

Facility Name & ID Number Manorcare of Hinsdale

0049445 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	5,319	16,857	44,712	66,888	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,319	16,857	44,712	66,888	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.63%

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 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 36,211

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: 06/01/09 Ending: 05/31/10

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	635,755	45,538	13,768	695,061	19,165	714,226		714,226		1
2	Food Purchase		470,862		470,862		470,862	(22,088)	448,774		2
3	Housekeeping	320,515	38,564	3,096	362,175		362,175		362,175		3
4	Laundry	76,516	34,730	268	111,514		111,514	(5,784)	105,730		4
5	Heat and Other Utilities			312,119	312,119	5,333	317,452		317,452		5
6	Maintenance	120,033	36,444	195,842	352,319		352,319		352,319		6
7	Other (specify):* Medical Waste			1,202	1,202		1,202		1,202		7
8	TOTAL General Services	1,152,819	626,138	526,295	2,305,252	24,498	2,329,750	(27,872)	2,301,878		8
	B. Health Care and Programs										
9	Medical Director			67,268	67,268		67,268		67,268		9
10	Nursing and Medical Records	6,125,309	584,671	149,048	6,859,028	7,039	6,866,067	(4,198)	6,861,869		10
10a	Therapy	2,792,740	23,626	126,640	2,943,006		2,943,006		2,943,006		10a
11	Activities	150,996	10,325	2,539	163,860		163,860	(30)	163,830		11
12	Social Services	349,478			349,478		349,478		349,478		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	9,418,523	618,622	345,495	10,382,640	7,039	10,389,679	(4,228)	10,385,451		16
	C. General Administration										
17	Administrative	182,473		1,022,925	1,205,398	(345,744)	859,654		859,654		17
18	Directors Fees										18
19	Professional Services			59,158	59,158		59,158	(59,158)			19
20	Dues, Fees, Subscriptions & Promotions			88,282	88,282		88,282	(49,979)	38,303		20
21	Clerical & General Office Expenses	505,999	90,379	888,281	1,484,659		1,484,659	(607,758)	876,901		21
22	Employee Benefits & Payroll Taxes			1,876,105	1,876,105	159,115	2,035,220		2,035,220		22
23	Inservice Training & Education			4,292	4,292		4,292		4,292		23
24	Travel and Seminar			27,906	27,906		27,906		27,906		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			513,042	513,042		513,042		513,042		26
27	Other (specify):*										27
28	TOTAL General Administration	688,472	90,379	4,479,991	5,258,842	(186,629)	5,072,213	(716,895)	4,355,318		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,259,814	1,335,139	5,351,781	17,946,734	(155,092)	17,791,642	(748,995)	17,042,647		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:

06/01/09

Ending:

05/31/10

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			720,093	720,093	42,544	762,637	(103,141)	659,496			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(6,590)	(6,590)	112,548	105,958		105,958			32
33	Real Estate Taxes			147,616	147,616		147,616		147,616			33
34	Rent-Facility & Grounds			22,399	22,399		22,399		22,399			34
35	Rent-Equipment & Vehicles			190,885	190,885		190,885		190,885			35
36	Other (specify):*											36
37	TOTAL Ownership			1,074,403	1,074,403	155,092	1,229,495	(103,141)	1,126,354			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			12,536	12,536		12,536		12,536			38
39	Ancillary Service Centers		1,408,837	497	1,409,334		1,409,334		1,409,334			39
40	Barber and Beauty Shops		7,406	55,574	62,980		62,980		62,980			40
41	Coffee and Gift Shops	18,486			18,486		18,486		18,486			41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* IV X-Ray & Lab		275,110	199,313	474,423		474,423		474,423			43
44	TOTAL Special Cost Centers	18,486	1,691,353	377,420	2,087,259		2,087,259		2,087,259			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,278,300	3,026,492	6,803,604	21,108,396		21,108,396	(852,136)	20,256,260			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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(22,088)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(5,784)	4		8
9	Non-Straightline Depreciation	(103,141)	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	(587)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,198)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(656)	21		18
19	Entertainment				19
20	Contributions	(4,150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(59,158)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(600,127)	21		24
25	Fund Raising, Advertising and Promotional	(49,979)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,266)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (852,136)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (852,136)		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: 06/01/09

Ending: 05/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (2,222)	21	1
2	Misc. Income	(14)	21	2
3	Activity Income	(30)	11	3
4	Loss on Disposal of Fixed Assets	0	36	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,266)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	(22,088)	0	0	0	0	0	0	0	0	0	0	(22,088)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(5,784)	0	0	0	0	0	0	0	0	0	0	(5,784)	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	(27,872)	0	(27,872)	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	(4,198)	0	0	0	0	0	0	0	0	0	0	(4,198)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(30)	0	0	0	0	0	0	0	0	0	0	(30)	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	(4,228)	0	(4,228)	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	(59,158)	0	0	0	0	0	0	0	0	0	0	(59,158)	19
20	Fees, Subscriptions & Promotions	(49,979)	0	0	0	0	0	0	0	0	0	0	(49,979)	20
21	Clerical & General Office Expenses	(607,758)	0	0	0	0	0	0	0	0	0	0	(607,758)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(716,895)	0	(716,895)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(748,995)	0	(748,995)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	(103,141)	0	0	0	0	0	0	0	0	0	0	(103,141)	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	(103,141)	0	0	0	0	0	0	0	0	0	0	(103,141)	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)	(852,136)	0	0	0	0	0	0	0	0	0	0	(852,136)	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	Home Office Allocation	\$ 1,022,926	HCR Manor Care, Inc.	100.00%	\$ 1,022,926	\$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	81,404	Heartland Rehab Services, LLC	100.00%	81,404		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,104,330			\$ 1,104,330	\$ *		14

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

Facility Name & ID Number Manorcare of Hinsdale # 0049445 Report Period Beginning: 06/01/09 Ending: 05/31/10

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:

06/01/09

Ending: 05/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

HCR Manor Care, Inc.

Street Address

333 North Summit St.

City / State / Zip Code

Toledo, OH 43604-2617

Phone Number

(419) 252-5500

Fax Number

(419) 254-5495

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	\$ 2,826,629	\$ 1,585,087	19,376,386	\$ 19,165	1
2	1	Dietary - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	19,376,386	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	0	0	19,376,386	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	0	0	19,376,386	0	4
5	5	Utilities - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	19,376,386	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	911,333	0	19,376,386	5,333	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	19,376,386	4,290	7
8	10	Nursing - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	19,376,386	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	469,810	0	19,376,386	2,749	9
10	17	General & Admin - Direct to All S	Accumulated Cost	2,857,768,524	359 NFs	35,518,981	0	19,376,386	240,828	10
11	17	General & Admin - Direct to Cent	Accumulated Cost	691,284,298	95NFs	1,045,204	0	19,376,386	29,297	11
12	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	69,554,530	79,745,671	19,376,386	407,057	12
13	22	Employee Benefits - Direct to All S	Accumulated Cost	2,857,768,524	359 NFs	6,239,311	0	19,376,386	42,304	13
14	22	Employee Benefits - Direct to Cent	Accumulated Cost	691,284,298	95NFs	2,434,366	0	19,376,386	68,234	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	8,300,418	0	19,376,386	48,577	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714	0	19,376,386	696	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	691,284,298	95NFs	43,612	0	19,376,386	1,222	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	6,941,685	0	19,376,386	40,626	18
19										19
20	32	Directly Assigned Interest				21,122,019			112,548	20
21		Non Central Division Nursing Home Allocation				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 1,022,926	25

Facility Name & ID Number

Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	Various				\$ 4,419,968	\$ 4,419,968		2.5464	\$ 112,548	1						
2													2						
3													3						
4													4						
5													5						
Working Capital																			
6													6						
7													7						
8	Interest Income Other											(6,590)	8						
9	TOTAL Facility Related						\$ 4,419,968	\$ 4,419,968				\$ 105,958	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				\$ 105,958	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.		\$	129,274	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	143,352	2
3. Under or (over) accrual (line 2 minus line 1).		\$	14,078	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	133,538	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	147,616	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	134,722	8
	2006	140,710	9
	2007	134,320	10
	2008	141,026	11
	2009	145,678	12

Line 2: \$143,352 = \$70,513 for 2nd half of 2008 paid in Sept. '09 + \$72,839 for 1st half of 2009 paid in May 2010.

Line 4: \$133,538 = \$72,839 2nd half 2009 + \$60,699 estimate for Jan-May 2010.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/09

Ending:

05/31/10

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

0049445

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	\$ 95,392		\$ 95,392		\$ 2,478,531	4
5	100			1980	1,913,000						5
6	PT addition			2006	400,868						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					231,647		231,647		4,187,008	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:

06/01/09

Ending:

05/31/10

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	\$ 327,039		\$ 327,039	\$	\$ 6,665,539	70

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	\$ 327,039		\$ 327,039	\$	\$ 6,665,539	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	\$ 327,039		\$ 327,039	\$	\$ 6,665,539	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	\$ 327,039		\$ 327,039	\$	\$ 6,665,539	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	Renov. - Elevator Upgrade	2009	11,209						28
29	Doors (8) HM	2009	18,810						29
30	Renov. - Fire Rate Access Panels	2009	27,588						30
31	Renov. - Fire dampers & access panels	2009	78,095						31
32	Frights for Corner Guards	2009	240						32
33	Renov. - Fire Proof Acces Panels	2010	7,682						33
34	TOTAL (lines 1 thru 33)		\$ 8,396,031	\$ 327,039		\$ 327,039	\$	\$ 6,665,539	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 8,396,031	\$ 327,039		\$ 327,039	\$	\$ 6,665,539	1
2	2010	25,501						2
3	2010	20,127						3
4	2010	16,131						4
5	2010	16,017						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		\$ 8,473,807	\$ 327,039		\$ 327,039	\$	\$ 6,665,539	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	\$ 3,249,939	\$ 289,913	\$ 289,913	\$		\$ 2,506,961	71
72	Current Year Purchases	669,916						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			42,544	42,544			74
75	TOTALS	\$ 3,919,855	\$ 289,913	\$ 332,457	\$ 42,544		\$ 2,506,961	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)	\$ 13,751,772	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 616,952	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 659,496	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 42,544	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,172,500	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	\$ 103,141	\$ 2,948,101	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,713,060	\$ 103,141	\$ 2,948,101	91

G. Construction-in-Progress

	Description	Cost	
92	Various	\$ 291,203	92
93			93
94			94
95		\$ 291,203	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: MIH, LLC / HSS Management Company

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	Portion of Parking Lot			01/01/2010	22,399	1 1/2		5
6								6
7	TOTAL				\$ 22,399			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?

YES NO

16. Rental Amount for movable equipment: \$ 186,351 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		\$	\$ 4,534	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 4,534	21

10. Effective dates of current rental agreement:

Beginning 01/01/2010

Ending 06/30/2011

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

Fiscal Year Ending Annual Rent

12. 05/31/2011 \$ 22,399

13. 05/31/2012 \$ 1,867

14. 05/31/2013 \$ 0

* 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, 1	16383	hrs	\$ 694,134	23	\$ 1,121	\$ 8,062	16,406	\$ 703,317	1
2	Licensed Speech and Language Development Therapist	10a, 1	6009	hrs	254,575	344	16,931	292	6,353	271,798	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	17267	hrs	731,596			15,272	17,267	746,868	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				1,408,837		1,408,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Theray</u>	43, 2						275,110		275,110	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					199,313			199,313	13
14	TOTAL				\$ 1,680,305	367	\$ 217,365	\$ 1,707,573	40,026	\$ 3,605,243	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: 06/01/09Ending: 05/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/10

(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	\$ 54,083	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>948,772</u>)	3,360,490		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)	\$ 3,420,691	\$	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	12,186,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,919,855		16
17	Accumulated Depreciation (book methods)	(12,120,601)		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>	291,203		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,635,434	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,056,125	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 393,187	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,148,358		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,538		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>	88,335		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,763,418	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	4,419,968		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	147,017		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,566,985	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,330,403	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,725,722	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,056,125	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,623,795	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,623,795	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,044,425	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)	\$ 8,044,425	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(11,942,498)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (11,942,498)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,725,722	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Hinsdale# 0049445Report Period Beginning: 06/01/09Ending: 05/31/10

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	\$ 29,262,584	1
2	Discounts and Allowances for all Levels	(10,660,934)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,601,650	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,533,016	6
7	Oxygen	35,596	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,568,612	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	6,420	12
13	Barber and Beauty Care	50,740	13
14	Non-Patient Meals	22,088	14
15	Telephone, Television and Radio	2	15
16	Rental of Facility Space	113	16
17	Sale of Drugs	1,514,391	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	161,076	19
20	Radiology and X-Ray	101,409	20
21	Other Medical Services	120,522	21
22	Laundry	5,784	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,982,545	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	14	28
28a	Late Charges		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 29,152,821	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,305,252	31
32	Health Care	10,382,640	32
33	General Administration	5,258,842	33
B. Capital Expense			
34	Ownership	1,074,403	34
C. Ancillary Expense			
35	Special Cost Centers	1,977,759	35
36	Provider Participation Fee	109,500	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,108,396	40
41	Income before Income Taxes (line 30 minus line 40)**	8,044,425	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 8,044,425	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:

06/01/09

Ending:

05/31/10

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	2,251	2,435	\$ 109,544	\$ 44.99	1
2	Assistant Director of Nursing	5,369	5,808	213,775	36.81	2
3	Registered Nurses	55,639	60,183	2,001,580	33.26	3
4	Licensed Practical Nurses	50,427	54,545	1,389,054	25.47	4
5	CNAs & Orderlies	163,588	177,294	2,332,715	13.16	5
6	CNA Trainees					6
7	Licensed Therapist	41,977	45,487	1,927,227	42.37	7
8	Rehab/Therapy Aides	31,054	33,651	865,513	25.72	8
9	Activity Director	11,404	12,370	150,996	12.21	9
10	Activity Assistants					10
11	Social Service Workers	12,629	13,683	349,478	25.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,664	44,097	635,755	14.42	15
16	Dishwashers					16
17	Maintenance Workers	4,520	4,897	120,033	24.51	17
18	Housekeepers	26,265	28,483	320,515	11.25	18
19	Laundry	7,225	7,836	76,516	9.76	19
20	Administrator	2,080	2,080	121,260	58.30	20
21	Assistant Administrator	1,959	1,959	61,213	31.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,702	22,912	505,999	22.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,635	5,028	78,641	15.64	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,492	1,618	18,486	11.43	33
34	TOTAL (lines 1 - 33)	483,880	524,366	\$ 11,278,300 *	\$ 21.51	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	67,268	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,117	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)		\$ 71,385		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: 06/01/09Ending: 05/31/10**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 \$7307
- (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
- (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. \$ 119,520 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500
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. \$ 22,088
- (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.