

		FOR BHF USE					

LL1

**2010**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2010)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0049361</u></p> <p><b>Facility Name:</b> <u>Manorcare of South Holland</u></p> <p><b>Address:</b> <u>2145 East 170th Street</u> <u>South Holland</u> <u>60473</u>  Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708) 895-3255</u> Fax # <u>(708) 895-3315</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>12/1/88</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____ </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  Name: <u>Garv Geise</u> Telephone Number: <u>(419) 252-5731</u>  Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/09</u> to <u>05/31/10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) Fax # ( )</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) Fax # ( )							

Facility Name & ID Number Manorcare of South Holland

# 0049361 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	15,270	6,345	37,588	59,203	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,270	6,345	37,588	59,203	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.10%

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

1 (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 28,919

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCURAL  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: 06/01/09 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
	<b>A. General Services</b>										
1	Dietary	468,958	36,710	1,210	506,878	16,828	523,706		523,706		1
2	Food Purchase		385,390		385,390		385,390	(500)	384,890		2
3	Housekeeping	237,054	27,937		264,991		264,991		264,991		3
4	Laundry	83,401	25,923	427	109,751		109,751		109,751		4
5	Heat and Other Utilities			255,256	255,256	4,683	259,939		259,939		5
6	Maintenance	73,020	18,423	223,753	315,196		315,196		315,196		6
7	Other (specify):* <b>Med Waste</b>			1,554	1,554		1,554		1,554		7
8	<b>TOTAL General Services</b>	862,433	494,383	482,200	1,839,016	21,511	1,860,527	(500)	1,860,027		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			27,452	27,452		27,452		27,452		9
10	Nursing and Medical Records	4,923,370	517,615	70,936	5,511,921	6,181	5,518,102		5,518,102		10
10a	Therapy	1,996,951	32,407	409,952	2,439,310		2,439,310		2,439,310		10a
11	Activities	93,751	13,640	630	108,021		108,021		108,021		11
12	Social Services	188,535			188,535		188,535		188,535		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	7,202,607	563,662	508,970	8,275,239	6,181	8,281,420		8,281,420		16
	<b>C. General Administration</b>										
17	Administrative	173,571		834,963	1,008,534	(240,385)	768,149		768,149		17
18	Directors Fees										18
19	Professional Services			105,749	105,749		105,749	(105,749)			19
20	Dues, Fees, Subscriptions & Promotions			77,808	77,808		77,808	(42,423)	35,385		20
21	Clerical & General Office Expenses	627,212	65,702	373,725	1,066,639		1,066,639	(277,210)	789,429		21
22	Employee Benefits & Payroll Taxes			1,480,134	1,480,134	139,707	1,619,841		1,619,841		22
23	Inservice Training & Education			824	824		824		824		23
24	Travel and Seminar			9,238	9,238		9,238		9,238		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			501,691	501,691		501,691		501,691		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	800,783	65,702	3,384,132	4,250,617	(100,678)	4,149,939	(425,382)	3,724,557		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	8,865,823	1,123,747	4,375,302	14,364,872	(72,986)	14,291,886	(425,882)	13,866,004		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 &amp; ID Number

Manorcare of South Holland

#0049361

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 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			646,467	646,467	37,354	683,821		683,821			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(6,687)	(6,687)	35,632	28,945		28,945			32
33	Real Estate Taxes			806,375	806,375		806,375	3,999	810,374			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			96,207	96,207		96,207		96,207			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,542,362	1,542,362	72,986	1,615,348	3,999	1,619,347			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		997,310		997,310		997,310		997,310			39
40	Barber and Beauty Shops			7,885	7,885		7,885		7,885			40
41	Coffee and Gift Shops	10,522			10,522		10,522		10,522			41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* <b>IV Ther/EKG/Xray/Lab</b>		153,815	219,712	373,527		373,527		373,527			43
44	<b>TOTAL Special Cost Centers</b>	10,522	1,151,125	337,097	1,498,744		1,498,744		1,498,744			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,876,345	2,274,872	6,254,761	17,405,978		17,405,978	(421,883)	16,984,095			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(500)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(656)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(105,749)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(273,997)	21		24
25	Fund Raising, Advertising and Promotional	(42,423)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	3,999	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,552)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (421,883)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (421,883)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Manorcare of South Holland

ID# 0049361

Report Period Beginning: 06/01/09

Ending: 05/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (2,532)	21	1
2	Miscellaneous Income	(20)	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	<b>Total</b>	(2,552)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of South Holland

# 0049361

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**

	<b>Operating Expenses</b>	<b>PAGES</b>	<b>PAGE</b>	<b>SUMMARY</b>										
	<b>A. General Services</b>	<b>5 &amp; 5A</b>	<b>6</b>	<b>6A</b>	<b>6B</b>	<b>6C</b>	<b>6D</b>	<b>6E</b>	<b>6F</b>	<b>6G</b>	<b>6H</b>	<b>6I</b>	<b>TOTALS</b>	
													<b>(to Sch V, col.7)</b>	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(500)	0	0	0	0	0	0	0	0	0	0	(500)	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	<b>TOTAL General Services</b>	<b>(500)</b>	<b>0</b>	<b>(500)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(105,749)	0	0	0	0	0	0	0	0	0	0	(105,749)	19
20	Fees, Subscriptions & Promotions	(42,423)	0	0	0	0	0	0	0	0	0	0	(42,423)	20
21	Clerical & General Office Expenses	(277,210)	0	0	0	0	0	0	0	0	0	0	(277,210)	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	<b>TOTAL General Administration</b>	<b>(425,382)</b>	<b>0</b>	<b>(425,382)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(425,882)</b>	<b>0</b>	<b>(425,882)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of South Holland# 0049361

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)	
	<b>D. Ownership</b>													
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	3,999	0	0	0	0	0	0	0	0	0	0	3,999	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	<b>TOTAL Ownership</b>	<b>3,999</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,999</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(421,883)	0	0	0	0	0	0	0	0	0	0	(421,883)	45

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Home Office Allocation	\$ 834,963	HCR Manorcare, Inc.	100.00%	\$ 834,963	\$	1
2	V	Pg 8						2
3	V							3
4	V	10a Therapy Management	69,217	Heartland Management Services	100.00%	69,217		4
5	V							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		\$ 904,180			\$ 904,180	\$ *	14

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

Facility Name &amp; ID Number

Manorcare of South Holland

#

0049361

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 South Holland

# 0049361

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

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 to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	\$ 2,826,629	\$ 1,585,087	17,012,895	\$ 16,828	1
2	1	Dietary - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			17,012,895	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs,HHs, Rehab			17,012,895	0	3
4	5	Utilities - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs			17,012,895	0	4
5	5	Utilities - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			17,012,895	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	911,333		17,012,895	4,683	6
7	10	Nursing - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	17,012,895	3,767	7
8	10	Nursing - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			17,012,895	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	469,810		17,012,895	2,414	9
10	17	Gen/Admin - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	35,518,981		17,012,895	211,451	10
11	17	Gen/Admin - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	1,045,204		17,012,895	25,723	11
12	17	Gen/Admin - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	69,554,530	79,745,671	17,012,895	357,404	12
13	22	Empl Bnfts -Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	6,239,311		17,012,895	37,144	13
14	22	Empl Bnfts -Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	2,434,366		17,012,895	59,911	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	8,300,418		17,012,895	42,652	15
16	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714		17,012,895	611	16
17	30	Deprec - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	43,612		17,012,895	1,073	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	6,941,685		17,012,895	35,670	18
19										19
20	32	Directly Assigned Interest				21,122,019			35,632	20
21		Non Central Div Nrsg Hm				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 834,963	25

Facility Name & ID Number

Manorcare of South Holland

# 0049361

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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Conv. Sub Debentures		X	Various				\$ 1,399,326	\$ 1,399,326		0.0255	\$ 35,632	1						
2													2						
3													3						
4													4						
5													5						
<b>Working Capital</b>																			
6													6						
7													7						
8	Interest Income / Interest Exp											(6,687)	8						
9	<b>TOTAL Facility Related</b>						\$ 1,399,326	\$ 1,399,326				\$ 28,945	9						
<b>B. Non-Facility Related*</b>																			
10													10						
11													11						
12													12						
13													13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,399,326	\$ 1,399,326				\$ 28,945	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.		\$	<b>700,079</b>		<b>1</b>
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.)		\$	<b>759,834</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>59,755</b>		<b>3</b>
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>750,460</b>		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>159</b>		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>810,374</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<b>284,206</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2006	<b>619,077</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009 \$ <b>13</b>
	2007	<b>650,575</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2008	<b>700,079</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
	2009	<b>814,634</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>
<b>Line 2: \$759,834.26 = \$385,043.26 for 1st half 2009 + \$374,791 for 2nd half 2008</b>					
<b>Line 4: \$750,460.25 = \$429,590.87 for 2nd half 2009 + \$320,869.38 for Jan - May 2010</b>					
<b>Line 5: Vihon &amp; Worsek invoice</b>					

**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 South Holland

# 0049361

Report Period Beginning:

06/01/09

Ending:

05/31/10

**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	<b>TOTALS</b>			<b>\$ 929,902</b>	<b>3</b>

**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	\$	\$ 3,143,429	4
5	60			1991	1,912,803						5
6	10			1997	1,054,638						6
7				2006	1,222,040						7
8											8
	<b>Improvement Type**</b>										
9	<b>Current Year Depreciation</b>					221,123		221,123		2,471,597	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 &amp; ID Number Manorcare of South Holland

# 0049361

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	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	\$ 406,005		\$ 406,005	\$	\$ 5,615,026	70

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

Facility Name &amp; ID Number Manorcare of South Holland

# 0049361

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 9,430,706	\$ 406,005		\$ 406,005	\$	\$ 5,615,026	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	Renov -Resilient Flooring	2009	12,131						27
28	Renov - Painting	2009	24,262						28
29	Renov - wallcovering	2009	968						29
30	exit steel door	2009	3,788						30
31	hand & crash rail	2009	17,378						31
32	dining room floor upgrade	2009	10,677						32
33	painting	2009	4,044						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,525,131	\$ 406,005		\$ 406,005	\$	\$ 5,615,026	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		\$ 10,525,131	\$ 406,005		\$ 406,005	\$	\$ 5,615,026
2	2009	750					
3	2009	8,273					
4	2009	12,032					
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 10,546,186	\$ 406,005		\$ 406,005	\$	\$ 5,615,026

\*\*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	\$ 3,073,330	\$ 240,462	\$ 240,462	\$		\$ 2,356,743	71
72	Current Year Purchases	128,839						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			37,354	37,354			74
75	TOTALS	\$ 3,202,169	\$ 240,462	\$ 277,816	\$ 37,354		\$ 2,356,743	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 GHS		\$ 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)	\$ 14,695,257	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 646,467	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 683,821	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 37,354	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,988,769	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	CIP	\$ 13,616	92
93			93
94			94
95		\$ 13,616	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: \$ 96,207 Description: O2 Concentrators, Wheelchairs, Geri Charis, Elec. Beds, Etc.

YES  NO

(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. \_\_\_\_\_/2011 \$ \_\_\_\_\_

13. \_\_\_\_\_/2012 \$ \_\_\_\_\_

14. \_\_\_\_\_/2013 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	11586	hrs	\$ 490,309	20	\$ 1,008	\$ 2,200	11,606	\$ 493,517	1
2	Licensed Speech and Language Development Therapist	10a	6603	hrs	255,225	116	5,706	896	6,719	261,827	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	10192	hrs	428,671	6,405	315,115	29,311	16,597	773,097	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 prescripts				997,310		997,310	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>	43,2						153,815		153,815	12
13	Other (specify): <u>EKG/Xray/Lab</u>	43, 3					219,712			219,712	13
14	<b>TOTAL</b>				\$ 1,174,205	6,541	\$ 541,541	\$ 1,183,532	34,922	\$ 2,899,278	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# 0049361Report 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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 69,664	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (1,080,092) )	3,077,446		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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,153,228	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	929,902		13
14	Buildings, at Historical Cost	10,546,186		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,219,169		16
17	Accumulated Depreciation (book methods)	(7,988,769)		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>	13,616		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,720,104	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 9,873,332	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 295,138	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	699,832		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,820		31
32	Accrued Real Estate Taxes(Sch.IX-B)	750,460		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Payables</u>	75,226		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,823,476	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,399,328		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	34,947		42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,434,275	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,257,751	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 6,615,581	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 9,873,332	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>8,363,188</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>8,363,188</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>4,901,069</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>4,901,069</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	<b>(6,648,676)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(6,648,676)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>6,615,581</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of South Holland# 0049361Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 22,335,309	1
2	Discounts and Allowances for all Levels	(8,097,278)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 14,238,031</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,604,569	6
7	Oxygen	1	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 6,604,570</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,532	12
13	Barber and Beauty Care	7,014	13
14	Non-Patient Meals	500	14
15	Telephone, Television and Radio	5	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,120,945	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	155,612	19
20	Radiology and X-Ray	125,103	20
21	Other Medical Services	52,690	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,464,401</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	20	28
28a	<u>Hospitality Income</u>	25	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 45</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 22,307,047</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,839,016	31
32	Health Care	8,275,239	32
33	General Administration	4,250,617	33
<b>B. Capital Expense</b>			
34	Ownership	1,542,362	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,389,244	35
36	Provider Participation Fee	109,500	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 17,405,978</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>4,901,069</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 4,901,069</b>	<b>43</b>

\* 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: **06/01/09**

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	2,084	2,261	\$ 98,021	\$ 43.35	1
2	Assistant Director of Nursing	5,784	6,276	217,386	34.64	2
3	Registered Nurses	65,358	70,911	2,390,275	33.71	3
4	Licensed Practical Nurses	22,018	23,889	594,336	24.88	4
5	CNAs & Orderlies	140,755	152,832	1,564,628	10.24	5
6	CNA Trainees					6
7	Licensed Therapist	29,497	31,820	1,325,229	41.65	7
8	Rehab/Therapy Aides	24,294	26,208	671,722	25.63	8
9	Activity Director	6,952	7,521	93,751	12.47	9
10	Activity Assistants					10
11	Social Service Workers	7,620	8,229	188,535	22.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,831	34,400	468,958	13.63	15
16	Dishwashers					16
17	Maintenance Workers	3,787	4,105	73,020	17.79	17
18	Housekeepers	21,291	23,001	237,054	10.31	18
19	Laundry	8,512	9,200	83,401	9.07	19
20	Administrator	2,080	2,080	120,564	57.96	20
21	Assistant Administrator	1,826	1,826	53,007	29.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,497	33,244	627,212	18.87	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	3,864	4,176	58,724	14.06	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	683	736	10,522	14.30	33
34	TOTAL (lines 1 - 33)	408,733	442,715	\$ 8,876,345 *	\$ 20.05	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	27,452	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,828	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)		\$ 31,280		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 South Holland# 0049361Report 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. ICHA \$7,307
- (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 \$8368
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 114,946 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. \$ 500
- (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.