

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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>I. IDPH License ID Number: <u>0049445</u></p> <p>Facility Name: <u>Manorcare of Hinsdale</u></p> <p>Address: <u>600 West Ogden Ave</u> <u>Hinsdale</u> <u>60521</u> Number City Zip Code</p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630) 325-9630</u> Fax # <u>(630) 325-9648</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/01/81</u></p> <p>Type of Ownership:</p> <table border="0"><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____</td><td><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><input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____</td></tr></table> <p>In the event there are further questions about this report, please contact: Name: <u>Jeff Lewandowski</u> Telephone Number: <u>(419) 252-5736</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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/17</u> to <u>05/31/18</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"><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Martin D. Allen</u></td><td></td></tr><tr><td></td><td>(Title) <u>Director</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td>(Telephone) <u>() () ()</u> Fax # <u>() () ()</u></td><td></td></tr></table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Martin D. Allen</u>			(Title) <u>Director</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>() () ()</u> Fax # <u>() () ()</u>	
<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 _____																			
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	(Title) <u>Director</u>																				
Paid Preparer	(Signed) _____	(Date) _____																			
	(Print Name and Title) _____																				
	(Firm Name & Address) _____																				
	(Telephone) <u>() () ()</u> Fax # <u>() () ()</u>																				

Facility Name & ID Number Manorcare of Hinsdale

0049445 Report Period Beginning: 06/01/17 Ending: 05/31/18

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	202	Skilled (SNF)	202	73,730	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	202	TOTALS	202	73,730	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,001	5,932	32,089	52,022	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,001	5,932	32,089	52,022	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.56%

D. How many bed reserve days during this year were paid by the Department? _____ (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES NO

I. On what date did you start providing long term care at this location?
 Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 04/07/11 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 202 and days of care provided 21,106

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name & ID Number Manorcare of Hinsdale # 0049445 Report Period Beginning: 06/01/17 Ending: 05/31/18

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	561,184	42,283	1,926	605,393		605,393		605,393		1
2	Food Purchase		410,489		410,489		410,489	(2,815)	407,674		2
3	Housekeeping	246,783	32,879	639	280,301		280,301		280,301		3
4	Laundry	77,578	28,952	806	107,336		107,336		107,336		4
5	Heat and Other Utilities			300,886	300,886	4,848	305,734		305,734		5
6	Maintenance	64,694	22,507	199,912	287,113		287,113		287,113		6
7	Other (specify):* Medical Waste			1,355	1,355		1,355		1,355		7
8	TOTAL General Services	950,239	537,110	505,524	1,992,873	4,848	1,997,721	(2,815)	1,994,906		8
	B. Health Care and Programs										
9	Medical Director			35,389	35,389		35,389		35,389		9
10	Nursing and Medical Records	6,025,254	451,706	131,871	6,608,831	111	6,608,942		6,608,942		10
10a	Therapy	2,997,793	13,573	48,387	3,059,753		3,059,753		3,059,753		10a
11	Activities	125,540	1,470	6,193	133,203		133,203		133,203		11
12	Social Services	325,514			325,514		325,514		325,514		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	9,474,101	466,749	221,840	10,162,690	111	10,162,801		10,162,801		16
	C. General Administration										
17	Administrative	185,685		1,267,353	1,453,038	(628,862)	824,176		824,176		17
18	Directors Fees										18
19	Professional Services			74,772	74,772	(1,180)	73,592	(73,592)			19
20	Dues, Fees, Subscriptions & Promotions			133,228	133,228		133,228	(36,122)	97,106		20
21	Clerical & General Office Expenses	545,023	117,077	749,347	1,411,447	1,180	1,412,627	(568,660)	843,967		21
22	Employee Benefits & Payroll Taxes			1,694,566	1,694,566	89,805	1,784,371		1,784,371		22
23	Inservice Training & Education			1,085	1,085		1,085		1,085		23
24	Travel and Seminar			4,281	4,281		4,281		4,281		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			888,915	888,915		888,915		888,915		26
27	Other (specify):*							(4,246)	(4,246)		27
28	TOTAL General Administration	730,708	117,077	4,813,547	5,661,332	(539,057)	5,122,275	(682,620)	4,439,655		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,155,048	1,120,936	5,540,911	17,816,895	(534,098)	17,282,797	(685,435)	16,597,362		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			594,443	594,443	29,768	624,211	(42,975)	581,236			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,050,971	6,050,971	504,330	6,555,301	(6,064,132)	491,169			32
33	Real Estate Taxes			171,086	171,086		171,086		171,086			33
34	Rent-Facility & Grounds			36,150	36,150		36,150		36,150			34
35	Rent-Equipment & Vehicles			117,523	117,523		117,523		117,523			35
36	Other (specify):*											36
37	TOTAL Ownership			6,970,173	6,970,173	534,098	7,504,271	(6,107,107)	1,397,164			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		914,663		914,663		914,663		914,663			39
40	Barber and Beauty Shops		169	19,054	19,223		19,223		19,223			40
41	Coffee and Gift Shops	8,084			8,084		8,084		8,084			41
42	Provider Participation Fee			276,190	276,190		276,190		276,190			42
43	Other (specify):* IV X-Ray & Lab		168,554	168,558	337,112		337,112		337,112			43
44	TOTAL Special Cost Centers	8,084	1,083,386	463,802	1,555,272		1,555,272		1,555,272			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	11,163,132	2,204,322	12,974,886	26,342,340		26,342,340	(6,792,542)	19,549,798			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,815)	2		4
5	Telephone, TV & Radio in Resident Rooms		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	(42,975)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(901)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(232)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,246)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,161)	21		18
19	Entertainment				19
20	Contributions	(4,902)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(30,515)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(559,364)	21		24
25	Fund Raising, Advertising and Promotional	(36,122)	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 Pg. 5A	(6,107,309)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,792,542)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (6,792,542)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exeptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Manorcare of Hinsdale

ID# 0049445

Report Period Beginning: 06/01/17

Ending: 05/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ 0	11	1
2	Misc. Income	0	21	2
3	Vending Income	0	21	3
4	Donations Revenue	(100)	21	4
5	Accounting/Collection Fees	(43,077)	19	5
6	Collection Agency	0	19	6
7	Loss on Disposal of Fixed Asset	0	36	7
8	HCP Lease Interest	(6,064,132)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,107,309)		49

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 Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HCR Manor Care Svcs	Toledo	Therapy Mgmt Svcs
				HL Home Health Care	Toledo	Nursing Staff

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	See	Home Office Allocation	\$ 1,267,353	HCR Manor Care Services, LLC	0.00%	\$ 1,267,353	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	11,163,132	Heartland Employment Services, LLC	0.00%	11,163,132		4
5	V	10a	Therapy Management	28,077	HCR Manor Care Services, LLC	0.00%	28,077		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		\$ 12,458,562				\$ 12,458,562	\$ *	14

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

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 Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care of Homewood IL, LLC	Homewood				14
15			Manor Care of Libertyville IL, LLC	Libertyville				15
16			Manor Care of Naperville IL, LLC	Naperville				16
17			Manor Care of Northbrook IL, LLC	Northbrook				17
18			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				18
19			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				19
20			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				20
21			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				21
22			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				22
23			Manor Care of South Holland IL, LLC	South Holland				23
24			Manor Care of Westmont IL, LLC	Westmont				24
25			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				25
26			Arden Courts of Geneva IL, LLC	Geneva				26
27			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				27
28			Arden Courts of Northbrook IL, LLC	Northbrook				28
29			Arden Courts of Palos Heights IL, LLC	Palos Heights				29
30			Arden Courts of South Holland IL, LLC	South Holland				30

Facility Name & ID Number Manorcare of Hinsdale # 0049445 Report Period Beginning: 06/01/17 Ending: 05/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/17

Ending: 05/31/18

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) 252-5500
 Fax Number (419) 254-5495

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	\$ 699,205	\$ 0	25,916,479	\$ 4,848	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	0	0	25,916,479	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	25,916,479	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	16,031	10,238	25,916,479	111	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	0	0	25,916,479	0	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	25,916,479	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	59,973,786	32,867,234	25,916,479	415,806	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	16,450,188	6,362,586	25,916,479	131,367	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	738,730,669	72 NFs	2,602,958	0	25,916,479	91,318	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	5,900,308	0	25,916,479	40,908	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	6,123,085	0	25,916,479	48,897	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	738,730,669	72 NFs	0	0	25,916,479	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	3,738,067,390	560 NFs, HHs, & Re	3,462,953	0	25,916,479	24,009	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,245,338,484	359 NFs	721,157	0	25,916,479	5,759	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	738,730,669	72 NFs	0	0	25,916,479	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	3,738,067,390		28,591,078		25,916,479	198,225	22
23	32	Directly Assigned Interest	Not Allocated			16,243,764			306,105	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,016,444				24
25	TOTALS					\$ 174,800,957	\$ 39,240,058		\$ 1,267,353	25

Facility Name & ID Number

Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/17

Ending:

05/31/18

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Conv. Sub. Debentures		X				\$ 4,419,968	\$ 3,955,349			0.0774	\$ 306,105	1					
2													2					
3													3					
4													4					
5													5					
Working Capital																		
6	Home Office Pooled Interest Expense											198,225	6					
7	Interest Income / Interest Expense											(13,161)	7					
8													8					
9	TOTAL Facility Related						\$ 4,419,968	\$ 3,955,349				\$ 491,169	9					
B. Non-Facility Related*																		
10													10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$	14					
15	TOTALS (line 9+line14)						\$ 4,419,968	\$ 3,955,349				\$ 491,169	15					

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

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

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

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

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Ending:

05/31/18

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1. Real Estate Tax accrual used on 2017 report.				\$	<u>152,792</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>168,236</u>	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	<u>15,444</u>	3	
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<u>155,641</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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<u>171,085</u>	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2013	<u>164,171</u>	8	FOR BHF USE ONLY			
	2014	<u>167,424</u>	9	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	2015	<u>166,143</u>	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2016	<u>166,682</u>	11	15	LESS REFUND FROM LINE 6	\$	15
	2017	<u>169,791</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
Line 2: \$168,236.25 = \$83,340.97 for 2nd half 2016 + \$84,895.28 for 1st half 2017							
Line 4: \$155,641.11 = \$84,895.28 for 2nd half 2017 + \$70,745.83 for Jan - May 2018							

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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Hinsdale COUNTY DuPage
 FACILITY IDPH LICENSE NUMBER 0049445
 CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski
 TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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>09-02-212-001</u>	<u>See Attached</u>	\$ <u>151,519.80</u>	\$ <u>151,519.80</u>
2. <u>09-02-212-006</u>	<u>See Attached</u>	\$ <u>15,793.64</u>	\$ <u>15,793.64</u>
3. <u>09-02-404-001</u>	<u>See Attached</u>	\$ <u>2,477.12</u>	\$ <u>2,477.12</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>169,790.56</u>	\$ <u>169,790.56</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Hinsdale

0049445 Report Period Beginning:

06/01/17 Ending:

05/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,479 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Row 1: Facility, 1981, \$1,358,110. Row 2: (blank). Row 3: TOTALS, \$1,358,110.

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	102		1972		\$ 1,160,300	\$ 45,593		\$ 45,593		\$ 3,191,861	4
5	100			1980	1,913,000						5
6	Therapy addition			2006	400,868						6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					311,625		311,625		6,264,825	9
10				1984	4,367						10
11				1985	6,383						11
12				1987	14,207						12
13				1988	22,849						13
14				1989	173,344						14
15				1990	114,281						15
16				1991	240,682						16
17				1992	111,750						17
18				1993	421,420						18
19				1994	145,930						19
20				1995	182,224						20
21				1996	326,618						21
22				1997	407,293						22
23				1998	392,286						23
24				1999	128,464						24
25				1999	(11,509)						25
26				2000	138,632						26
27				2001	142,009						27
28				2002	339,762						28
29	STEEL/METAL DOORS			2003	4,336						29
30	ROOF REPAIR			2003	1,084						30
31	ARCH AND ENGINEERING COSTS			2004	553						31
32	ELECTRICAL			2004	3,776						32
33	Arch and Engineering Costs			2004	42,165						33
34	General Construction Overhead Cost & Interest			2004	55,967						34
35	Flooring			2004	9,800						35
36	Carpeting			2004	11,210						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/17

Ending:

05/31/18**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	Painting	2004	\$ 63,111	\$		\$	\$	\$	37
38	Wallcovering & Corner Guards	2004	5,782						38
39	Carpentry	2004	27,527						39
40	Electrical	2004	24,620						40
41	Roofing & Doors	2004	1,685						41
42	Fire Wall	2004	4,625						42
43	VWC & Paint	2004	2,092						43
44	Exterior Painting	2004	7,405						44
45	Flooring	2004	12,981						45
46	Air Separator	2004	9,942						46
47	Flooring	2005	113,382						47
48	Doors	2005	4,865						48
49	VWC	2005	1,474						49
50	Flooring	2005	9,070						50
51	Shower Door	2005	6,140						51
52	Painting, Wallcovering, & Base	2005	3,531						52
53	Install fire server cabinet & shelves	2005	3,700						53
54	Fire Alarm Panels	2005	10,265						54
55	Masonry Work	2005	3,875						55
56	Smoke Detectors	2005	1,160						56
57	Electrical Circuit for Smoke Detecor	2005	801						57
58	Wallcovering	2005	5,240						58
59	Electrical Work in 28 patient rooms	2005	2,284						59
60	Wallcovering	2005	1,233						60
61	Smoke Detectors	2005	2,685						61
62	Remodel Janitor Closet & Greenhouse	2005	4,800						62
63	Remodel Janitor Closet & Greenhouse	2006	4,799						63
64	Electrical Work for Elevator - Hookup shunt switch	2006	503						64
65	Phone Wiring	2006	7,231						65
66	Exhaust Fan	2006	2,272						66
67	Phone Wiring Additional Work	2006	1,605						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,254,736	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	70

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/17

Ending:

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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 12A, Carried Forward		\$ 7,254,736	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	1
2	Corner guards	2006	353						2
3	Engineering for conceptual site plan - parking lot, lighting, lanscap	2006	6,767						3
4	Drywall & Paint to rebuild plumbing walls in 6 resident rooms	2006	8,023						4
5	Plumbing - Replace 4 wall hydrants	2006	3,224						5
6	Overhead & Interest on HVAC Project	2006	1,344						6
7	HVAC - 35 ton roof unit & related electrical work	2006	61,639						7
8	Overhead & Interest on addition/renovation project	2006	157,013						8
9	Addition/Renov. - Architect & Engineering	2006	71,504						9
10	Addition/Renov. - Permit fees, plan reviews, consultant misc.	2006	16,591						10
11	Addition/Renov. - Drywall canopies on 41 light fixtures	2006	1,017						11
12	Addition/Renov. - Ceil Tile & Paint Grid	2006	4,365						12
13	Addition/Renov. - Flooring	2006	5,147						13
14	Addition/Renov. - Wall Covering & Corner Guards	2006	17,428						14
15	Addition/Renov. - Fire Sprinkler System	2006	84,188						15
16	Addition/Renov. - Plumbing	2006	4,895						16
17	Addition/Renov. - HVAC	2006	2,594						17
18	Addition/Renov. - Electrical	2006	11,569						18
19	Addition/Renov. - Site Preparation	2006	39,350						19
20	Addition/Renov. - Fencing	2006	1,637						20
21	Addition/Renov. - Lanscaping block, trees, plants, etc.	2006	112,980						21
22	Electrical - Parking lot lights	2006	2,413						22
23	Roof Termination Strip	2006	967						23
24	Electrical work	2006	2,215						24
25	Patio with raised seating area	2006	24,113						25
26	Concrete curbs & pavement for new parking spaces	2006	28,645						26
27	Electrical - Parking lot lights	2006	13,005						27
28	Lawn sprinler system	2006	9,800						28
29	Carpet	2007	10,314						29
30	Remodel Shower Room - Tile, Sink, Faucets, Paint	2007	15,820						30
31	Flooring in Corridors	2007	11,448						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,985,104	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	34

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

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/17

Ending:

05/31/18**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 12B, Carried Forward		\$ 7,985,104	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	1
2	Electrical at nurses station	2007	2,538						2
3	Windows (9)	2007	14,245						3
4	Drainage	2007	17,001						4
5	Wallcovering	2007	15,483						5
6	Electrical for pill dispenser	2007	1,773						6
7	Elevator Upgrade	2007	4,370						7
8	Piping in laundry room	2007	1,700						8
9	Parking lot paving	2007	9,900						9
10	Curbing in Parking lot	2007	2,550						10
11	Paving	2007	8,016						11
12	Sidewalk & Railing	2007	36,550						12
13									13
14	Roofing over generator - Wate Tight Membrane	2008	16,314						14
15	Renov. - Vinyl Flooring	2008	37,310						15
16	ELEVATOR SWITCHES	2008	4,370						16
17	20 AMP CIRCUIT	2008	2,250						17
18	AC ELECTRICAL	2008	9,505						18
19	CONCRETE BOARD IN SHOWER	2008	2,680						19
20	ELECTRIC Change outlets from 2 to 4	2009	5,040						20
21	CIRCUIT BREAKER	2009	3,880						21
22	LAUNDRY CIRCUIT BREAKER	2009	5,140						22
23	225 AMP CIRCUIT BREAKER	2009	2,120						23
24	15 AMP RECEPTACLES	2008	3,360						24
25	Renov.- Front Elevator Upgrade	2009	54,708						25
26	HM Doors	2009	6,500						26
27									27
28	Renov. - Elevator Upgrade	2009	11,209						28
29	Doors (8) HM	2009	18,810						29
30	Renov. - Fire Rate Access Panels	2009	27,588						30
31	Renov. - Fire dampers & access panels	2009	78,095						31
32	Frights for Corner Guards	2009	240						32
33	Renov. - Fire Proof Acces Panels	2010	7,682						33
34	TOTAL (lines 1 thru 33)		\$ 8,396,031	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

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Ending:

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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 12C, Carried Forward		\$ 8,396,031	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	1
2	Renov. - Flooring	2010	25,501						2
3	Renov. - Wallcovering & guards	2010	20,127						3
4	Radiant heaters	2010	16,131						4
5	Emergency lights (15) led wall packs	2010	16,017						5
6									6
7	Renov. - Surveys	2010	5,625						7
8	Renov. - Millwork	2010	24,495						8
9	Renov. - Gypsum, Studs, & Tile Work	2010	110,702						9
10	Wiring For Phones In Arcadia Wing	2010	4,027						10
11	Renov. - Acoustic Ceiling System & Other	2010	161,931						11
12	Renov. - Roof Replacement	2010	114,435						12
13	Renov. - Flooring	2010	108						13
14	Renov. - Flooring & Wallcovering	2010	2,700						14
15	Cabinetry and Faucet	2010	6,841						15
16	VCT Flooring & Paint	2010	5,168						16
17	Renov. - Overhead & Interest (\$19,887.59)	2010							17
18	Renov. - 40 Ton A/C Unit, Trane	2010	56,970						18
19	Renov. - Flooring, Paint, & Wallcoverings	2010	135,403						19
20	Renov. - Interior Renovations	2010	28,587						20
21	Renov. - Carpentry	2010	125,759						21
22	French Drain & new pavers around flag pole (1/2 of invoice)	2011	6,375						22
23									23
24	Upgrade main electrical breaker, switch, & wire to generator	2011	65,223						24
25	French Drain & new pavers around flag pole (1/2 of invoice)	2011	6,375						25
26	Replace hand rails in Monroe corridor	2011	6,192						26
27	Paint, wallcovering, corner guards in Monroe corridor	2011	19,585						27
28	Chiller 40 ton - Revno. 11-11C	2011	66,756						28
29	Wander System at Elevators (3)	2011	22,853						29
30	Sprinkler System Upgrade	2011	11,910						30
31	Nurse Call System - Renov. 2011	2011	41,396						31
32	Physician Paging System	2011	3,025						32
33	Boiler	2011	5,390						33
34	TOTAL (lines 1 thru 33)		\$ 9,511,638	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/17

Ending:

05/31/18

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 12D, Carried Forward		\$ 9,511,638	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	1
2	Fire Wall, Doors, & Duct Dampers - Mechanical & Locker Rm	2012	36,210						2
3	Drywall, studs, & windows to enclose new OT area	2012	18,990						3
4	Exhaust system & ductwork for new OT area	2012	18,002						4
5									5
6	Electrical Panel & Wiring Upgrade	2012	4,787						6
7	Parking Lot Paving - Renov. 15-12MW	2012	54,973						7
8	Boiler, Lochinvar 1,300,000 BTU	2012	19,178						8
9	Compressor - 40 Ton	2012	2,848						9
10	Stainless Steel Corner Guards in Kitchen	2012	6,530						10
11	Install Fire Walls & Sprinklers - Renov 47-12MW as follows:	2012	30,120						11
12	1 1/2 hr. rated fire doors for second floor								12
13	Smoke wall repair by room 170								13
14	Smoke wall repair at stairwell next to room 213								14
15	Fire door repair for PT Mechanical Room								15
16	Sprinkler head extension outside room 233								16
17	Door repair for OT Storage room								17
18	HVAC - Laundry	2012	12,965						18
19	HVAC - OT Room	2013	14,980						19
20	Renovations to Lobby, Foyer, Office, 1st floor corridors, OT area, 2nd floor dining, 2nd floor corridor (elevator area) consisting of:								20
21	Carpentry, Millwork, Drywall, Handrails - Renov. 11-12MW	2013	158,004						21
22	Carpeting, Wallcovering - Renov. 11-12MW	2013	18,753						22
23	Light Fixtures - Renov. 11-12MW	2013	3,447						23
24	Water Heater	2013	4,971						24
25									25
26	Roofing on Penthouse & Mansard	2013	16,110						26
27	Compressor Replacement, RTU for 1st Flr NW Dining Area	2013	2,187						27
28	Doors & locksets - refrigeration rm, laundry & other areas.	2013	45,832						28
29	Smoke Dampers & Motors, Dinning, Lounge, Lobby, Rm 238	2014	10,755						29
30	EM Electric Upgrades to Med rm, Nurse station, Kiosk, Offices(3)	2014	6,585						30
31	Build/Repair Multiple Firestopping Walls	2014	72,800						31
32	Light fixture upgrade - whole building	2014	16,187						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,086,852	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	34

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

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/17

Ending:

05/31/18

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		\$ 10,086,852	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	1
2	Drainage System Upgrades - front entrance to bldg	2014	17,658						2
3	Smoke Wall Upgrades - kitchen, deck, internet café	2014	12,857						3
4	Sprinkler System Upgrades - three exterior overhangs	2014	3,078						4
5	Sun Porch Roofing Upgrades - Bashing and Kaynar	2014	18,234						5
6	Fire Door Upgrade - Install hollow metal stairwell door by 285	2014	2,076						6
7	Gutter and Fascia Upgrades - sheet metal	2014	8,055						7
8	Sun Porch Roofing Upgrades	2014	1,633						8
9	Security - door sensors	2014	4,447						9
10	Flooring - ceramic tile	2014	2,320						10
11	Fence - 6 ft pvc fencing	2014	4,290						11
12	Engineer - generator	2013	1,000						12
13	Engineer - generator	2013	1,300						13
14	Sprinkler pipe - repair broken water main	2015	5,772						14
15	Wall Cover Freight	2015	317						15
16	Qmark Base Board Heater Upgrad - room 331 new base board heater	2014	2,757						16
17	Electric Heating Upgrades - 3rd floor resident rooms	2014	17,550						17
18	Sensor	2015	2,804						18
19	Transmitter - HVAC unit	2014	1,145						19
20	Motor - Kitchen	2014	3,041						20
21	5 Ton HVAC	2014	4,199						21
22	Generator	2013	4,924						22
23	A#3697 Parking Lot Sealing Ad	2014	675						23
24	Parking Lot Sealing Upgrades - repair hole	2014	6,867						24
25	Parking Lot Lighting	2014	32,364						25
26									26
27	Fire walls-1st flr pt rooms, MR off	2015	22,850						27
28	Window rod/caulk-front ent area	2015	3,774						28
29	Combustion motor on boiler pump	2015	3,155						29
30	Surface mount high impact door	2015	3,027						30
31	Hot water tank	2015	13,725						31
32	28 room heater in 3rd floor resident rooms	2015	17,030						32
33	Fire stop smoke wall next to room 245	2015	20,870						33
34	TOTAL (lines 1 thru 33)		\$ 10,330,646	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	34

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

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/17

Ending:

05/31/18**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 12F, Carried Forward		\$ 10,330,646	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	1
2	Door Operator	2015	3,815						2
3	Concrete curb in front ent area to building	2015	5,845						3
4	Generator Radiator and coolant hoses	2015	15,595						4
5	Conduit wiring as needed-kitchen air unit	2015	27,400						5
6	Life safety lighting circuit for light fixtures in lobby and front office	2015	22,321						6
7	Wiring to relocate Life safety circuits -2nd floor dining closet and Med	2015	20,667						7
8	Reno 1st floor(williamsburg) & 3rd floor corridors & resident rooms:								8
9	Carpeting, Paint, Wallcovering, Corner Guards	2015	386,905						9
10	Basic/Composite Electrical	2015	170,806						10
11	HVAC	2015	2,498						11
12	Carpentry-Subcontractor/Millwork	2015	227,158						12
13	Drywall/studs, Flooring, Plumbing	2015	107,739						13
14	Exterior Sign	2015	2,458						14
15	Storage room Door	2016	4,410						15
16									16
17	Compressor condenser fan motor	2016	3,368						17
18	HVAC Split Rooms 208 - 210	2016	10,350						18
19	Cove heaters (2) in res bathrooms 336 & 352	2016	4,084						19
20	PVC conduit to 4 new lights poles @ locations 5, 6, 7 & 8.	2016	24,855						20
21	Fire stopping @ 3rd flr smoke wall by res rooms #328 & 329	2016	8,381						21
22	Conduit/wiring for 3 new light fixtures @ main entrance bollard lights	2016	7,375						22
23	Fire rated door, door closer, glass wire insert for fire exit to stairway	2017	3,775						23
24	Replaced grease basin w/grease seperator	2017	3,200						24
25	Circulation pump on water heater for kitchen & laundry	2017	10,920						25
26									26
27	Ductless AC in the basement records office	2017	8,895						27
28	Conduit and wiring for AC unit in basement	2017	2,685						28
29	Fuses & pwr supply unit in controller for kitchen Elevator #3	2017	3,740						29
30	Rehang/Rewire/Relamp Chandeliers(6) in Fireside Dining room	2017	6,480						30
31	Roof Repair	2017	10,030						31
32	Fusible Links & Inspection for 141 Fire Dampers	2017	11,800						32
33	Fire damper & 6 smoke dampers in main entrance lobby	2017	3,950						33
34	TOTAL (lines 1 thru 33)		\$ 11,452,150	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	34

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

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		\$ 11,452,150	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	1
2	Drier Core in AC for 2nd floor Monroe unit	2017	3,796						2
3	LED flood lights(4) & concrete bases @ road sign	2017	8,355						3
4	Fire stop voids 2nd flr stairs, rm 221, janitor closet, internet café (1st f	2017	8,947						4
5	Exit signs(4) on 1st floor, door holder & electirc for Therapy Office	2017	3,624						5
6	Floor Sink in kitchen and related concrete work	2018	6,510						6
7	Cove Heater & Eletric in room 259 Bathroom	2018	2,968						7
8	Main entrance doors, frames, electrical, ADA operator, mag lock (1/2	2018	16,000						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	TOTAL (lines 1 thru 33)		\$ 11,502,349	\$ 357,218		\$ 357,218	\$	\$ 9,456,686	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	\$ 5,578,503	\$ 194,250	\$ 194,250	\$		\$ 4,759,185	71
72	Current Year Purchases	110,302						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			29,768	29,768			74
75	TOTALS	\$ 5,688,805	\$ 194,250	\$ 224,018	\$ 29,768		\$ 4,759,185	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)	\$ 18,549,264	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 551,468	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 581,236	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,768	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,215,871	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Step-up Building Cost	\$ 3,713,060	\$ 42,975	\$ 3,713,060	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,713,060	\$ 42,975	\$ 3,713,060	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 Hinsdale

0049445

Report Period Beginning: 06/01/17

Ending: 05/31/18

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:	<u>N/A</u>			\$			3
4	Additions							4
5	<u>Portion of Parking Lot</u>			<u>3/26/2018</u>	<u>36,150</u>			5
6								6
7	TOTAL				\$ 36,150			7

10. Effective dates of current rental agreement:

Beginning 4/1/18

Ending 4/1/19

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

Fiscal Year Ending Annual Rent

12.	<u>/2019</u>	\$ <u>48,150</u>
13.	<u>/2020</u>	\$ _____
14.	<u>/2021</u>	\$ _____

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: \$ 105,214

Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Patient Transportation</u>	<u>2017 Ford Econline Cutaw</u>	\$	\$ <u>12,309</u>	17
18					18
19				<u>above figures includes</u>	19
20				<u>gas and maintenance</u>	20
21	TOTAL		\$	\$ 12,309	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.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	17262 hrs	\$ 794,205		\$	\$ 1,040	17,262	\$ 795,245	1
2	Licensed Speech and Language Development Therapist	10a	3335 hrs	153,427			1,678	3,335	155,105	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	15572 hrs	716,480			10,855	15,572	727,335	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				914,663		914,663	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Inhal Therapy</u>	10a, 3			165	10,117		165	10,117	12
13	Other (specify): <u>X-Ray & Lab IV</u>	43, 2 & 3				168,558	168,554		337,112	13
14	TOTAL			\$ 1,664,112	165	\$ 178,675	\$ 1,096,790	36,334	\$ 2,939,577	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning: 06/01/17

Ending:

05/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/18

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (188)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,023,959</u>)	2,463,467		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	23,753		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,487,032	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,358,110		13
14	Buildings, at Historical Cost	15,215,409		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,688,805		16
17	Accumulated Depreciation (book methods)	(17,928,931)		17
18	Deferred Charges	224,970		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) <u>OMIT</u>	218,251		22
23	Other(specify): <u>CIP</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,776,614	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,263,646	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 459,249	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	900,732		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	155,641		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accounts Payable</u>	164,771		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,680,393	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,955,349		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,955,349	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,635,742	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,627,904	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,263,646	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,077,493	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,077,493	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,391,050)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (3,391,050)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	2,941,461	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 2,941,461	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,627,904	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning: 06/01/17

Ending:

05/31/18

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 23,482,103	1
2	Discounts and Allowances for all Levels	(14,383,953)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,098,150	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	11,602,575	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 11,602,575	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,246	12
13	Barber and Beauty Care	18,926	13
14	Non-Patient Meals	2,815	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,824,159	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	145,291	19
20	Radiology and X-Ray	138,647	20
21	Other Medical Services	115,480	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,249,564	23
D. Non-Operating Revenue			
24	Contributions	100	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 100	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Discount</u>	901	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 901	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 22,951,290	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,992,873	31
32	Health Care	10,162,690	32
33	General Administration	5,661,332	33
B. Capital Expense			
34	Ownership	6,970,173	34
C. Ancillary Expense			
35	Special Cost Centers	1,279,082	35
36	Provider Participation Fee	276,190	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 26,342,340	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,391,050)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,391,050)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,152,749	44
45	Private Pay - Net Inpatient Revenue	2,214,909	45
46	Medicare - Net Inpatient Revenue	3,832,463	46
47	Other-(specify) <u>Hospice</u>	64,302	47
48	Other-(specify) <u>Insurance</u>	833,727	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,098,150	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Manorcare of Hinsdale

0049445

Report Period Beginning:

06/01/17

Ending:

05/31/18

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	4,031	4,417	\$ 243,430	\$ 55.11	1
2	Assistant Director of Nursing	5,919	6,487	261,688	40.34	2
3	Registered Nurses	64,554	70,750	2,411,254	34.08	3
4	Licensed Practical Nurses	32,161	35,248	1,010,821	28.68	4
5	CNAs & Orderlies	117,988	129,627	2,033,477	15.69	5
6	CNA Trainees	26	29	413	14.24	6
7	Licensed Therapist	39,472	43,274	1,991,022	46.01	7
8	Rehab/Therapy Aides	30,461	33,396	1,006,771	30.15	8
9	Activity Director	7,738	8,497	125,540	14.77	9
10	Activity Assistants					10
11	Social Service Workers	11,438	12,555	325,514	25.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,481	34,566	561,184	16.24	15
16	Dishwashers					16
17	Maintenance Workers	2,120	2,303	64,694	28.09	17
18	Housekeepers	18,145	19,926	246,783	12.38	18
19	Laundry	6,009	6,594	77,578	11.76	19
20	Administrator	2,080	2,080	141,362	67.96	20
21	Assistant Administrator	1,353	1,353	44,323	32.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,221	22,296	545,023	24.44	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	3,046	3,344	64,171	19.19	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	651	713	8,084	11.34	33
34	TOTAL (lines 1 - 33)	398,894	437,455	\$ 11,163,132 *	\$ 25.52	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	35,389	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)	\$	35,389		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Katherine Marrero	Administrator	0	\$ 141,362	Workers' Compensation Insurance	\$ 235,696	IDPH License Fee	\$ 3,980	
Matthew Smucker (June-Aug)	Asst. Administrator	0	10,560	Unemployment Compensation Insurance	98,149	Advertising: Employee Recruitment	38,498	
Nicole Lightfoot (Nov-May)	Asst. Administrator	0	33,763	FICA Taxes	814,246	Health Care Worker Background Check (Indicate # of checks performed <u>670</u>)	12,478	
				Employee Health Insurance	423,786	Patient Background Checks <u>1238</u>	12,380	
				Employee Meals		Dues & Subscriptions	9,958	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues	12,665	
				Disability Payments		Advertising	32,450	
				401K	78,673	Other Licenses and Permits	10,819	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 185,685	Appreciation, Oth Benefits & Mktg Adj	11,940	Less: Non-Allowable Association Dues	(3,672)	
B. Administrative - Other				Tuition Program	19,045	Less: Public Relations Expense	()	
Description			Amount	SMSP Match	7,402	Non-allowable advertising	(32,450)	
Various Home Office Services - See Page 8 for breakdown			\$ 1,267,353	Employee Uniforms	5,629	Yellow page advertising	()	
				Home Office Allocation	89,805			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,267,353	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,784,371	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 97,106	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Various	Legal Fees		\$ 30,515			\$	Out-of-State Travel	\$
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.								
Various	Collections		43,077				In-State Travel	4,281
AR Collection Costs were adjusted off via Page 5A, Lines 6 & 7, therefore, no detail schedule is attached.							Includes travel expense to the Home Office in Toledo, OH for regional meetings	
Michigan Peer Review	Consulting Fees		1,180				Seminar Expense	
(Consultant fees are relcassed to line 21, therefore, no invoices are attached).								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 74,772	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 4,281

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare of Hinsdale# 0049445

Report Period Beginning:

06/01/17

Ending:

05/31/18**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 \$6,028 & AHCA \$2,965
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5-10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 89,857 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? 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. \$ 276,190
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,815
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NO
Attach invoices and a summary of services for all architect and appraisal fees