

		FOR BHF USE					

LL1

**2012**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2012)**

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>0049650</u></p> <p><b>Facility Name:</b> <u>Manorcare of Wilmette</u></p> <p><b>Address:</b> <u>432 Poplar Drive</u> <u>Wilmette</u> <u>60091</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>847-256-5000</u> <b>Fax #</b> <u>847-256-0225</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>06/12/95</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>  <b>Name:</b> <u>Garv Geise</u> <b>Telephone Number:</b> <u>419-252-5731</u>  <b>Email Address:</b> _____</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>06/01/11</u> to <u>05/31/12</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 style="width:100%; border: none;"> <tr> <td style="width:15%; border: none; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;">           (Signed) _____            (Type or Print Name) <u>Barry A. Lazarus</u>            (Title) <u>Vice President - Reimbursement</u> </td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">           (Signed) _____            (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>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> 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) _____ (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) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number Manorcare of Wilmette

# 0049650 Report Period Beginning: 06/01/11 Ending: 05/31/12

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	80	Skilled (SNF)	80	29,280	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	80	TOTALS	80	29,280	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,443	2,295	8,114	24,852	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,443	2,295	8,114	24,852	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.88%

D. How many bed-hold days during this year were paid by the Department? \_\_\_\_\_ (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 06/12/95

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/07/2011 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 80 and days of care provided 6,440

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCRAUAL  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 &amp; ID Number

Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**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	255,256	21,644	4,277	281,177		281,177		281,177		1
2	Food Purchase		168,222		168,222		168,222	(241)	167,981		2
3	Housekeeping	134,748	13,201	(1,171)	146,778		146,778		146,778		3
4	Laundry		7,065	88,723	95,788		95,788		95,788		4
5	Heat and Other Utilities			131,243	131,243	1,481	132,724		132,724		5
6	Maintenance	48,014	19,647	144,394	212,055		212,055		212,055		6
7	Other (specify):* <b>Medical Waste</b>			346	346		346		346		7
8	<b>TOTAL General Services</b>	<b>438,018</b>	<b>229,779</b>	<b>367,812</b>	<b>1,035,609</b>	<b>1,481</b>	<b>1,037,090</b>	<b>(241)</b>	<b>1,036,849</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			40,800	40,800		40,800		40,800		9
10	Nursing and Medical Records	2,128,736	148,225	67,321	2,344,282	9,343	2,353,625		2,353,625		10
10a	Therapy	690,269	8,592	159,500	858,361		858,361		858,361		10a
11	Activities	45,408	5,768	4,977	56,153		56,153		56,153		11
12	Social Services	94,283		1,946	96,229		96,229		96,229		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,958,696</b>	<b>162,585</b>	<b>274,544</b>	<b>3,395,825</b>	<b>9,343</b>	<b>3,405,168</b>		<b>3,405,168</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	94,300		322,873	417,173	(106,218)	310,955		310,955		17
18	Directors Fees										18
19	Professional Services			7,877	7,877	(245)	7,632	(7,632)			19
20	Dues, Fees, Subscriptions & Promotions			59,756	59,756	245	60,001	(34,781)	25,220		20
21	Clerical & General Office Expenses	353,821	52,669	479,932	886,422		886,422	(455,263)	431,159		21
22	Employee Benefits & Payroll Taxes			576,586	576,586	19,973	596,559		596,559		22
23	Inservice Training & Education			1,694	1,694		1,694		1,694		23
24	Travel and Seminar			527	527		527		527		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			239,017	239,017		239,017		239,017		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>448,121</b>	<b>52,669</b>	<b>1,688,262</b>	<b>2,189,052</b>	<b>(86,245)</b>	<b>2,102,807</b>	<b>(497,676)</b>	<b>1,605,131</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,844,835</b>	<b>445,033</b>	<b>2,330,618</b>	<b>6,620,486</b>	<b>(75,421)</b>	<b>6,545,065</b>	<b>(497,917)</b>	<b>6,047,148</b>		<b>29</b>

\*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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>											
30	Depreciation			474,124	474,124	10,319	484,443		484,443			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,398	91,398	65,102	156,500	(95,337)	61,163			32
33	Real Estate Taxes			235,465	235,465		235,465		235,465			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,810	35,810		35,810		35,810			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			836,797	836,797	75,421	912,218	(95,337)	816,881			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		238,837	2,099	240,936		240,936		240,936			39
40	Barber and Beauty Shops			8,436	8,436		8,436		8,436			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			175,001	175,001		175,001		175,001			42
43	Other (specify):* <b>IV, X-ray &amp; Lab</b>		80,270	43,679	123,949		123,949		123,949			43
44	<b>TOTAL Special Cost Centers</b>		319,107	229,215	548,322		548,322		548,322			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,844,835	764,140	3,396,630	8,005,605		8,005,605	(593,254)	7,412,351			45

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

Facility Name & ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning: 06/01/11

Ending: 05/31/12

**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	(241)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	21		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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,632)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(424,023)	21		24
25	Fund Raising, Advertising and Promotional	(34,781)	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	(126,500)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (593,254)		\$	30

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

**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>	\$ (593,254)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Manorcare of Wilmette

ID# 0049650

Report Period Beginning: 06/01/11

Ending: 05/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Wages - Marketing	\$ (24,439)	21	1
2	P/R O/H Alloc- Mktg	(5,993)	21	2
3	HCP Lease Interest	(95,337)	32	3
4	Vending Income	(731)	21	4
5	Misc Income	0	21	5
6	Activity Income	0	11	6
7	Loss on disposal of Fixed Asset	0	36	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>		(126,500)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Wilmette# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(241)	0	0	0	0	0	0	0	0	0	0	(241)	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>(241)</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>(241)</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	(7,632)	0	0	0	0	0	0	0	0	0	0	(7,632)	19
20	Fees, Subscriptions & Promotions	(34,781)	0	0	0	0	0	0	0	0	0	0	(34,781)	20
21	Clerical & General Office Expenses	(455,263)	0	0	0	0	0	0	0	0	0	0	(455,263)	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>(497,676)</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>(497,676)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(497,917)</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>(497,917)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Wilmette# 0049650

Report Period Beginning:

06/01/11 Ending:05/31/12

## 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	(95,337)	0	0	0	0	0	0	0	0	0	0	(95,337)	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	<b>TOTAL Ownership</b>	<b>(95,337)</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>(95,337)</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	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(593,254)</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>(593,254)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Heath Care	Toledo	Nursing Staff
		See Pg 6 Supp for list of related nursing homes in Illinois				

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Home Office Allocation	\$ 322,873	HCR Manor Care Services, LLC	100.00%	\$ 322,873	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	3,844,835	Heartland Employment Services, LLC	100.00%	3,844,835		4
5	V	10a Therapy Management	9,089	Heartland Rehab Services, LLC	100.00%	9,089		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		\$ 4,176,797			\$ 4,176,797	\$ *	14

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

Facility Name & ID Number

Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights West IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights IL, LLC	Palos Heights				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				26
27			Manor Care of South Holland IL, LLC	South Holland				27
28			Manor Care of Westmont IL, LLC	Westmont				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30								30

Facility Name & ID Number

Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Geneva IL, LLC	Geneva				1
2			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				2
3			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				3
4			Arden Courts of Northbrook IL, LLC	Northbrook				4
5			Arden Courts of Palos Heights IL, LLC	Palos Heights				5
6			Arden Courts of South Holland IL, LLC	South Holland				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

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

# 0049650

Report Period Beginning:

06/01/11

Ending: 05/31/12

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 Services, LLC  
 Street Address 333 North Summit Street  
 City / State / Zip Code Toledo, OH 43604-2617  
 Phone Number ( 419-252-5000  
 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	5	Utilities - Pooled	Accumulated Cost	731 NFs, HHs, & R	\$ 775,999	\$ 0	7,184,038	\$ 1,481	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	353 NFs	0	0	7,184,038	0	2
3	5	Utilities - Direct to Central Division	Accumulated Cost	92 NFs	0	0	7,184,038	0	3
4	5	Utilities - Direct to Midwest Division	Accumulated Cost	48 NFs	0	0	7,184,038	0	4
5	10	Nursing - Pooled	Accumulated Cost	731 NFs, HHs, & R	485,056	352,684	7,184,038	925	5
6	10	Nursing - Direct to All SNFs	Accumulated Cost	353 NFs	3,905,972	1,829,606	7,184,038	8,418	6
7	10	Nursing - Direct to Central Division	Accumulated Cost	92 NFs	0	0	7,184,038	0	7
8	10	Nursing - Direct to Midwest Division	Accumulated Cost	48 NFs	0	0	7,184,038	0	8
9	17	General & Administrative - Pooled	Accumulated Cost	731 NFs, HHs, & R	71,430,003	38,287,220	7,184,038	136,288	9
10	17	General & Administrative - Direct to All SNFs	Accumulated Cost	353 NFs	23,601,055	18,695,747	7,184,038	50,863	10
11	17	General & Administrative - Direct to Central Division	Accumulated Cost	92 NFs	1,782,698	1,278,408	7,184,038	15,942	11
12	17	General & Administrative - Direct to Midwest Division	Accumulated Cost	48 NFs	895,017	639,204	7,184,038	13,562	12
13	22	Employee Benefits - Pooled	Accumulated Cost	731 NFs, HHs, & R	2,952,374	0	7,184,038	5,633	13
14	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	353 NFs	6,653,909	0	7,184,038	14,340	14
15	22	Employee Benefits - Direct to Central Division	Accumulated Cost	92 NFs	0	0	7,184,038	0	15
16	22	Employee Benefits - Direct to Midwest Division	Accumulated Cost	48 NFs	0	0	7,184,038	0	16
17	30	Depreciation - Pooled	Accumulated Cost	731 NFs, HHs, & R	4,719,938	0	7,184,038	9,006	17
18	30	Depreciation - Direct to All SNFs	Accumulated Cost	353 NFs	609,966	0	7,184,038	1,313	18
19	30	Depreciation - Direct to Central Division	Accumulated Cost	92 NFs	0	0	7,184,038	0	19
20	30	Depreciation - Direct to Midwest Division	Accumulated Cost	48 NFs	0	0	7,184,038	0	20
21									21
22	32	Pooled Interest	Accumulated Cost		26,343,470		7,184,038	50,263	22
23	32	Directly Assigned Interest	Not Allocated		18,851,990			14,839	23
24		H/O Costs allocated to Non-SNFs and Other Divisions			32,615,916				24
25	TOTALS				\$ 195,623,363	\$ 61,082,869		\$ 322,873	25

Facility Name & ID Number

Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	Long-Term																
1	Various		X	Facility			\$ 223,000	\$ 223,000		0.0665	\$ 14,839						
2																	
3																	
4																	
5																	
	<b>Working Capital</b>																
6																	
7	Home Office Pooled Interest										50,263						
8	Interest Income Other										(3,939)						
9	<b>TOTAL Facility Related</b>						\$ 223,000	\$ 223,000			\$ 61,163						
	<b>B. Non-Facility Related*</b>																
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 223,000	\$ 223,000			\$ 61,163						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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 2011 report.		\$	<u>232,211</u>		1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>258,114</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>25,903</u>		3														
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>202,809</u>		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<u>6,753</u>		5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>235,465</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2007	<u>209,097</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2011 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2008	<u>209,097</u>	9																
	2009	<u>160,702</u>	10																
	2010	<u>223,549</u>	11																
	2011	<u>229,949</u>	12																
<u>Line 2-2nd 1/2 2010 (\$135162.46) &amp; 1st 1/2 2011 (\$122951.75)</u>																			
<u>Line 4-2nd 1/2 2011 (\$106997.22) &amp; 1st 1/2 2012 estimated (\$95812)</u>																			
<u>Line5-\$6753-Worsek &amp; Vihon P.C.-2010 real estate assessment appeals</u>																			

**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.**



## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Wilmette COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049650

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE 419-252-5731 FAX #: 419-254-5495

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-34-121-042-0000</u>	<u>See Attached</u>	\$ <u>2,397.63</u>	\$ <u>2,397.63</u>
2. <u>05-34-121-050-0000</u>	<u>See Attached</u>	\$ <u>2,813.44</u>	\$ <u>2,813.44</u>
3. <u>05-34-121-041-0000</u>	<u>See Attached</u>	\$ <u>3,504.13</u>	\$ <u>3,504.13</u>
4. <u>05-34-121-051-0000</u>	<u>See Attached</u>	\$ <u>3,623.00</u>	\$ <u>3,623.00</u>
5. <u>05-34-121-048-0000</u>	<u>See Attached</u>	\$ <u>7,706.45</u>	\$ <u>7,706.45</u>
6. <u>05-34-121-056-0000</u>	<u>See Attached</u>	\$ <u>209,904.32</u>	\$ <u>209,904.32</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>229,948.97</u></u>	\$ <u><u>229,948.97</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        X   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Manorcare of Wilmette

# 0049650 Report Period Beginning:

06/01/11 Ending:

05/31/12

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 21,881 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).

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1995</u>	<u>\$ 500,819</u>	<u>1</u>
2			<u>2007</u>	<u>3,225</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 504,044</b>	<b>3</b>

Facility Name &amp; ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	80	1995	1969	\$ 661,737	\$ 108,418		\$ 108,418	\$	\$ 1,814,917	4
5	CR 05/31/03 Audit Adj	1995		3,635,000						5
6	CR 05/31/03 Audit Adj	1995		40,000						6
7										7
8										8
<b>Improvement Type**</b>										
9	BUILDING IMPROVEMENTS (Current year Depreciation)				228,708		228,708		1,915,933	9
10			1983	7,273						10
11			1985	17,043						11
12			1988	1,961						12
13			1989	7,178						13
14			1990	20,800						14
15			1991	2,428						15
16			1992	34,209						16
17			1993	55,467						17
18	INSTALL GARBAGE DISPOSAL/EJECTORS		1995	1,726						18
19	STORAGE TANKS		1995	7,303						19
20	PAINTING		1995	2,355						20
21	FLOOR/WALL TILE		1995	1,643						21
22	VERTICLE VESSELS		1995	21,838						22
23	CARPET CLEANING		1996	1,197						23
24	CAPITALIZED LABOR		1996	4,074						24
25	CR 5/31/99 AUDIT ADJ		1996	(4,074)						25
26	SIGN		1996	162						26
27	ELECTRICAL		1996	181,279						27
28	GENERAL REQUIREMENTS		1996	110,589						28
29	FLOORING/CEILING		1996	75,391						29
30	ARCHITECT/ENGINEER/LEGAL FEES		1996	52,531						30
31	CR 5/31/99 AUDIT ADJ		1996	(16,232)						31
32	CARPENTRY/MASONRY		1996	35,295						32
33	MILLWORK		1996	17,943						33
34	DOOR & WINDOW FRAMES		1996	26,753						34
35	FINISH STUD/DRYWALL		1996	8,964						35
36										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 Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<u>PAINTING/WALLCOVERINGS</u>	1996	\$ 28,690	\$		\$	\$	\$	37
38	<u>PLUMBING</u>	1996	63,189						38
39	<u>HVAC</u>	1996	22,253						39
40	<u>CORNER GUARDS</u>	1996	4,423						40
41	<u>NURSE CALL STATION</u>	1996	32,513						41
42	<u>LIGHTING</u>	1996	15,386						42
43	<u>PERMITS</u>	1996	4,646						43
44	<u>CORPORATE OVERHEAD</u>	1996	86,993						44
45	<u>CR 5/31/99 AUDIT ADJ</u>	1996	(86,993)						45
46	<u>TRAVEL/DELIVERY</u>	1996	13,507						46
47	<u>SIGNS</u>	1996	2,875						47
48	<u>KICKPLATES</u>	1996	1,697						48
49	<u>CABLE/WIRING</u>	1996	2,218						49
50	<u>CARPET</u>	1996	37,911						50
51	<u>WALLCOVERINGS</u>	1996	30,453						51
52	<u>NEW COIL</u>	1996	6,413						52
53	<u>PIPING/INSULATION</u>	1996	10,765						53
54	<u>PUMP UPGRADE</u>	1996	2,639						54
55	<u>RANGE GUARD</u>	1996	1,649						55
56	<u>NURSE CALL SYSTEM</u>	1997	7,208						56
57	<u>ARCHITECT/ENGINEER FEES</u>	1997	3,491						57
58	<u>GENERAL CONTRACTOR</u>	1997	21,640						58
59	<u>FURNISH &amp; INSTALL HEATER</u>	1997	5,109						59
60	<u>REPLACE DOORS/ALARM</u>	1997	2,957						60
61	<u>REPLACE WATER LINE</u>	1997	2,423						61
62	<u>CORPORATE OVERHEAD</u>	1997	10,516						62
63	<u>CR 5/31/99 AUDIT ADJ</u>	1997	(10,516)						63
64	<u>SITE PREP/LANDSCAPE</u>	1997	11,180						64
65	<u>FLOORING</u>	1997	916						65
66	<u>ROOFTOP A/C</u>	1997	39,990						66
67	<u>FACILITY PLAN ALLOC</u>	1997	5,964						67
68	<u>CR 5/31/99 AUDIT ADJ</u>	1997	(5,964)						68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 5,387,974	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	70

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

Facility Name &amp; ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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>		\$ 5,387,974	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	1
2	INSTALL NEW SUNROOM	1997	59,481						2
3	ASBESTOS REMOVAL	1997	19,675						3
4	ELECTRICAL	1997	4,156						4
5	ROOF WORK	1997	1,129						5
6	VINYL SHED	1997	803						6
7	ELECTRICAL	1998	17,790						7
8	PAINTING/ROOF/SIDING/CONCRETE	1998	20,304						8
9	BEAMS/STEEL	1998	4,320						9
10	CARPENTRY	1998	4,532						10
11	GENERAL CONTRACTOR FEES	1998	4,416						11
12	CARPET	1998	4,767						12
13	REMOVE & INSTALL DIFUSERS/DUCTS	1998	1,865						13
14	INSTALL DOORS	1998	4,466						14
15	CORPORATE OVERHEAD	1998	1,651						15
16	CR 5/31/99 AUDIT ADJ	1998	(1,651)						16
17	ENIGNEER/ARCHITECT FEES	1998	1,539						17
18	PLUMBING	1998	11,963						18
19	ELECTRICAL	1998	4,659						19
20	DEVELOPERS	1998	5,555						20
21	HVAC	1998	9,751						21
22	SIGN	1998	14,116						22
23	ROOFING	1998	3,725						23
24	PAVING	1998	17,975						24
25	PAINTING/WALLCOVERING	1999	1,418						25
26	FLOORING/CEILING	1999	3,964						26
27	HVAC	1999	6,727						27
28	DOOR/WINDOW	1999	2,938						28
29	ROOFING	1999	6,915						29
30	ARCHITECT	1999	15,472						30
31	KICKPLATES, HANDRAILS	1999	2,938						31
32	REMOVE OLD BOILER	1999	980						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,646,313	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	34

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

Facility Name &amp; ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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 12B, Carried Forward</b>		\$ 5,646,313	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	1
2	BUILDING DECORATIONS	1999	4,680						2
3	A/C UPGRADE	1999	17,360						3
4	BOILER CONTROLS	1999	23,650						4
5	ENGINEERING SERVICE	1999	779						5
6	VWC RES RMS/CORRIDORS	2000	8,025						6
7	ACCESS PANEL/AC UNIT	2000	520						7
8	AIR CONDITIONING UNIT	2000	4,121						8
9	ROOF REPAIRS	2000	1,065						9
10	EVELATOR UPGRADE	2000	590						10
11	CIRCUIT BOARD - FIRE ALARM	2000	2,461						11
12	ROOF INSPECTION	2001	650						12
13	INJECTOR PUMP	2001	2,697						13
14	FREIGHT ON CARPET	2001	316						14
15	CARPET	2001	6,426						15
16	FREIGHT ON CARPET	2001	55						16
17	CARPET	2001	2,790						17
18	CARPET	2001	2,141						18
19	FAN COIL UNITS	2001	41,483						19
20	CARPET	2001	2,374						20
21	ROOF	2001	4,086						21
22	ROOFING	2001	7,151						22
23	ROOF	2001	1,800						23
24	WINDOWS	2002	15,000						24
25	ROOF	2002	1,886						25
26	RENOVATION-OVERHEAD & INTEREST	2002	4,258						26
27	CR 5/31/03 AUDIT ADJ	2002	(4,258)						27
28	RENOVATION-GENERAL CONST & ELECT	2002	55,642						28
29	RENOVATION-CARPET	2002	13,724						29
30	STAINLESS STEEL WALLCOVER	2002	6,780						30
31	BOLLARDS AROUND COOLING TOWERS	2002	3,386						31
32	WINDOWS	2002	14,606						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,892,555	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	34

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

Facility Name &amp; ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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 12C, Carried Forward</b>		\$ 5,892,555	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	1
2	DOUBLE DOORS	2002	3,985						2
3	CARPET	2002	770						3
4	FREIGHT ON CARPET	2002	103						4
5	ROOF	2002	6,130						5
6	ROOF	2002	3,065						6
7	ROOF	2002	2,680						7
8	INSTALL CARPET	2002	458						8
9	INSTALL THREE DRAINS	2003	1,341						9
10	METAL STEEL DOOR	2003	1,000						10
11	METAL STEEL DOOR	2003	1,890						11
12	ARCHITECTURAL ENGINEERING	2003	602						12
13	ARCHITECTURAL ENGINEERING	2003	1,101						13
14	CARPET	2003	1,580						14
15	FREIGHT ON CARPET	2003	84						15
16	FREIGHT ON CARPET	2003	48						16
17	15 LIGHT FIXTURES	2003	3,600						17
18	BORDER	2003	629						18
19	BORDER	2003	131						19
20	VINYL WALL COVERING	2003	997						20
21	VINYL WALL COVERING	2003	581						21
22	BORDER	2003	179						22
23	BORDER	2003	149						23
24	VINYL WALL COVERING	2003	1,470						24
25	FREIGHT ON CARPET	2003	73						25
26	METAL DOOR AND INSTALLATION	2003	2,620						26
27	FLOORING AND VINYL WALL COV	2003	25,902						27
28	ARTWORK	2004	2,283						28
29	FREIGHT ON WINDOW TREATMENT	2004	97						29
30	CARPET	2004	1,580						30
31	FLOORING AND VINYL WALL COV	2004	400						31
32	CASH RECEIPT FOR CARPET	2004	(1,580)						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,956,502	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	34

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



Facility Name &amp; ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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 12D, Carried Forward</b>		\$ 5,956,502	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	1
2	CONCRETE SLAB	2004	670						2
3	ARCH & ENGINEERING COST	2004	8,693						3
4	VWC	2004	1,270						4
5	FLOORING	2004	2,145						5
6	PAINTING	2004	11,005						6
7	Building Décor / 3 years Ta	2004	70						7
8	ARTWORK	2004	2,123						8
9	PAINTING	2004	4,635						9
10	Building Décor / 3 years Ta	2004	241						10
11	VWC	2004	990						11
12	INCANDESCENT EXPLOSION LI	2004	1,384						12
13	LAMP FIXTURES DUPLEX RECE	2004	5,450						13
14	HOBART OVEN	2004	2,436						14
15	INSTALL SINK & FAUCET	2005	1,110						15
16	CARPET	2005	1,350						16
17	FREIGHT ON CARPET	2005	77						17
18	CARPET	2005	1,733						18
19	Dumpster Corral	2005	14,222						19
20	PAINTING	2004	(4,635)						20
21	NEW CEILIN TILE	2005	4,314						21
22	INTERIOR RENOVATION	2005	6,000						22
23	CEILING PANELS	2005	1,875						23
24	INSTALL DOOR	2005	1,722						24
25	DOUBLE EGRESS DOOR	2005	5,755						25
26	Renov-Carpentry/Millwork	2005	70,189						26
27	Renov-Gen O/H & Int. on Construction	2005	70,345						27
28	Renov-Custom Casework	2005	3,860						28
29	Renov-Carpeting/Pads/ WC/Corner Guards	2005	14,643						29
30	Renov-Fire Sprinkler Sys.	2005	6,215						30
31	Renov-Plumbing	2005	2,247						31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,198,635	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	34

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

Facility Name &amp; ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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 12E, Carried Forward		\$ 6,198,635	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	1
2	Renov-Basic Electrical	2005	12,120						2
3	2 Btyan Boilers	2005	45,280						3
4	Light Fixtures	2005	2,534						4
5	Fire system	2005	25,895						5
6	INSTALL RESET CONTROL	2005	2,105						6
7	Gen O/H & Int. on Construction	2006	34,385						7
8	Carp./Lobby Fin./Doors/Windows/HVAC	2006	78,084						8
9	HM Doors/Frames/Plumbing	2006	35,064						9
10	Resilient Flooring	2006	30,265						10
11	Carpet/Pads/WC/Corner Guards	2006	9,666						11
12	Basic Electrical	2006	16,811						12
13	wallcovering	2006	539						13
14	FLOORING	2006	7,500						14
15	fan coil unit	2006	5,870						15
16	flooring	2006	8,885						16
17	carpet	2006	4,755						17
18	carpet	2006	1,818						18
19	fire rated access panels	2007	25,525						19
20	SPRINKLER SYSTEM	2007	3,093						20
21	00000000737 REPAIR ROOF	2007	2,365						21
22	00000000749 GUTTERS AND SPOUTS	2007	4,748						22
23	00000000752 ENGINEERING	2007	4,950						23
24	767 Gen O/H on Construction	2007	1,851						24
25	768 Install Fluorecent fixtures	2007	2,084						25
26	770 12 Sliding closet doors & install	2007	14,960						26
27	Site Development Survey sewer	2008	11,650						27
28	00000000773 skylight re-roof	2008	1,185						28
29	00000000774 Fire Dampers	2008	7,820						29
30	775 1707 General Overhead Elevator Upgrade	2008	5,236						30
31	776 1707 Electrical Elevator Upgrade	2008	30,565						31
32	Carpet resilient flooring wall covering	2008	74,974						32
33	00000000790 Concrete Pad Dumpster	2008	2,395						33
34	TOTAL (lines 1 thru 33)		\$ 6,713,612	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	34

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

Facility Name &amp; ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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 12F, Carried Forward</b>		\$ 6,713,612	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	1
2	786 0608 2ND FL Corridor Resilient flooring	2008	22,553						2
3	791 Painting & Wall Covering RMS 211 & 311	2008	3,893						3
4	000000000793 WALL COVERING (ADJ #782) 1ST FL RES RENOV	2008	2,759						4
5	000000000794 Painting & Wall Covering RMS 209 & 309	2008	3,925						5
6	000000000795 METAL DOORS	2008	5,622						6
7	796 1108 General O/H Elevator Upgrade	2008	2,186						7
8	797 1108 Elevator & Elevator electric	2008	43,013						8
9	798 New Control elevator (#776)	2008	5,458						9
10	804 1108 Elevator handrails	2008	1,890						10
11	804 1108 Elevator controls	2008	5,545						11
12	000000000813 hollow metal door	2009	3,789						12
13	000000000814 DOOR ACCESS SYSTEM	2009	15,735						13
14	HM DOOR	2009	3,789						14
15	FREIGHT FOR FLOORING	2009	984						15
16	FLOORING	2009	1,217						16
17	FLOORING	2009	4,685						17
18	CARPET VINYL TILE	2009	6,974						18
19	DEMO 3 SHOWER STALLS	2009	29,220						19
20	DOOR ACCESS SYSTEM	2009	12,100						20
21	2009 ROOF REPLACEMENT	2009	131						21
22	2009 ROOF REPLACEMENT	2009	69,936						22
23	1ST FLOOR HANDRAIL	2009	8,733						23
24	HANDRAILS ELEVATOR	2009	6,758						24
25	1409 Parking Electric concrete bases, Poles, fence	2009	193,758						25
26	1409 Storm Sewer Excavate & intall	2009	37,740						26
27	SEALCOATING & STRIPING	2009	7,518						27
28	FLOOR TILE ELECTRICAL WORK ACCESS PANELS SOLARIUM	2010	72,167						28
29	HVAC LOBBY SOLARIUM	2010	6,982						29
30	WIRING FIXTURES SOLARIUM	2010	20,805						30
31	CARPETING	2010	3,364						31
32	FREIGHT CARPETING	2010	527						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,317,367	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	34

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

Facility Name &amp; ID Number Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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 12G, Carried Forward		\$ 7,317,367	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	1
2	FLOOR CARPET	2010	6,281						2
3	steel hand reailing	2010	14,720						3
4	VCT flooring, and steel studdi	2010	15,480						4
5	Interior stairwell handrail repairs and shaftwall for fire damper	2010	2,871						5
6	Interior stairwell handrail repairs and shaftwall for fire damper	2010	21,579						6
7	2" cast iron drain	2010	2,450						7
8	HM door w/tempered glass	2010	10,525						8
9	CARPETING	2010	10,527						9
10	FREIGHT FOR CARPETING	2010	875						10
11	3 doors	2010	11,204						11
12	Laundry rm Architect drawings	2010	22,014						12
13	Rooftop heat exchanger	2011	9,114						13
14	FREIGHT CARPET	2011	226						14
15	temperature controls on roofto	2011	3,550						15
16	Painting	2011	3,630						16
17	Fence	2010	6,650						17
18									18
19	00000000906 HM DOOR	2011	1,350						19
20	00000000907 HM DOOR	2011	1,350						20
21	00000000910 2610 3RD FL RES ROOM FLOOR	2011	22,060						21
22	00000000911 MED RECORDS OFFICE FLOORING	2011	20,115						22
23	00000000915 VCT FLOOR AND PAINTING	2011	11,543						23
24	00000000922 1811 MANSFORD ROOF	2011	33,494						24
25	00000000926 DRYWALL, & PAINT (RMS 302	2011	10,764						25
26	00000000935 CONCRETE APRON (SSIDE OF	2012	5,542						26
27	00000000936 2511 TRASH & LAUNDRY CHUTE	2012	42,470						27
28	00000000944 VCT TILE AND BASE	2012	8,081						28
29	00000000946 KITCHEN PRE-RINSE STATION	2012	4,135						29
30	00000000949 walk in cooler	2012	9,900						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,629,867	\$ 337,126		\$ 337,126	\$	\$ 3,730,850	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,912,964	\$ 136,998	\$ 136,998	\$		\$ 1,597,182	71
72	Current Year Purchases	168,434						72
73	Fully Depreciated Assets							73
74	<u>Home Office</u>			10,319	10,319			74
75	TOTALS	\$ 2,081,398	\$ 136,998	\$ 147,317	\$ 10,319		\$ 1,597,182	75

D. Vehicle Costs. (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)	\$ 10,215,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 474,124	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 484,443	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,319	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,328,032	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Manorcare of Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending: 05/31/12

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

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: \$ 35,810 Description: 02 Concentrators, wheelchairs, gerichairs, electric beds

(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	<b>TOTAL</b>		\$	\$	21

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

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

Facility Name & ID Number Manorcare of Wilmette # 0049650 Report Period Beginning: 06/01/11 Ending: 05/31/12  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	4430	hrs	\$ 200,402	139	\$ 10,086	\$ 371	4,569	\$ 210,859	1
2	Licensed Speech and Language Development Therapist	10a	3588	hrs	162,292			8	3,588	162,300	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	3807	hrs	172,217	1,905	138,268	8,213	5,712	318,698	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescripts				238,837		238,837	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						80,270		80,270	12
13	Other (specify): <u>X-ray &amp; Lab</u>	43, 3					43,679			43,679	13
14	TOTAL				\$ 534,911	2,044	\$ 192,033	\$ 327,699	13,869	\$ 1,054,643	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 Wilmette# 0049650Report Period Beginning: 06/01/11Ending: 05/31/12

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/12

(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	\$ (78,685)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (649,244) )	1,370,595		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,447		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>	\$ 1,294,357	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	504,044		13
14	Buildings, at Historical Cost	7,629,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,081,398		16
17	Accumulated Depreciation (book methods)	(5,328,032)		17
18	Deferred Charges	89,988		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>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,977,265	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,271,622	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 109,079	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	283,575		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	202,809		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 Payable</u>	159,992		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 755,455	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	223,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			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>	\$ 223,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 978,455	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 5,293,167	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,271,622	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,055,429</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>4,055,429</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,031,482)	<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>(1,031,482)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	2,269,220	<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>2,269,220</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>5,293,167</b>	<b>24</b> *

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

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,207,289	1
2	Discounts and Allowances for all Levels	(2,349,199)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,858,090</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,802,225	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,802,225</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	731	12
13	Barber and Beauty Care	8,773	13
14	Non-Patient Meals	241	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	256,910	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,537	19
20	Radiology and X-Ray	767	20
21	Other Medical Services	35,849	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 313,808</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			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,974,123</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,035,609	31
32	Health Care	3,395,825	32
33	General Administration	2,189,052	33
<b>B. Capital Expense</b>			
34	Ownership	836,797	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	373,321	35
36	Provider Participation Fee	175,001	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>\$ 8,005,605</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(1,031,482)</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (1,031,482)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,864,469	44
45	Private Pay - Net Inpatient Revenue	596,167	45
46	Medicare - Net Inpatient Revenue	2,124,660	46
47	Other-(specify) <u>Hospice</u>	93,892	47
48	Other-(specify) <u>Insurance</u>	178,902	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 4,858,090</b>	<b>49</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 Wilmette

# 0049650

Report Period Beginning:

06/01/11

Ending:

05/31/12

**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	2,031	2,200	\$ 93,045	\$ 42.29	1
2	Assistant Director of Nursing	4,161	4,508	159,477	35.38	2
3	Registered Nurses	20,630	22,350	750,699	33.59	3
4	Licensed Practical Nurses	9,384	10,166	289,013	28.43	4
5	CNAs & Orderlies	58,727	63,815	834,493	13.08	5
6	CNA Trainees	118	128	2,009	15.70	6
7	Licensed Therapist	11,826	12,797	578,836	45.23	7
8	Rehab/Therapy Aides	3,350	3,626	111,433	30.73	8
9	Activity Director	3,621	3,928	45,408	11.56	9
10	Activity Assistants					10
11	Social Service Workers	3,556	3,858	94,283	24.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,080	18,532	255,256	13.77	15
16	Dishwashers					16
17	Maintenance Workers	1,934	2,098	48,014	22.89	17
18	Housekeepers	9,514	10,317	134,748	13.06	18
19	Laundry	0	0	0		19
20	Administrator	2,080	2,080	94,300	45.34	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,737	16,175	323,389	19.99	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	0	0	0		31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	162,749	176,578	\$ 3,814,403 *	\$ 21.60	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 40,800	9, 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			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)	\$ 40,800		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



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Manorcare of Wilmette# 0049650Report Period Beginning: 06/01/11Ending: 05/31/12**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 \$2679
- (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 \$3858
- (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. \$ 36,331 Line 10, 2
- (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? Yes  
If YES, give effective date of lease. 04/07/11
- (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. \$ 175,001  
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. \$ 241
- (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.