

Facility Name & ID Number Manorcare of South Holland

0049361 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	17,145	7,000	38,572	62,717	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,145	7,000	38,572	62,717	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.91%

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 29,486

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 of South Holland # 0049361 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	443,520	39,847	44,682	528,049	5,111	533,160		533,160		1
2	Food Purchase		371,684		371,684		371,684	750	372,434		2
3	Housekeeping	124,580	26,517	127,085	278,182		278,182		278,182		3
4	Laundry	32,302	22,357	85,742	140,401		140,401		140,401		4
5	Heat and Other Utilities			248,865	248,865	9,689	258,554		258,554		5
6	Maintenance	76,855	22,102	211,802	310,759		310,759		310,759		6
7	Other (specify):* Med Waste			1,817	1,817		1,817		1,817		7
8	TOTAL General Services	677,257	482,507	719,993	1,879,757	14,800	1,894,557	750	1,895,307		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	4,986,744	503,326	385,658	5,875,728	8,195	5,883,923		5,883,923		10
10a	Therapy	1,845,536	28,254	451,848	2,325,638		2,325,638		2,325,638		10a
11	Activities	100,678	20,652	800	122,130		122,130		122,130		11
12	Social Services	214,768			214,768		214,768		214,768		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,147,726	552,232	862,306	8,562,264	8,195	8,570,459		8,570,459		16
	C. General Administration										
17	Administrative	157,631		784,944	942,575	(205,961)	736,614		736,614		17
18	Directors Fees										18
19	Professional Services			34,292	34,292		34,292	(34,292)			19
20	Dues, Fees, Subscriptions & Promotions			137,699	137,699		137,699	(37,387)	100,312		20
21	Clerical & General Office Expenses	652,278	79,354	988,420	1,720,052		1,720,052	(898,060)	821,992		21
22	Employee Benefits & Payroll Taxes			1,320,966	1,320,966	85,916	1,406,882		1,406,882		22
23	Inservice Training & Education			1,487	1,487		1,487		1,487		23
24	Travel and Seminar			19,570	19,570		19,570		19,570		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			312,457	312,457		312,457		312,457		26
27	Other (specify):*							22	22		27
28	TOTAL General Administration	809,909	79,354	3,599,835	4,489,098	(120,045)	4,369,053	(969,717)	3,399,336		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,634,892	1,114,093	5,182,134	14,931,119	(97,050)	14,834,069	(968,967)	13,865,102		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 South Holland

#0049361

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			624,088	624,088	26,450	650,538		650,538			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(516)	(516)	70,600	70,084		70,084			32
33	Real Estate Taxes			662,834	662,834		662,834	15,749	678,583			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			128,477	128,477		128,477		128,477			35
36	Other (specify):*											36
37	TOTAL Ownership			1,414,883	1,414,883	97,050	1,511,933	15,749	1,527,682			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,069,641		1,069,641		1,069,641		1,069,641			39
40	Barber and Beauty Shops			8,141	8,141		8,141		8,141			40
41	Coffee and Gift Shops	28,829			28,829		28,829		28,829			41
42	Provider Participation Fee			110,265	110,265		110,265		110,265			42
43	Other (specify):* IV Ther/EKG/Xray/Lab		153,927	181,289	335,216		335,216		335,216			43
44	TOTAL Special Cost Centers	28,829	1,223,568	299,695	1,552,092		1,552,092		1,552,092			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,663,721	2,337,661	6,896,712	17,898,094		17,898,094	(953,218)	16,944,876			45

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

Manorcare of South Holland

ID# 0049361

Report Period Beginning: 06/01/08

Ending: 05/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ 1,021	21	1
2	Miscellaneous Income	24	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,045		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of South Holland# 0049361

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	750	0	0	0	0	0	0	0	0	0	0	750	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	750	0	750	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	(34,292)	0	0	0	0	0	0	0	0	0	0	(34,292)	19
20	Fees, Subscriptions & Promotions	(37,387)	0	0	0	0	0	0	0	0	0	0	(37,387)	20
21	Clerical & General Office Expenses	(898,060)	0	0	0	0	0	0	0	0	0	0	(898,060)	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):*	22	0	0	0	0	0	0	0	0	0	0	22	27
28	TOTAL General Administration	(969,717)	0	(969,717)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(968,967)	0	(968,967)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of South Holland# 0049361

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	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	15,749	0	0	0	0	0	0	0	0	0	0	15,749	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	15,749	0	0	0	0	0	0	0	0	0	0	15,749	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)	(953,218)	0	0	0	0	0	0	0	0	0	0	(953,218)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	\$ 784,944	HCR Manor Care, Inc.	100.00%	\$ 784,944	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V	10a	75,607	Heartland Management Services	100.00%	75,607		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		\$ 860,551			\$ 860,551	\$ *	14

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

Facility Name & ID Number Manorcare of South Holland # 0049361 Report Period Beginning: 06/01/08 Ending: 05/31/09

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 South Holland

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

1	2	3	4	5	6	7	8	9		
Schedule V 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. Facs.	\$ 1,686	\$ 0	15,106,612	\$ 9	1
2	1	Dietary - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Facs.	1,103,816	559,529	15,106,612	5,102	2
3	5	Utilities - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Facs.	287,502		15,106,612	1,574	3
4	5	Utilities - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Facs.	1,755,769		15,106,612	8,115	4
5	10	Nursing - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Facs.	0	0	15,106,612	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Facs.	1,773,058	110,606	15,106,612	8,195	6
7	17	Gen & Admin - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Facs.	30,646,209	36,538,442	15,106,612	167,783	7
8	17	Gen & Admin - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Facs.	88,964,011	51,489,483	15,106,612	411,200	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Facs.	6,188,752		15,106,612	33,883	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Facs.	11,257,416		15,106,612	52,033	10
11	30	Depreciation - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Facs.	0		15,106,612	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Facs.	5,722,441		15,106,612	26,450	12
13										13
14		Interest				10,928,075			70,600	14
15		Non Nursing Home Allocation				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	\$ 88,698,060		\$ 784,944	25

Facility Name & ID Number

Manorcare of South Holland

0049361

Report Period Beginning:

06/01/08

Ending:

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Conv. Sub. Debentures		X	Facility				\$ 1,399,326	\$ 1,399,326		5.0453	\$ 70,600	1							
2													2							
3													3							
4													4							
5													5							
Working Capital																				
6													6							
7													7							
8	Interest Income											(516)	8							
9	TOTAL Facility Related						\$ 1,399,326	\$ 1,399,326				\$ 70,084	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				\$ 70,084	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 South Holland

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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:

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

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	120			1988	\$ 3,317,990	\$ 184,882		\$ 184,882		\$ 2,958,547	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					212,026		212,026		2,250,474	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 of South Holland

0049361

Report Period Beginning:

06/01/08

Ending:

05/31/09

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	exhaust system	2006	4,400						69
70	TOTAL (lines 4 thru 69)		\$ 9,430,706	\$ 396,908		\$ 396,908	\$	\$ 5,209,021	70

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

Facility Name & ID Number Manorcare of South Holland

0049361

Report Period Beginning:

06/01/08

Ending:

05/31/09

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		\$ 9,430,706	\$ 396,908		\$ 396,908	\$	\$ 5,209,021	1
2	door	2006	2,288						2
3	addition - architecture/engineering costs/permit fees	2006	404,618						3
4	addition - carpet / wallcovering	2006	33,532						4
5	addition - millwork & sprinklers	2006	36,507						5
6	ac unit	2006	5,100						6
7	1 birch door for therapy	2006	1,288						7
8	addition - general contr - site prep	2006	147,406						8
9	addition - engineering inspection	2006	4,041						9
10	paving	2006	2,650						10
11	electrical	2008	10,940						11
12	corridor electrical	2008	15,823						12
13	replacement roof	2008	163,410						13
14	wallcovering	2008	50,522						14
15	fence	2007	26,375						15
16	concrete patio & sidewalk	2007	16,296						16
17	wallcovering	2008	5,875						17
18	air handlers	2008	15,240						18
19	electronic ballast	2009	3,430						19
20	Renov - Gen overhead capital	2009	1,848						20
21	Renov - Interest on Construction	2009	94						21
22	Renov - Carpeting & pads	2009	11,240						22
23	Renov - wallcovering	2009	8,637						23
24	Renov - Gen overhead capital	2008	3,032						24
25	Renov - Paving of parking lot	2008	50,435						25
26	Renov - Interest on Construction	2008	551						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,451,883	\$ 396,908		\$ 396,908	\$	\$ 5,209,021	34

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

Facility Name & ID Number Manorcare of South Holland

0049361

Report Period Beginning:

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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	\$ 2,971,774	\$ 227,180	\$ 227,180	\$		\$ 2,116,281	71
72	Current Year Purchases	101,556						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			26,450	26,450			74
75	TOTALS	\$ 3,073,330	\$ 227,180	\$ 253,630	\$ 26,450		\$ 2,116,281	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)	\$ 14,472,115	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 624,088	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 650,538	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,450	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,342,302	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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: \$ 128,477 Description: O2 Concentrators, Wheelchairs, Geri chairs, 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

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	11357	hrs	\$ 464,856	598	\$ 27,613	\$ 1,951	11,955	\$ 494,420	1
2	Licensed Speech and Language Development Therapist	10a	5569	hrs	216,093	1,182	54,598	219	6,751	270,910	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	7926	hrs	319,641	6,122	282,857	26,084	14,048	628,582	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 3		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Ther</u>	43,2						153,927		153,927	12
13	Other (specify): <u>EKG/Xray/Lab</u>	43,3					181,289			181,289	13
14	TOTAL				\$ 1,000,590	7,902	\$ 546,357	\$ 182,181	32,754	\$ 1,729,128	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 South Holland**

0049361

Report Period Beginning: **06/01/08**

Ending:

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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 11,420	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,258,668))	2,944,451		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)	\$ 2,961,989	\$	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	10,451,883		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,090,330		16
17	Accumulated Depreciation (book methods)	(7,342,302)		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 (spe CIP)	12,072		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,141,885	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,103,874	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 344,128	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	630,291		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	660,334		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>	92,713		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,727,466	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	13,220		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 13,220	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,740,686	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,363,188	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,103,874	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,556,973	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,556,973	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,559,997	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)	\$ 3,559,997	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(4,753,782)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4,753,782)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,363,188	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of South Holland# 0049361Report 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	\$ 19,342,587	1
2	Discounts and Allowances for all Levels	(5,504,348)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,838,239	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,101,844	6
7	Oxygen	56,696	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,158,540	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	1,043	12
13	Barber and Beauty Care	6,488	13
14	Non-Patient Meals	750	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,218,608	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	142,207	19
20	Radiology and X-Ray	80,584	20
21	Other Medical Services	11,906	21
22	Laundry	(298)	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,461,288	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>Miscellaneous Income</u>	24	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,458,091	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,879,757	31
32	Health Care	8,562,264	32
33	General Administration	4,489,098	33
B. Capital Expense			
34	Ownership	1,414,883	34
C. Ancillary Expense			
35	Special Cost Centers	1,441,827	35
36	Provider Participation Fee	110,265	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,898,094	40
41	Income before Income Taxes (line 30 minus line 40)**	3,559,997	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,559,997	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 South Holland**

0049361

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	2,352	2,532	\$ 105,088	\$ 41.50	1
2	Assistant Director of Nursing	6,432	6,926	229,978	33.21	2
3	Registered Nurses	59,342	63,897	2,130,914	33.35	3
4	Licensed Practical Nurses	37,803	40,705	1,017,158	24.99	4
5	CNAs & Orderlies	130,327	140,513	1,452,084	10.33	5
6	CNA Trainees					6
7	Licensed Therapist	24,293	26,032	1,081,099	41.53	7
8	Rehab/Therapy Aides	28,748	30,807	764,437	24.81	8
9	Activity Director	7,791	8,408	100,678	11.97	9
10	Activity Assistants					10
11	Social Service Workers	9,278	10,023	214,768	21.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,239	34,729	443,520	12.77	15
16	Dishwashers					16
17	Maintenance Workers	4,077	4,392	76,855	17.50	17
18	Housekeepers	10,960	11,817	124,580	10.54	18
19	Laundry	3,400	3,642	32,302	8.87	19
20	Administrator	2,080	2,080	97,455	46.85	20
21	Assistant Administrator	2,124	2,124	60,176	28.33	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	32,995	35,712	652,278	18.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,480	3,749	51,522	13.74	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,910	2,058	28,829	14.01	33
34	TOTAL (lines 1 - 33)	399,631	430,146	\$ 8,663,721 *	\$ 20.14	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	24,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,636	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)		\$ 32,636		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,725	\$ 166,804	10, 3	50
51	Licensed Practical Nurses	2,674	95,593	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,399	\$ 262,397		53

Facility Name & ID Number Manorcare of South Holland# 0049361Report 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. ICHA \$7,284
- (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 \$8913
- (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. \$ 105,925 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. \$ 110,265
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. \$ 750
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.