

		FOR BHF USE					

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**2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)**

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>0049387</u></p> <p>Facility Name: <u>Manorcare Elk Grove Village</u></p> <p>Address: <u>1920 Nerge Road</u> <u>Elk Grove Villag</u> <u>60007</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 301-0550</u> Fax # <u>(847) 301-0013</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>07/03/90</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501(c)(3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>A. Dean Shipman</u> Telephone Number: <u>(419) 254-7841</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<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>06/01/2019</u> to <u>05/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Martin D. Allen</u> (Title) <u>Director</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="center">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) _____ (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) () _____ Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name & ID Number Manorcare Elk Grove Village

0049387 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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	190	Skilled (SNF)	190	69,540	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	190	TOTALS	190	69,540	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	26,859	5,656	17,701	50,216	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,859	5,656	17,701	50,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.21%

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 07/30/90

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 07/25/2018 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 190 and days of care provided 11,228

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 Elk Grove Village # 0049387 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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	589,419	21,943	3,231	614,593		614,593		614,593		1
2	Food Purchase		292,050		292,050		292,050	(1,395)	290,655		2
3	Housekeeping	243,844	39,224	490	283,558		283,558		283,558		3
4	Laundry	74,684	27,101		101,785		101,785		101,785		4
5	Heat and Other Utilities			261,964	261,964	4,846	266,810		266,810		5
6	Maintenance	113,471	31,974	200,895	346,340		346,340		346,340		6
7	Other (specify):* Security & Waste			25,664	25,664		25,664		25,664		7
8	TOTAL General Services	1,021,418	412,292	492,244	1,925,954	4,846	1,930,800	(1,395)	1,929,405		8
	B. Health Care and Programs										
9	Medical Director			17,000	17,000		17,000		17,000		9
10	Nursing and Medical Records	5,659,886	445,562	180,839	6,286,287	224	6,286,511		6,286,511		10
10a	Therapy	1,515,997	13,677	43,261	1,572,935		1,572,935		1,572,935		10a
11	Activities	155,281	3,402	2,454	161,137		161,137	(511)	160,626		11
12	Social Services	277,583	950		278,533		278,533		278,533		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	7,608,747	463,591	243,554	8,315,892	224	8,316,116	(511)	8,315,605		16
	C. General Administration										
17	Administrative	119,213		659,810	779,023	(117,977)	661,046		661,046		17
18	Directors Fees										18
19	Professional Services			98,337	98,337	273	98,610	(98,610)			19
20	Dues, Fees, Subscriptions & Promotions			110,637	110,637		110,637	(29,831)	80,806		20
21	Clerical & General Office Expenses	749,306	129,088	1,038,658	1,917,052	(273)	1,916,779	(841,727)	1,075,052		21
22	Employee Benefits & Payroll Taxes			1,678,054	1,678,054	83,823	1,761,877		1,761,877		22
23	Inservice Training & Education			3,800	3,800		3,800		3,800		23
24	Travel and Seminar			17,427	17,427		17,427		17,427		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			784,518	784,518		784,518		784,518		26
27	Other (specify):*										27
28	TOTAL General Administration	868,519	129,088	4,391,241	5,388,848	(34,154)	5,354,694	(970,168)	4,384,526		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,498,684	1,004,971	5,127,039	15,630,694	(29,084)	15,601,610	(972,074)	14,629,536		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			361,795	361,795	34,447	396,242		396,242		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(6,090)	(6,090)	(5,363)	(11,453)		(11,453)		32
33	Real Estate Taxes			1,106,574	1,106,574		1,106,574		1,106,574		33
34	Rent-Facility & Grounds			1,880,097	1,880,097		1,880,097	(1,880,097)			34
35	Rent-Equipment & Vehicles			46,178	46,178		46,178		46,178		35
36	Other (specify):*										36
37	TOTAL Ownership			3,388,554	3,388,554	29,084	3,417,638	(1,880,097)	1,537,541		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		558,592		558,592		558,592		558,592		39
40	Barber and Beauty Shops			10,478	10,478		10,478		10,478		40
41	Coffee and Gift Shops	25,532		313,577	339,109		339,109		339,109		41
42	Provider Participation Fee		76,826	108,842	185,668		185,668		185,668		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers	25,532	635,418	432,897	1,093,847		1,093,847		1,093,847		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,524,216	1,640,389	8,948,490	20,113,095		20,113,095	(2,852,171)	17,260,924		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	(1,395)	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		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	34	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(163)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(28,810)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(840,498)	21		24
25	Fund Raising, Advertising and Promotional	(29,831)	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	(1,951,508)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,852,171)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,852,171)		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	

Manorcare Elk Grove Village

ID# 0049387

Report Period Beginning: 06/01/2019

Ending: 05/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ (511)	11	1
2	Misc. Income		21	2
3	Vending Income	(1,100)	21	3
4	Donations Revenue		21	4
5	Accounting/Collection Fees	(69,800)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest		32	8
9	WT Rent Expense	(1,880,097)	34	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,951,508)		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
				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	\$ 659,810	HCR Manor Care Services, LLC	0.00%	\$ 659,810	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	9,524,217	Heartland Employment Services, LLC	0.00%	9,524,217		4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 10,184,027			\$ 10,184,027	\$ *	14

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

Facility Name & ID Number

Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019

Ending:

05/31/2020

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 Galesburg IL, LLC	Galesburg				1
2			Heartland of Henry IL, LLC	Henry				2
3			Heartland of Macomb IL, LLC	Macomb				3
4			Heartland of Moline IL, LLC	Moline				4
5			Manor Care at Arlington Heights	Arlington Heights				5
6			Manor Care of Hinsdale IL, LLC	Hinsdale				6
7			Manor Care of Homewood IL, LLC	Homewood				7
8			Manor Care of Libertyville IL, LLC	Libertyville				8
9			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				9
10			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				10
11			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				11
12			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				12
13			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Arden Courts of Geneva IL, LLC	Geneva				14
15			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				15
16			Arden Courts of Northbrook IL, LLC	Northbrook				16
17			Arden Courts of Palos Heights IL, LLC	Palos Heights				17
18			Arden Courts of South Holland IL, LLC	South Holland				18
19								19
20								20
21			REMEMBER TO DELETE THE FACILITY YOU ARE WORKING ON AND THIS COMMENT!					21
22								22
23								23
24	Martin D. Allen	BOD						24
25	Lynne Davis	BOD						25
26	Kathryn S. Hoops	BOD						26
27	Thomas Kile	BOD						27
28	Patricia McCormick	BOD						28
29	Rami Ubaydi	BOD						29
30								30

Facility Name & ID Number Manorcare Elk Grove Village # 0049387 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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 Elk Grove Village

0049387

Report Period Beginning:

06/01/2019

Ending: 5/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization HCR Manor Care 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

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	2,636,740,077	485 NFs, HHs, & Re	\$ 709,073	\$ 0	18,021,810	\$ 4,846	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs		0	18,021,810	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	18,021,810	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	32,137	0	18,021,810	220	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	454	0	18,021,810	4	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	18,021,810	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	57,708,481	23,053	18,021,810	394,431	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	7,841,321	0	18,021,810	66,912	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs	2,818,405	0	18,021,810	80,490	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	5,631,859	35,913,957	18,021,810	38,493	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	5,312,192	1,179,502	18,021,810	45,330	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs		0	18,021,810	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	4,013,110	0	18,021,810	27,429	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	822,456	0	18,021,810	7,018	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	18,021,810	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	2,636,740,077		(782,905)		18,021,810	(5,351)	22
23	32	Directly Assigned Interest	Not Allocated			(8,038)			(12)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,182,124				24
25	TOTALS					\$ 118,280,668	\$ 37,116,512		\$ 659,810	25

Facility Name & ID Number

Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019

Ending:

05/31/2020

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				\$	\$			#DIV/0!	\$						
2																		
3																		
4																		
5																		
Working Capital																		
6	Home Office Pooled Interest Expense											(5,363)						
7	Interest Income / Interest Expense											(6,090)						
8																		
9	TOTAL Facility Related						\$	\$				(11,453)						
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$										
15	TOTALS (line 9+line14)						\$	\$				(11,453)						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 report.		\$	795,427	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.)		\$	916,762	2
3. Under or (over) accrual (line 2 minus line 1).		\$	121,335	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	999,434	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.)		\$	11,410	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 \$ (25,605) For 16 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(25,605)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	1,106,574	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	834,627	8
	2016	838,049	9
	2017	897,745	10
	2018	910,014	11
	2019	558,275	12

Line 2: \$916,761.97 = \$416,254.17 for 2nd half 2018+ \$500,507.80 for 1st half 2019

Line 4: \$999,434.00= \$558,274.83 for 2nd half 2019 + \$441,159.17 for 1st half 2020

Line 5: \$11,410 = Worsek & Vihon invoices Specific Objeections: 2017 - \$170.33 & 2016 - \$6,407.35. Stout Inv for \$4,831.83

Line 56: \$(25,605) = refund for 2016 Specific Objections

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare Elk Grove Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049387

CONTACT PERSON REGARDING THIS REPORT A. Dean Shipman

TELEPHONE (419) 254-7841 FAX #: (800) 422-2089

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>07-35-200-022-0000</u>	<u>See Attached</u>	\$ <u>751,379.32</u>	\$ <u>558,274.83</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>751,379.32</u></u>	\$ <u><u>558,274.83</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? X YES 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Elk Grove Village

0049387

Report Period Beginning:

06/01/2019 Ending:

05/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,963 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

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

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

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

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

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

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

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: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, 390,567, 1990, \$ 853,628, 1. Row 2: 2, 2. Row 3: 3 TOTALS, 390,567, \$ 853,628, 3.

Facility Name & ID Number Manorcare Elk Grove Village# 0049387

Report Period Beginning:

06/01/2019

Ending:

05/31/2020**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	120			1990	\$ 5,025,494	\$ 205,329		\$ 205,329	\$	\$ 5,278,496	4
5	60			1996	1,726,800						5
6	10			2000	786,725						6
7				2009	631,865						7
8											8
	Improvement Type**										
9	Current Year Depreciation					55,959		55,959		3,988,883	9
10				1990	12,954						10
11				1991	41,034						11
12				1992	89,111						12
13				1993	29,775						13
14				1994	18,939						14
15				1995	182,383						15
16				1996	485,188						16
17				1997	111,890						17
18				1998	127,587						18
19				1999	52,156						19
20				2000	68,449						20
21				2001	5,850						21
22				2002	53,586						22
23				2003	132,189						23
24				2004	111,973						24
25				2005	2,435						25
26				2006	28,102						26
27				2007	284,818						27
28				2008	337,468						28
29	Renov. - Internet Café Construction (Contracted Total)			2009	88,371						29
30	Double Egress Kitchen Doors			2009	6,076						30
31	Renov. - Millwork (Hand Rails)			2009	14,910						31
32	Renov. - Electrical (Light Fixtures)			2009	5,990						32
33	Renov. - Carpet			2009	6,195						33
34	Renov. - Wallcovering, Corner Guards			2009	8,076						34
35	Generator - Installation & Materials			2009	11,108						35
36	Renov. - Carpentry			2009	45,000						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 Elk Grove Village

0049387

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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	Renov. - Millwork (Hand Rails)	2009	\$ 16,827	\$		\$	\$	\$	37
38	Renov. - Carpet	2009	9,331						38
39	Renov. - Wallcovering	2009	9,237						39
40	THERAPY ADD - SOIL TESTING	2009	600						40
41	THERAPY ADD - CONCRETE TESTING	2009	2,155						41
42	THERAPY ADD - SITE PREPARATION	2009	240,173						42
43	THERAPY ADD - LANDSCAPING	2009	14,240						43
44	LIGHTPOLE W/ CONCRETE BASE	2009	5,483						44
45	THERAPY ADD - ARCH & ENGINEER COST	2009	56,780						45
46	THERAPY ADD - ARCHITECT REIMB EXTER	2009	7,886						46
47	THERAPY ADD - ENGINEERING - CIVIL	2009	4,740						47
48	THERAPY ADD - INTERIOR DESIGN CONSULTANT	2009	102,773						48
49	THERAPY ADD - LANDSCAPE DESIGN CONSULTANT	2009	8,487						49
50	THERAPY ADD - PLAN REVIEWS	2009	8,853						50
51	THERAPY ADD - SALES USE TAX	2009	22						51
52	THERAPY ADD - WALL COVERING	2009	14,602						52
53	THERAPY ADD - CORNER GUARDS	2009	1,548						53
54	THERAPY ADD - TV IN PT WAITING ROOM	2010	1,745						54
55	7/1/2019 Capital Audit Adj - reclass to Equipment	2010	(1,745)						55
56	THERAPY ADD - CRASH RAIL	2010	3,941						56
57	PAINTING FOR NOURISHMENT	2009	3,800						57
58	10 DOORS	2009	27,900						58
59	CARPETING	2009	1,040						59
60	7/1/2019 Capital Audit Adj - under minimum for capitalization	2009	(1,040)						60
61	HM DOOR	2009	4,867						61
62	HM DOOR	2010	4,830						62
63	C-WING SPRINKLERS	2010	25,181						63
64	3808 C WING REHAB RENO - CARPENTRY	2009	43,296						64
65	3808 C WING REHAB RENO - HM DOORS & FRAMES	2009	3,324						65
66	3808 C WING REHAB RENO - ELECTRICAL	2009	6,930						66
67	3808 C WING REHAB RENO - CORNER GUARDS	2009	268						67
68	2107 GENERATOR REPLACE - LABOR & MATERIALS	2009	25,804						68
69	1409 SPRINKLER HEADS - SPRINKLERS	2009	32,500						69
70	TOTAL (lines 4 thru 69)		\$ 11,218,875	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	70

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

Facility Name & ID Number Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 11,218,875	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	1
2	1809 INTERIOR RENO - FLOORING	2010	1,906						2
3	1809 INTERIOR RENO - CARPETING	2010	9,289						3
4	1809 INTERIOR RENO - WALL COVERING	2010	45,056						4
5	1809 INTERIOR RENO - ELECTRICAL	2010	1,984						5
6	1809 INTERIOR RENOVATION - Wall Covering	2010	44,154						6
7	7/1/2019 Capital Audit Adj - reclass to Equipment		(44,154)						7
8	HM Doors	2010	10,350						8
9	0910 HERITAGE RENOVATION - Lobby Finishes	2010	76,149						9
10	0910 HERITAGE RENOVATION - Carpeting & Pads	2010	8,725						10
11	0910 HERITAGE RENOVATION - Wall Covering	2010	8,753						11
12	0910 HERITAGE RENOVATION - Corner Guards	2010	2,827						12
13	0910 HERITAGE RENOVATION - Millwork	2010	15,549						13
14	0910 HERITAGE RENOVATION - Basic Electrical	2010	8,612						14
15	SMOKE DETECTOR SYSTEM	2011	10,890						15
16	1211 C-WING RES BTHRM HEATERS	2011	18,560						16
17	HM DOORS - ASST ADMIN OFFICE & BATHROOM	2011	19,050						17
18	DRAINAGE SYSTEM (COURTYARD)	2011	28,203						18
19	300 FT OF SEWER PIPING	2011	27,190						19
20	concrete walk sections	2011	14,426						20
21	CABINETS (NOURISHMENT RM)	2011	3,969						21
22	ELEC HEATERS IN LAUNDRY/RMS 421/141/C-WING SHOW	2011	14,233						22
23	208 volt 30 amp circuit (steam	2011	2,153						23
24	7/1/2019 Capital Audit Adj - under minimum for capitalization		(2,153)						24
25									25
26	HERITAGE WING RENOV - GEN OVERHEAD & INTEREST	2011	79,909						26
27	7/1/2019 Capital Audit Adj -related party overhead and interest	2011	(79,909)						27
28									28
29	HERITAGE WING RENOV - RESILIENT FLOORING	2011	109,165						29
30	HERITAGE WING RENOV - CARPETING	2011	21,188						30
31	HERITAGE WING RENOV - WALLCOVERING	2011	85,740						31
32	HERITAGE WING RENOV - BASIC ELECTRICAL	2011	25,016						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,785,705	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	34

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

Facility Name & ID Number Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 11,785,705	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	1
2	SHOWER RENOVATIONS HERITAGE WING	2011	4,857						2
3	PLANTER BOXES, ADDL CONCRETE FOR COURTYARD	2011	3,375						3
4	SPRINKLER PIPING	2012	15,836						4
5	DOUBLE DOORS @ STORAGE SHED	2012	2,915						5
6									6
7	FIRE DAMPERS in C-Wing	2012	13,320						7
8	5 DOORS-rms 115, 126, 320 ,328, & DCD office	2012	17,084						8
9	PATIO CANOPY	2012	2,086						9
10	Roof	2012	39,130						10
11	MINOR KITCHEN RENOV - flooring	2012	9,804						11
12	MINOR KITCHEN RENOV -tile	2012	2,280						12
13	FIRE SPRINKLER	2012	14,504						13
14	FLOORING-employee baths	2012	6,785						14
15									15
16	PIPE INSULATION - janitors closets	2013	4,860						16
17	DOORWAY- kitchen entrance	2013	7,443						17
18	Doors- rms 118-119/308/313, conf rm, A-Wing & central bath	2013	22,752						18
19	Doors (5)- rm 111, C-Wing Shower, ST, BOM & front ofc hall	2013	24,400						19
20	Sprinkler piping & data cables @ smoke walls	2013	17,019						20
21									21
22	Electrical - dish machine	2014	3,630						22
23	Electrical, additional to line above - dish machine	2014	1,090						23
24	Workstation, Wall Mounted- dietary mgr ofc	2014	2,770						24
25	Firestopping elec rm -data lines, sprinkler piping, conduits,ductw	2014	29,700						25
26	Windows - 14 Resident Rooms	2013	5,950						26
27	Electrical, AC- maint ofc	2014	2,455						27
28	7/1/2019 Capital Audit Adj - under minimum for capitalization	2014	(2,455)						28
29	Firestop @ plumbing pipes ceiling	2014	2,200						29
30	7/1/2019 Capital Audit Adj - under minimum for capitalization	2014	(2,200)						30
31	Doors, Fire @ B-Wing Shower, Womans restrm by rm 300, & Soiled Utility								31
32		2014	8,158						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,045,453	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	34

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

Facility Name & ID Number Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 12,045,453	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	1
2	Compressor , 4 ton 3 phase 460V	2014	2,030						2
3	Compressor / contactor for HVAC	2014	3,142						3
4	VALVE-plumbing repairs showers	2014	3,642						4
5	MOTOR-RTU #3	2014	1,465						5
6	CO2 DETECTORS	2015	4,266						6
7	Compressor HVAC	2014	2,801						7
8	PARKING LOT SEALING	2014	54,079						8
9	EZ path devices (11)-3"x3" @ smoke walls- fire alarm cabling	2014	8,828						9
10									10
11	Firestopping-main svc hall, mech rm	2014	26,512						11
12	Electrical	2014	9,248						12
13	Pipe, 60 lineal ft 4" perf sewer grade & 2 downspouts	2014	8,046						13
14	Roofing	2014	1,620						14
15	7/1/2019 Capital Audit Adj - under minimum for capitalization	2014	(1,620)						15
16	Conculuting on fire alarm system	2014	1,500						16
17	7/1/2019 Capital Audit Adj - under minimum for capitalization	2014	(1,500)						17
18	Renov - Wallcovering	2015	2,700						18
19	Renov - Basic electrical	2015	4,003						19
20	Tile kitchen sink area	2015	2,924						20
21	WATER HEATER	2015	9,420						21
22	CIRCUIT-life safty corrections	2015	12,642						22
23	SPRINKLER PIPE	2015	2,233						23
24	7/1/2019 Capital Audit Adj - under minimum for capitalization	2015	(2,233)						24
25	Renov - fire alarm system	2015	146,022						25
26	FIRE WALL ext internet café	2015	17,790						26
27	Drywall-med prep room in A Wing	2015	7,109						27
28	painting in main dining room	2015	2,585						28
29	Doors-empl lounge, hall @ rm 112, @ library, rm 401	2015	11,650						29
30	Thermometer & solenoid valve @ hot water supply -Maint Ofc & boiler rm								30
31	& tempering valve -C-wing mech rm.	2015	6,290						31
32	Elec, 120V circuit @ boiler rm, Maint Ofc , C-Wing Mech Rm	2015	2,707						32
33	Magnets, 24V wall-main hall: DCD, ST Ofc doors & A-wing door	2015	2,640						33
34	TOTAL (lines 1 thru 33)		\$ 12,397,994	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	34

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

Facility Name & ID Number Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 12,397,994	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	1
2	Grout/caulk shower bays - A-wing (4) & B-Wing (1)	2015	2,730						2
3	Floors - walk in cooler/freezer	2015	12,297						3
4	Wiring/conduit - W pole light & to S pole near main entrance	2015	9,289						4
5	Pipes- leaking above sprinkler rm hatch	2015	4,217						5
6	Quarry tile floor - kitchen	2015	7,238						6
7	Electrical,3 phase 42 circuit 100 amp- kitchen steamer panel	2015	14,761						7
8	Solenoids & aqua-stats-main boiler rm, maint shop, & mech rm -Medbridge S	2015	4,778						8
9									9
10	Metal framing, (2) linen closets-Medbridge N @ DCD ofc & A-wing Nurse stat	2015	6,755						10
11									11
12	Concrete (2sq) & mud-jack (7sq) to level patio	2015	4,370						12
13	Door w sidelight, HM ext. @ #7 Exit door N end - B-wing	2015	5,960						13
14	Door w sidelight, HM ext. @ #3 Exit door N end - Medbridge S	2015	6,735						14
15	Quarry floor tile, 6x8 ft - kitchen	2015	2,350						15
16	7/1/2019 Capital Audit Adj - under minimum for capitalization	2015	(2,350)						16
17	Piping- kitchen drain	2015	5,410						17
18	Mixing valve on hot water tank - Mech. room	2015	8,452						18
19	Heat Pump,4 ton -service hall	2015	7,500						19
20	Freezer Door	2015	3,885						20
21	Itercom master stations: medbridge & "A" nurse station	2015	3,785						21
22	Fusible links -approx 400 fire dampers thru out bldg	2015	24,650						22
23	Mixing valve & expansion tank -boiler room	2016	9,414						23
24	Drain line -steam table	2016	5,410						24
25	Relocate door op from LS panel to CR panel in Main elect rm	2016	2,210						25
26	7/1/2019 Capital Audit Adj - under minimum for capitalization	2016	(2,210)						26
27	P-trap & drain - oven area of kitchen	2016	5,515						27
28	Piping -copper refrigeration lines @ Medbridge N nurses stat	2016	2,035						28
29	7/1/2019 Capital Audit Adj - under minimum for capitalization	2016	(2,035)						29
30	Compressor/accumulator-heat pump, 7.5 ton - Medbridge N	2016	4,900						30
31	Fire stopping: PT, rms 102 & 400, lounge, Soc Svc, PT Storage	2016	24,510						31
32	Roof: ridge vent approx 40 ft	2016	2,090						32
33	7/1/2019 Capital Audit Adj - under minimum for capitalization	2016	(2,090)						33
34	TOTAL (lines 1 thru 33)		\$ 12,580,555	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	34

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

Facility Name & ID Number Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 12,580,555	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	1
2	Fire dampers (36) through out bldg	2016	10,440						2
3	Piping -dry fire sprinkler 15A system.	2016	1,160						3
4	7/1/2019 Capital Audit Adj - under minimum for capitalization	2016	(1,160)						4
5									5
6	Plumbing-sink drain,garbage disposal, dish wash station & Tile fl	2016	10,925						6
7	Compressor- 5T for A-Wing air handler	2016	3,061						7
8	Ductwork-rm 112, door coord-main dining , sweep-Mech door	2016	5,575						8
9	Doors & assemblies @ new linen rm, dining, O2, & ST rms	2016	6,160						9
10	Wandering Patient system-controller for main front door plus Maglocks (2)-								10
11	front hall exit door in 300 wing	2016	3,951						11
12	Doors @ A-Wing & Medbridge S exits	2016	12,365						12
13	Piping -fire sprinkler sys -ceiling Medbridge S Lounge	2017	4,054						13
14	Piping-fire sprinkler: rms 103,104,108,110, & @ hatch-nurse st	2017	5,467						14
15									15
16	Compressor, for 4 Ton A/C - B-wing nurses station	2017	2,813						16
17	Compressor, 1HP, Horizontal w/tank for Fire Sprinkler system	2017	3,500						17
18	Piping - Fire Sprinkler System	2017	62,146						18
19	Accelerator, Model B1 -Fire Sprinkler System (2)	2017	4,249						19
20	Compressor, for AC unit - Accounting Ofc	2017	2,860						20
21	Sprinkler Heads -Fire Sprinkler Sys (460): A-Wing Res Rms 102-141, Utility & central shower								21
22	and TCU-Wing Res rms 213-233, Utility & central shower	2017	136,256						22
23	Mixing Valve-Maint Rm	2017	2,794						23
24	Backflow Assy -Fire System	2017	8,876						24
25	Roofing	2017	2,985						25
26	Mixing Valve-Medbidge South	2017	2,794						26
27	Tubing-AC Unit -B-Wing Hall Unit #1	2017	3,194						27
28	Concrete Sidewalk @ C-wing Exit	2017	4,885						28
29	Mixing Valve - Kitchen	2017	3,091						29
30	Door-Dining rm ebtry door to Coffee Bar	2017	4,450						30
31	Paving - Asphalt Parking Lot	2017	13,639						31
32	RTU 12.5T -Kitchen	2017	14,950						32
33	Backflow Assy -Fire System	2017	8,875						33
34	TOTAL (lines 1 thru 33)		\$ 12,924,910	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	34

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

Facility Name & ID Number Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 12,924,910	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	1
2	Doors, HM (4) - boiler rm & Mech rms by Brookview W & Medbridge E								2
3	Nurse stations & Rec Ther.	2017	4,341						3
4	Hinges (4) for front entrance	2018	2,783						4
5	Doors, HC Metal-Boiler Rm by Brookview N, Mech Rms by Medbridge E								5
6	& Activities	2018	4,778						6
7	Mixing valve in boiler room	2018	4,117						7
8	Doors, HM (2) @ #5 & #6 Exterior doors	2018	11,652						8
9	Replace compressor in Medbridge West & Main hallway	2018	4,720						9
10	Dry fire sprinkler system repair	2018	3,710						10
11	Piping and Tyco accelerator for sprinkler sytem repair	2018	5,780						11
12	ROOF REPAIR	2018	2,845						12
13	Installed 2 white windows in rehab unit	2018	2,705						13
14	Fire sprinkler system repair	2019	3,374						14
15	Installed 2.5Ton Ac unit for electrical gear room	2019	8,800						15
16	Replaced dry fire spinkler heads	2019	4,960						16
17	Storm Drain Basin/Piping-Main parking lot	2019	8,855						17
18	Plumbing for Dish area	2019	2,928						18
19	Carpet Tiles- Medbridge East Section of the building	2019	10,410						19
20	Carpeting - Main Lobby	2019	8,015						20
21	Fire Sprinkler System Flush	2019	15,810						21
22	Piping -21ft/4in -sprinkler system 15	2019	2,797						22
23	Disposer-Kitchen	2019	3,399						23
24	Boiler Pump-Boiler rm	2019	3,094						24
25	Sprinkler, Hydrant + 3 ton stone	2019	7,500						25
26	Mixing Vales (2)- Rada 425R -Maint rm	2020	4,641						26
27	SCREENS-(17)-Brookview & (7)-Medbridge South	2020	3,644						27
28	Mixing Valve (2) -Kitchen	2020	3,195						28
29	Piping -21ft/1.25in -sprinkler system	2019	4,590						29
30	Roof - Valley sections	2019	2,832						30
31	Fire/Smoke Dampers (368) through out bldg; (18) PT Rm	2020	25,182						31
32	Grills/Diffusers (11) -Kitchen/Prep areas	2020	3,290						32
33	Doors, Exterior -HM (2)- Main entrance	2020	12,456						33
34	TOTAL (lines 1 thru 33)		\$ 13,112,112	\$ 261,288		\$ 261,288	\$	\$ 9,267,379	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	\$ 4,659,967	\$ 100,507	\$ 100,507	\$		\$ 4,432,577	71
72	Current Year Purchases	35,336						72
73	Fully Depreciated Assets							73
74	7/1/19 Audit Adjustment & HO Depr respectively	45,899		34,447	34,447			74
75	TOTALS	\$ 4,741,202	\$ 100,507	\$ 134,954	\$ 34,447		\$ 4,432,577	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)	\$ 18,706,942	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 361,795	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 396,242	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,447	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,699,956	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ 46,178 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	8088 hrs	\$ 340,297		\$	2,701	8,088	\$ 342,998	1
2	Licensed Speech and Language Development Therapist	10a	2764 hrs	116,321			9,417	2,764	125,738	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	11115 hrs	467,693			1,559	11,115	469,252	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				558,592		558,592	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	761	32,005	315	20,191		1,076	52,196	12
13	Other (specify): <u>X-Ray & Lab IV</u>	43, 2 & 3				0	0			13
14	TOTAL			\$ 956,316	315	\$ 20,191	\$ 572,269	23,043	\$ 1,548,776	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **05/31/2020**

(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	\$ 448	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (976,148))	931,560		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,581		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 939,589	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	853,628		13
14	Buildings, at Historical Cost	13,112,112		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,741,202		16
17	Accumulated Depreciation (book methods)	(13,699,956)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) OMIT	259,562		22
23	Other(specify): CIP			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,266,548	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,206,137	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 252,579	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	636,530		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,626		31
32	Accrued Real Estate Taxes(Sch.IX-B)	999,434		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	215,687		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,106,856	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,106,856	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,099,281	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,206,137	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,525,832	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,525,832	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,944,241)	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)	\$ (1,944,241)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	517,690	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 517,690	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,099,281	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare Elk Grove Village

0049387

Report Period Beginning: 06/01/2019

Ending: 05/31/2020

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 17,612,979	1
2	Discounts and Allowances for all Levels	(6,812,668)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,800,311	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,732,292	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,732,292	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,100	12
13	Barber and Beauty Care	13,243	13
14	Non-Patient Meals	1,395	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,260,694	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	109,830	19
20	Radiology and X-Ray	64,164	20
21	Other Medical Services	111,223	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,561,649	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Discount	1,074,602	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,074,602	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,168,854	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,925,954	31
32	Health Care	8,315,892	32
33	General Administration	5,388,848	33
B. Capital Expense			
34	Ownership	3,388,554	34
C. Ancillary Expense			
35	Special Cost Centers	908,179	35
36	Provider Participation Fee	185,668	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,113,095	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,944,241)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,944,241)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,965,288	44
45	Private Pay - Net Inpatient Revenue	2,078,637	45
46	Medicare - Net Inpatient Revenue	2,946,894	46
47	Other-(specify) <u>Hospice</u>	202,571	47
48	Other-(specify) <u>Insurance</u>	606,921	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,800,311	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 Elk Grove Village

0049387

Report Period Beginning: 06/01/2019

Ending: 05/31/2020

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	2,193	\$ 121,818	\$ 55.55	1
2	Assistant Director of Nursing	5,969	6,445	273,131	42.38	2
3	Registered Nurses	73,661	79,522	2,952,751	37.13	3
4	Licensed Practical Nurses	16,817	18,155	537,307	29.60	4
5	CNAs & Orderlies	98,631	106,698	1,740,089	16.31	5
6	CNA Trainees	47	52	637	12.25	6
7	Licensed Therapist	26,424	28,432	1,196,313	42.08	7
8	Rehab/Therapy Aides	9,656	10,390	319,684	30.77	8
9	Activity Director	8,399	9,069	155,281	17.12	9
10	Activity Assistants					10
11	Social Service Workers	9,090	9,801	277,583	28.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,939	34,482	589,419	17.09	15
16	Dishwashers					16
17	Maintenance Workers	3,761	4,026	113,471	28.18	17
18	Housekeepers	16,032	17,247	243,844	14.14	18
19	Laundry	5,632	6,064	74,684	12.32	19
20	Administrator	2,080	2,080	119,213	57.31	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,714	27,619	749,306	27.13	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	1,871	2,023	34,153	16.88	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,904	2,055	25,532	12.42	33
34	TOTAL (lines 1 - 33)	339,658	366,353	\$ 9,524,216 *	\$ 26.00	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 17,000	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)	\$ 17,000		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	1,353 41,928	10, 3	52
53	TOTAL (lines 50 - 52)	1,353 \$ 41,928		53

Facility Name & ID Number

Manorcare Elk Grove Village

0049387

Report Period Beginning:

06/01/2019

Ending:

05/31/2020

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	
Danielle Woods King (6.1.19-4.9.20)	Administrator	0	\$ 107,141	Workers' Compensation Insurance	\$ 150,781	IDPH License Fee	\$ 3,980	
Madiha Waheed (4.10-5.31.20)	Administrator	0	12,072	Unemployment Compensation Insurance	14,673	Advertising: Employee Recruitment	45,652	
				FICA Taxes	683,140	Health Care Worker Background Check (Indicate # of checks performed 243)	5,623	
				Employee Health Insurance	598,571	Patient Background Checks	463	
				Employee Meals		Dues & Subscriptions	9,567	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues	12,364	
				Disability Payments	4,287	Advertising	26,085	
				401K	81,425	Other Licenses and Permits	2,736	
				Oth Benefits & Mktg Adj	138,678	Less: Non-Allowable Association Dues	(3,746)	
				Employee Appreciation	1,405	Less: Public Relations Expense	()	
				SMSP Match		Non-allowable advertising	(26,085)	
				Employee Uniforms	5,094	Yellow page advertising	()	
				Home Office Allocation	83,823			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 119,213	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,761,877	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 80,806	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Various Home Office Services - See Page 8 for breakdown			\$ 659,810				Out-of-State Travel	\$
							In-State Travel	17,427
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 659,810				Includes travel expense to the Home Office in Toledo, OH for regional meetings	
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount					
Various	Legal Fees		\$ 28,810				Entertainment Expense	()
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 17,427
Various	Collections		69,527					
AR Collection Costs were adjusted off via Page 5A, Lines 6 & 7, therefore, no detail schedule is attached.								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 98,337	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare Elk Grove Village# 0049387Report Period Beginning: 06/01/2019Ending: 05/31/2020**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 \$5,876 & AHCA \$2,742
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 89,485 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. 7/28/18
- (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. \$ 108,842
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. \$ 1,395
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) 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.