

Facility Name & ID Number Manorcare of Hinsdale

0049445 Report Period Beginning: 06/01/08 Ending: 05/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,000	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	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	5,026	16,028	44,195	65,249	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,026	16,028	44,195	65,249	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.38%

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)

Adult Day Care

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 200 and days of care provided 36,543

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: 05/31

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

Facility Name & ID Number Manorcare of Hinsdale # 0049445 Report Period Beginning: 06/01/08 Ending: 05/31/09

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	633,154	36,239	2,154	671,547	6,082	677,629		677,629		1
2	Food Purchase		435,347		435,347		435,347	(26,465)	408,882		2
3	Housekeeping	291,681	42,010	4,910	338,601		338,601		338,601		3
4	Laundry	74,351	34,904	988	110,243		110,243	(11,902)	98,341		4
5	Heat and Other Utilities			408,929	408,929	11,529	420,458		420,458		5
6	Maintenance	85,040	37,187	186,993	309,220		309,220		309,220		6
7	Other (specify):* Medical Waste			1,221	1,221		1,221		1,221		7
8	TOTAL General Services	1,084,226	585,687	605,195	2,275,108	17,611	2,292,719	(38,367)	2,254,352		8
	B. Health Care and Programs										
9	Medical Director			41,800	41,800		41,800		41,800		9
10	Nursing and Medical Records	5,841,839	555,245	92,822	6,489,906	9,751	6,499,657	(28,223)	6,471,434		10
10a	Therapy	2,553,119	39,064	484,291	3,076,474		3,076,474		3,076,474		10a
11	Activities	156,056	8,589	3,073	167,718		167,718		167,718		11
12	Social Services	206,215			206,215		206,215		206,215		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	8,757,229	602,898	621,986	9,982,113	9,751	9,991,864	(28,223)	9,963,641		16
	C. General Administration										
17	Administrative	160,455		1,074,637	1,235,092	(384,062)	851,030		851,030		17
18	Directors Fees										18
19	Professional Services			249,533	249,533		249,533	(249,533)			19
20	Dues, Fees, Subscriptions & Promotions			126,968	126,968		126,968	(49,000)	77,968		20
21	Clerical & General Office Expenses	615,473	105,598	674,558	1,395,629		1,395,629	(479,675)	915,954		21
22	Employee Benefits & Payroll Taxes			1,872,718	1,872,718	102,227	1,974,945		1,974,945		22
23	Inservice Training & Education			6,694	6,694		6,694		6,694		23
24	Travel and Seminar			17,180	17,180		17,180		17,180		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			325,509	325,509		325,509		325,509		26
27	Other (specify):*							(33,426)	(33,426)		27
28	TOTAL General Administration	775,928	105,598	4,347,797	5,229,323	(281,835)	4,947,488	(811,634)	4,135,854		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,617,383	1,294,183	5,574,978	17,486,544	(254,473)	17,232,071	(878,224)	16,353,847		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 of Hinsdale

#0049445

Report Period Beginning:

06/01/08

Ending:

05/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			713,810	713,810	31,472	745,282	(103,140)	642,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,648)	(1,648)	223,001	221,353		221,353			32
33	Real Estate Taxes			143,820	143,820		143,820		143,820			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			254,121	254,121		254,121		254,121			35
36	Other (specify):*											36
37	TOTAL Ownership			1,110,103	1,110,103	254,473	1,364,576	(103,140)	1,261,436			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,379,281	688	1,379,969		1,379,969		1,379,969			39
40	Barber and Beauty Shops			48,774	48,774		48,774		48,774			40
41	Coffee and Gift Shops	11,588			11,588		11,588		11,588			41
42	Provider Participation Fee			110,172	110,172		110,172		110,172			42
43	Other (specify):* IV X-Ray & Lab		250,250	204,265	454,515		454,515		454,515			43
44	TOTAL Special Cost Centers	11,588	1,629,531	363,899	2,005,018		2,005,018		2,005,018			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,628,971	2,923,714	7,048,980	20,601,665		20,601,665	(981,364)	19,620,301			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (28,223)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(26,465)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,996)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(11,902)	4		8
9	Non-Straightline Depreciation	(103,140)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(529)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(33,426)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(249,533)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(465,725)	21		24
25	Fund Raising, Advertising and Promotional	(49,000)	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	(1,419)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (981,364)		\$	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)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (981,364)		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						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 of Hinsdale

ID# 0049445

Report Period Beginning: 06/01/08

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,419)	21	1
2				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	(1,419)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(26,465)	0	0	0	0	0	0	0	0	0	0	(26,465)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(11,902)	0	0	0	0	0	0	0	0	0	0	(11,902)	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	(38,367)	0	(38,367)	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	(28,223)	0	0	0	0	0	0	0	0	0	0	(28,223)	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	(28,223)	0	(28,223)	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	(249,533)	0	0	0	0	0	0	0	0	0	0	(249,533)	19
20	Fees, Subscriptions & Promotions	(49,000)	0	0	0	0	0	0	0	0	0	0	(49,000)	20
21	Clerical & General Office Expenses	(479,675)	0	0	0	0	0	0	0	0	0	0	(479,675)	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):*	(33,426)	0	0	0	0	0	0	0	0	0	0	(33,426)	27
28	TOTAL General Administration	(811,634)	0	(811,634)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(878,224)	0	(878,224)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

	Capital Expense	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)	
	D. Ownership													
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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(981,364)	0	0	0	0	0	0	0	0	0	0	(981,364)	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
HCR 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						
2	V	Page						
3	V	8						
4	V							
5	V							
6	V	10a						
		Therapy Management	103,809	Heartland Rehab Services, LLC	100.00%	103,809		
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 1,176,779			\$ 1,176,779	\$ *	

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

Facility Name & ID Number

Manorcare of Hinsdale

#

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VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/08

Ending: 05/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization HCR Manor Care, 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

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	2,759,273,494	369 Nurs. Fac.	\$ 1,686	\$ 17,974,720	\$ 11	1	
2	1	Dietary - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,103,816	559,529	17,974,720	6,071	2
3	5	Utilities - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	287,502		17,974,720	1,873	3
4	5	Utilities - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,755,769		17,974,720	9,656	4
5	10	Nursing - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.			17,974,720	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,773,058	1,106,606	17,974,720	9,751	6
7	17	General & Admin - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	30,646,209		17,974,720	199,638	7
8	17	General & Admin - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	88,964,011	51,489,483	17,974,720	489,270	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	6,188,752		17,974,720	40,315	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	11,257,416		17,974,720	61,912	10
11	30	Depreciation - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.			17,974,720	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	5,722,441		17,974,720	31,472	12
13										13
14	32	Interest				10,928,075			223,001	14
15		Non-Nursing Home Allocations				28,224,463				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 186,853,198	\$ 53,155,618		\$ 1,072,970	25

Facility Name & ID Number

Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/08

Ending:

05/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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		5.0453	\$ 217,232	1						
2	National City Bank		X	To fund fixed asset additions				114,335	114,335		5.0457	5,769	2						
3													3						
4													4						
5													5						
Working Capital																			
6													6						
7													7						
8	Interest Income Other											(1,648)	8						
9	TOTAL Facility Related						\$ 4,419,968	\$ 4,419,968				\$ 221,353	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				\$ 221,353	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.)

Facility Name & ID Number Manorcare of Hinsdale

0049445 Report Period Beginning:

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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).

None

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Manorcare of Hinsdale

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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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100		1972		\$ 1,160,300	\$ 100,306		\$ 100,306	\$	\$ 2,383,139	4
5	100			1980	1,913,000						5
6				2006	400,868						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					286,531		286,531		3,955,361	9
10				1984	4,367						10
11				1985	6,383						11
12				1987	14,207						12
13				1988	22,849						13
14				1989	173,344						14
15				1990	114,281						15
16				1991	240,682						16
17				1992	111,750						17
18				1993	421,420						18
19				1994	145,930						19
20				1995	182,224						20
21				1996	326,618						21
22				1997	407,293						22
23				1998	392,286						23
24				1999	128,464						24
25				1999	(11,509)						25
26				2000	138,632						26
27				2001	142,009						27
28				2002	339,762						28
29		STEEL/METAL DOORS		2003	4,336						29
30		ROOF REPAIR		2003	1,084						30
31		ARCH AND ENGINEERING COSTS		2004	553						31
32		ELECTRICAL		2004	3,776						32
33		Arch and Engineering Costs		2004	42,165						33
34		General Construction Overhead Cost & Interest		2004	55,967						34
35		Flooring		2004	9,800						35
36		Carpeting		2004	11,210						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

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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	\$ 386,837		\$ 386,837	\$	\$ 6,338,500	70

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

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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	\$ 386,837		\$ 386,837	\$	\$ 6,338,500	1
2	Corner guards	2006	353						2
3	Engineering for conceptual site plan - parking lot, lighting, lanscap	2006	6,767						3
4	Drywall & Paint to rebuild plumbing walls in 6 resident rooms	2006	8,023						4
5	Plumbing - Replace 4 wall hydrants	2006	3,224						5
6	Overhead & Interest on HVAC Project	2006	1,344						6
7	HVAC - 35 ton roof unit & related electrical work	2006	61,639						7
8	Overhead & Interest on addition/renovation project	2006	157,013						8
9	Addition/Renov. - Architect & Engineering	2006	71,504						9
10	Addition/Renov. - Permit fees, plan 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. - Lanscaping block, trees, plants, etc.	2006	112,980						21
22	Electrical - Parking lot lights	2006	2,413						22
23	Roof Termination Strip	2006	967						23
24	Electrical work	2006	2,215						24
25	Patio with raised seating area	2006	24,113						25
26	Concrete curbs & pavement for new parking spaces	2006	28,645						26
27	Electrical - Parking lot lights	2006	13,005						27
28	Lawn sprinler system	2006	9,800						28
29	Carpet	2007	10,314						29
30	Remodel Shower Room - Tile, Sink, Faucets, Paint	2007	15,820						30
31	Flooring in Corridors	2007	11,448						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,985,104	\$ 386,837		\$ 386,837	\$	\$ 6,338,500	34

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

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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 12B, Carried Forward		\$ 7,985,104	\$ 386,837		\$ 386,837	\$	\$ 6,338,500	1
2	Electrical at nurses station	2007	2,538						2
3	Windows (9)	2007	14,245						3
4	Drainage	2007	17,001						4
5	Wallcovering	2007	15,483						5
6	Electrical for pill dispenser	2007	1,773						6
7	Elevator Upgrade	2007	4,370						7
8	Piping in laundry room	2007	1,700						8
9	Parking lot paving	2007	9,900						9
10	Curbing in Parking lot	2007	2,550						10
11	Paving	2007	8,016						11
12	Sidewalk & Railing	2007	36,550						12
13									13
14	Roofing over generator - Wate Tight Membrane	2008	16,314						14
15	Renov. - Vinyl Flooring	2008	37,310						15
16	ELEVATOR SWITCHES	2008	4,370						16
17	20 AMP CIRCUIT	2008	2,250						17
18	AC ELECTRICAL	2008	9,505						18
19	CONCRETE BOARD IN SHOWER	2008	2,680						19
20	ELECTRIC Change outlets from 2 to 4	2009	5,040						20
21	CIRCUIT BREAKER	2009	3,880						21
22	LAUNDRY CIRCUIT BREAKER	2009	5,140						22
23	225 AMP CIRCUIT BREAKER	2009	2,120						23
24	15 AMP RECEPTACLES	2008	3,360						24
25	Renov.- Front Elevator Upgrade	2009	54,708						25
26	HM Doors	2009	6,500						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,252,407	\$ 386,837		\$ 386,837	\$	\$ 6,338,500	34

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

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	\$ 2,969,715	\$ 223,833	\$ 223,833	\$		\$ 2,217,048	71
72	Current Year Purchases	280,224						72
73	Fully Depreciated Assets							73
74				31,472	31,472			74
75	TOTALS	\$ 3,249,939	\$ 223,833	\$ 255,305	\$ 31,472		\$ 2,217,048	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)	\$ 12,860,456	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 610,670	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 642,142	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,472	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,555,548	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	\$ 2,844,960	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,713,060	\$ 103,140	\$ 2,844,960	91

G. Construction-in-Progress

	Description	Cost	
92	Various	\$ 45,273	92
93			93
94			94
95		\$ 45,273	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 251,407 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation		\$ _____	\$ <u>2,714</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>2,714</u>	21

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	13473 hrs	\$ 588,515	2,137	\$ 114,098	\$ 114,098	15,610	\$ 816,711	1
2	Licensed Speech and Language Development Therapist	10a	3421 hrs	149,440	243	12,960	0	3,664	162,400	2
3	Licensed Recreational Therapist	10a	596 hrs	26,058	1,855	99,038		2,451	125,096	3
4	Licensed Physical Therapist	10a	16271 hrs	710,757	2,748	146,768	146,768	19,019	1,004,293	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 prescripts				1,379,281		1,379,281	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>IV Therapy</u>	43, 2					250,250		250,250	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3				204,265			204,265	13
14	TOTAL			\$ 1,474,770	6,983	\$ 577,129	\$ 1,890,397	40,744	\$ 3,942,296	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 of Hinsdale# 0049445Report Period Beginning: 06/01/08Ending: 05/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/09

(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	\$ 56,417	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>615,815</u>)	3,132,824		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,118		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,195,359	\$	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	11,965,467		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,249,939		16
17	Accumulated Depreciation (book methods)	(11,400,508)		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>CIP</u>	45,273		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,218,281	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,413,640	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 380,414	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,072,711		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,274		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payable</u>	131,333		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,713,732	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	76,113		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 76,113	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,789,845	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,623,795	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,413,640	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,125,069	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,125,069	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	6,263,142	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)	\$ 6,263,142	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(6,764,416)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (6,764,416)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,623,795	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Hinsdale# 0049445Report Period Beginning: 06/01/08Ending: 05/31/09

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	\$ 21,272,607	1
2	Discounts and Allowances for all Levels	(4,196,709)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,075,898	3
B. Ancillary Revenue			
4	Day Care	28,223	4
5	Other Care for Outpatients		5
6	Therapy	7,467,487	6
7	Oxygen	234,232	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,729,942	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,845	12
13	Barber and Beauty Care	52,976	13
14	Non-Patient Meals	26,465	14
15	Telephone, Television and Radio	11,996	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,495,302	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	131,995	19
20	Radiology and X-Ray	97,485	20
21	Other Medical Services	226,001	21
22	Laundry	11,902	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,058,967	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discounts		28
28a	Late Charges		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 26,864,807	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,275,108	31
32	Health Care	9,982,113	32
33	General Administration	5,229,323	33
B. Capital Expense			
34	Ownership	1,110,103	34
C. Ancillary Expense			
35	Special Cost Centers	1,894,846	35
36	Provider Participation Fee	110,172	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,601,665	40
41	Income before Income Taxes (line 30 minus line 40)**	6,263,142	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 6,263,142	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 of Hinsdale**

0049445

Report Period Beginning:

06/01/08

Ending:

05/31/09

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	1,947	2,113	\$ 90,710	\$ 42.93	1
2	Assistant Director of Nursing	5,664	6,149	222,165	36.13	2
3	Registered Nurses	52,646	57,155	1,919,165	33.58	3
4	Licensed Practical Nurses	50,512	54,839	1,359,933	24.80	4
5	CNAs & Orderlies	150,723	163,957	2,163,915	13.20	5
6	CNA Trainees					6
7	Licensed Therapist	33,761	36,678	1,602,193	43.68	7
8	Rehab/Therapy Aides	34,946	37,966	950,926	25.05	8
9	Activity Director	12,327	13,406	156,056	11.64	9
10	Activity Assistants					10
11	Social Service Workers	7,854	8,245	206,215	25.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,221	45,925	633,154	13.79	15
16	Dishwashers					16
17	Maintenance Workers	3,363	3,652	85,040	23.29	17
18	Housekeepers	25,753	27,993	291,681	10.42	18
19	Laundry	6,662	7,248	74,351	10.26	19
20	Administrator	2,080	2,080	108,209	52.02	20
21	Assistant Administrator	1,755	1,755	52,246	29.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,860	27,610	615,473	22.29	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	5,159	5,605	85,951	15.33	31
32	Other Health Care(specify)					32
33	Other(specify) B&B, Hospitality	790	863	11,588	13.43	33
34	TOTAL (lines 1 - 33)	463,023	503,239	\$ 10,628,971 *	\$ 21.12	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	41,800	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,120	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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 49,920		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

Facility Name & ID Number Manorcare of Hinsdale# 0049445Report Period Beginning: 06/01/08Ending: 05/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$14530
- (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 \$8961
- (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. \$ 111,734 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. \$ 110,172
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. \$ 26,465
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.