	(248,353)	0	0	0	0	0	0	0	0	0	0	(248,353)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(248,793)	0	0	0	0	0	0	0	0	0	0	(248,793)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

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Summary B

05/31/08

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

	Capital Expense	PAGES	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	20,207	0	0	0	0	0	0	0	0	0	0	20,207	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	20,207	0	20,207	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)	(228,586)	0	(228,586)	45									

Facility Name & ID Number Manorcare at South Holland

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Report Period Beginning:

06/01/07

Ending:

05/31/08

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	\$ 934,246	HCR Manor Care, Inc.	100.00%	\$ 934,246	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V	10a Therapy Management	87,791	Heartland Management Services	100.00%	87,791		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,022,037			\$ 1,022,037	\$ *	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: 06/01/07 Ending: 05/31/08

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:

06/01/07

Ending: 05/31/08

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 Street
 City / State / Zip Code Toledo, OH 43604-2617
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	369 Nurs. Facs.	\$ 59,848	\$ 333	15,636,680	\$ 333	1
2	1	Dietary - Pooled	Accumulated Cost	369 Nurs. Facs.	1,061,370	4,923	15,636,680	4,923	2
3	5	Utilities - Direct	Accumulated Cost	369 Nurs. Facs.	497,772	2,766	15,636,680	2,766	3
4	5	Utilities - Pooled	Accumulated Cost	369 Nurs. Facs.	2,002,556	9,288	15,636,680	9,288	4
5	10	Nursing - Direct	Accumulated Cost	369 Nurs. Facs.	0	0	15,636,680	0	5
6	10	Nursing - Pooled	Accumulated Cost	369 Nurs. Facs.	2,100,636	9,743	15,636,680	9,743	6
7	17	Gen & Admin - Direct	Accumulated Cost	369 Nurs. Facs.	41,222,846	229,091	15,636,680	229,091	7
8	17	Gen & Admin - Pooled	Accumulated Cost	369 Nurs. Facs.	102,324,370	474,597	15,636,680	474,597	8
9	22	Employee Benefits - Direct	Accumulated Cost	369 Nurs. Facs.	7,830,100	43,515	15,636,680	43,515	9
10	22	Employee Benefits - Pooled	Accumulated Cost	369 Nurs. Facs.	17,187,062	79,716	15,636,680	79,716	10
11	30	Depreciation - Direct	Accumulated Cost	369 Nurs. Facs.	0	0	15,636,680	0	11
12	30	Depreciation - Pooled	Accumulated Cost	369 Nurs. Facs.	8,005,430	37,131	15,636,680	37,131	12
13									13
14		Interest			3,167,921			43,143	14
15		Non-Nursing Home Allocations			23,250,237				15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 208,710,148	\$ 891,103		\$ 934,246	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			\$ 1,399,326	\$ 1,399,326		3.0831	\$ 43,143	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8	Interest Income										(5,398)	8					
9	TOTAL Facility Related						\$ 1,399,326	\$ 1,399,326			\$ 37,745	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			\$ 37,745	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<u>590,082</u>	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.)		\$	<u>636,512</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>46,430</u>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>650,575</u>	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.)		\$	<u>8,750</u>	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 \$ <u>26,223</u> For <u>2004</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	<u>(26,223)</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>679,532</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<u>543,845</u>	<u>8</u>	
	2004	<u>567,544</u>	<u>9</u>	
	2005	<u>584,206</u>	<u>10</u>	
	2006	<u>619,077</u>	<u>11</u>	
	2007	<u>650,575</u>	<u>12</u>	
<u>Line 2: \$636,512 = \$309,538 for 1st half of 2007 + \$326,974 for 2nd half of 2006</u>				
<u>Line 4: \$650,575 = \$309,539 for Jan - June 2008 + \$341,037 for 2nd half 2007</u>				
<u>Line 5: Worsek & Vihon invoice for 2004 Real Estate Tax Appeal</u>				
<u>Line 6: 2004 Specific Objection Refund</u>				
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>650,575.30</u>	\$ <u>650,575.30</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>650,575.30</u>	\$ <u>650,575.30</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

06/01/07 Ending:

05/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/07

Ending:

05/31/08

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	\$ 184,881		\$ 184,881		\$ 2,773,665	4
5	60			1991	1,912,803						5
6	10			1997	1,054,638						6
7				2006	1,222,040						7
8											8
Improvement Type**											
9	Current Year Depreciation					205,484		205,484		2,038,447	9
10				1988	112,623						10
11				1989	36,052						11
12				1990	6,131						12
13				1991	255,298						13
14				1992	192,798						14
15				1993	108,676						15
16				1994	85,519						16
17				1995	50,587						17
18				1996	231,349						18
19				1997	120,584						19
20				1998	237,026						20
21				1999	8,872						21
22				2000	53,921						22
23				2001	103,358						23
24		Birch Doors & Shower Floors		2002	4,644						24
25		Eletrical Work		2002	5,390						25
26		Paint, Wallcovering & Borders		2002	3,884						26
27		General Construction		2002	11,200						27
28		Floor Tile for Break Room		2002	2,794						28
29		Roofing		2003	12,928						29
30		Carpet		2003	382						30
31		Carpet/Flooring & Base		2003	18,216						31
32		Wallcovering & Border		2003	13,718						32
33		Renovation to Vending Machine Room		2003	5,794						33
34		Roofing		2003	1,010						34
35		Concrete		2003	2,050						35
36				2003	3,033						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning:

06/01/07

Ending:

05/31/08

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	renov - flooring/carpeting/wallcovering	2006	41,695						60
61	renov - carpentry-subcontr	2006	14,549						61
62	renov - HM doors & frames	2006	2,456						62
63	door alarms	2006	8,525						63
64	VCT	2006	4,050						64
65	condensing unit	2006	4,175						65
66	carpet	2006	10,901						66
67	hollow door	2006	2,288						67
68	shower door	2006	724						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,426,306	\$ 390,365		\$ 390,365	\$	\$ 4,812,112	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:

06/01/07

Ending:

05/31/08

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		\$ 9,426,306	\$ 390,365		\$ 390,365	\$	\$ 4,812,112	1
2	exhaust system	2006	4,400						2
3	door	2006	2,288						3
4	addition - architecture/engineering costs/permit fees	2006	404,618						4
5	addition - carpet / wallcovering	2006	33,532						5
6	addition - millwork & sprinklers	2006	36,507						6
7	ac unit	2006	5,100						7
8	1 birch door for therapy	2006	1,288						8
9	addition - general contr - site prep	2006	147,406						9
10	addition - engineering inspection	2006	4,041						10
11	paving	2006	2,650						11
12	electrical	2008	10,940						12
13	corridor electrical	2008	15,823						13
14	replacement roof	2008	163,410						14
15	wallcovering	2008	50,522						15
16	fence	2007	26,375						16
17	concrete patio & sidewalk	2007	16,296						17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,351,501	\$ 390,365		\$ 390,365	\$	\$ 4,812,112	34

**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: 06/01/07 Ending: 05/31/08

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	\$ 2,891,487	\$ 233,180	\$ 233,180	\$		\$ 1,889,100	71
72	Current Year Purchases	80,287						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			37,131	37,131			74
75	TOTALS	\$ 2,971,774	\$ 233,180	\$ 270,311	\$ 37,131		\$ 1,889,100	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 GHC		\$ 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)	\$ 14,270,177	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 623,545	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 660,676	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 37,131	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,718,212	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.

Facility Name & ID Number Manorcare at South Holland

0033969

Report Period Beginning: 06/01/07

Ending: 05/31/08

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 82,208 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	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	7596 hrs	\$ 275,603		\$	\$ 1,309	7,596	\$ 276,912	1			
2	Licensed Speech and Language Development Therapist	10a	3720 hrs	135,002	512	25,804	213	4,232	161,019	2			
3	Licensed Recreational Therapist		hrs							3			
4	Licensed Physical Therapist	10a	11795 hrs	427,937	1,236	62,275	33,713	13,031	523,925	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				1,180,049		1,180,049	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10			
11	Academic Education		hrs							11			
12	Other (specify):									12			
13	Other (specify): <u>IV/X-Ray/Lab</u>	43, 3					285,054		285,054	13			
14	TOTAL			\$ 838,542	1,748	\$ 88,079	\$ 1,500,338	24,859	\$ 2,426,959	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: 06/01/07Ending: 05/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/08

(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	\$ 293,466	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (661,251))	3,360,413		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,114		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,659,993	\$	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	10,351,501		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,988,774		16
17	Accumulated Depreciation (book methods)	(6,718,212)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,551,965	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,211,958	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 134,963	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	554,346		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	650,575		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>	313,201		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,653,085	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1,900		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,900	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,654,985	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 9,556,973	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,211,958	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,229,335	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,229,335	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	3,149,111	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)	\$ 3,149,111	17
B. Transfers (Itemize):			
18	Change in Interdivision	(3,821,473)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3,821,473)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,556,973	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at South Holland# 0033969Report Period Beginning: 06/01/07Ending: 05/31/08**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	\$ 15,410,871	1
2	Discounts and Allowances for all Levels	(3,299,506)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,111,365	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,182,503	6
7	Oxygen	66,846	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,249,349	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	2,112	12
13	Barber and Beauty Care	9,765	13
14	Non-Patient Meals	440	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,234,747	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	126,534	19
20	Radiology and X-Ray	110,133	20
21	Other Medical Services	84	21
22	Laundry	1,186	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,485,001	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Discount</u>	285	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 285	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,846,000	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,802,969	31
32	Health Care	7,633,611	32
33	General Administration	4,131,328	33
B. Capital Expense			
34	Ownership	1,359,680	34
C. Ancillary Expense			
35	Special Cost Centers	1,660,266	35
36	Provider Participation Fee	109,035	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,696,889	40
41	Income before Income Taxes (line 30 minus line 40)**	3,149,111	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,149,111	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:

06/01/07

Ending:

05/31/08

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	1,633	1,763	\$ 72,892	\$ 41.35	1
2	Assistant Director of Nursing	3,912	4,224	138,192	32.72	2
3	Registered Nurses	46,875	50,616	1,623,206	32.07	3
4	Licensed Practical Nurses	50,302	54,317	1,349,361	24.84	4
5	CNAs & Orderlies	121,422	131,308	1,365,983	10.40	5
6	CNA Trainees					6
7	Licensed Therapist	23,111	24,992	906,790	36.28	7
8	Rehab/Therapy Aides	28,888	31,239	771,622	24.70	8
9	Activity Director	5,697	6,165	72,318	11.73	9
10	Activity Assistants					10
11	Social Service Workers	8,967	9,753	209,990	21.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,823	34,400	442,616	12.87	15
16	Dishwashers					16
17	Maintenance Workers	3,650	3,948	66,781	16.92	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	106,133	51.03	20
21	Assistant Administrator	1,244	1,244	33,393	26.84	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	34,297	36,912	652,465	17.68	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	4,571	4,951	60,302	12.18	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,917	2,072	28,081	13.55	33
34	TOTAL (lines 1 - 33)	370,389	399,984	\$ 7,900,125 *	\$ 19.75	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	23,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,144	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	3,000	10, 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,144		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,644	\$ 110,525	10, 3	50
51	Licensed Practical Nurses	567	23,312	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,211	\$ 133,837		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 \$15,864
- (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 \$5074
- (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. \$ 97,819 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. \$ 109,035
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. \$ 440
- (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.