



Facility Name & ID Number Manorcare at Palos Heights

# 0033324 Report Period Beginning: 06/01/04 Ending: 05/31/05

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 06/01/04

	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	<u>174</u>	Skilled (SNF)	<u>174</u>	<u>63,510</u>	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	<u>174</u>	TOTALS	<u>174</u>	<u>63,510</u>	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	<u>15,302</u>	<u>15,469</u>	<u>26,436</u>	<u>57,207</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,302</u>	<u>15,469</u>	<u>26,436</u>	<u>57,207</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.08%

D. How many bed-hold days during this year were paid by the Department? 4 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 06/02/88

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 174 and days of care provided 23,360

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/05 Fiscal Year: 05/31/05

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

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/04 Ending: 05/31/05

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	348,671	32,859	347	381,877	3,278	385,155		385,155		1
2	Food Purchase		253,199		253,199		253,199	(480)	252,719		2
3	Housekeeping	162,612	22,991	5,759	191,362		191,362		191,362		3
4	Laundry	59,625	30,007	237	89,869		89,869		89,869		4
5	Heat and Other Utilities			168,363	168,363	7,562	175,925		175,925		5
6	Maintenance	70,876	109,452	40,965	221,293		221,293		221,293		6
7	Other (specify):* <b>Medical Waste</b>			1,192	1,192		1,192		1,192		7
8	<b>TOTAL General Services</b>	<b>641,784</b>	<b>448,508</b>	<b>216,863</b>	<b>1,307,155</b>	<b>10,840</b>	<b>1,317,995</b>	<b>(480)</b>	<b>1,317,515</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,200	11,200		11,200		11,200		9
10	Nursing and Medical Records	3,317,678	217,176	28,006	3,562,860	55,905	3,618,765		3,618,765		10
10a	Therapy	438,494	16,471	570,682	1,025,647		1,025,647		1,025,647		10a
11	Activities	92,146	9,131	410	101,687		101,687		101,687		11
12	Social Services	59,846	10		59,856		59,856		59,856		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,908,164</b>	<b>242,788</b>	<b>610,298</b>	<b>4,761,250</b>	<b>55,905</b>	<b>4,817,155</b>		<b>4,817,155</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	94,314		646,639	740,953	(348,158)	392,795		392,795		17
18	Directors Fees										18
19	Professional Services			8,113	8,113		8,113	(8,113)			19
20	Dues, Fees, Subscriptions & Promotions			97,633	97,633		97,633	(39,047)	58,586		20
21	Clerical & General Office Expenses	351,779	54,242	296,402	702,423		702,423	(232,667)	469,756		21
22	Employee Benefits & Payroll Taxes			879,345	879,345	51,397	930,742		930,742		22
23	Inservice Training & Education			2,607	2,607		2,607		2,607		23
24	Travel and Seminar			3,264	3,264		3,264		3,264		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			178,670	178,670		178,670		178,670		26
27	Other (specify):* <b>Purch. Serv. Admin.</b>			1,385	1,385		1,385	(1,496)	(111)		27
28	<b>TOTAL General Administration</b>	<b>446,093</b>	<b>54,242</b>	<b>2,114,058</b>	<b>2,614,393</b>	<b>(296,761)</b>	<b>2,317,632</b>	<b>(281,323)</b>	<b>2,036,309</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,996,041</b>	<b>745,538</b>	<b>2,941,219</b>	<b>8,682,798</b>	<b>(230,016)</b>	<b>8,452,782</b>	<b>(281,803)</b>	<b>8,170,979</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Palos Heights #0033324 Report Period Beginning: 06/01/04 Ending: 05/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			466,808	466,808	22,355	489,163		489,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(401)	(401)	207,661	207,260		207,260			32
33	Real Estate Taxes			392,300	392,300		392,300		392,300			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			89,080	89,080		89,080		89,080			35
36	Other (specify):* Gain/Loss on Assets											36
37	<b>TOTAL Ownership</b>			947,787	947,787	230,016	1,177,803		1,177,803			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		559,432		559,432		559,432		559,432			39
40	Barber and Beauty Shops			38,108	38,108		38,108		38,108			40
41	Coffee and Gift Shops	155			155		155		155			41
42	Provider Participation Fee			95,265	95,265		95,265		95,265			42
43	Other (specify):* IV   X-Ray & Lab		138,385	40,581	178,966		178,966		178,966			43
44	<b>TOTAL Special Cost Centers</b>	155	697,817	173,954	871,926		871,926		871,926			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,996,196	1,443,355	4,062,960	10,502,511		10,502,511	(281,803)	10,220,708			45

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

Facility Name & ID Number **Manorcare at Palos Heights**

# **0033324**

Report Period Beginning: **06/01/04**

Ending: **05/31/05**

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(480)	2		4
5	Telephone, TV & Radio in Resident Rooms	(95)	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		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(339)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,496)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(1,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,113)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(229,972)	21		24
25	Fund Raising, Advertising and Promotional	(39,047)	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	(761)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (281,803)</b>		<b>\$</b>	<b>30</b>

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

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (281,803)</b>		<b>37</b>

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

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

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

Manorcare at Palos Heights

ID# 0033324

Report Period Beginning: 06/01/04

Ending: 05/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (761)	21	1
2	Misc. Income		21	2
3	Loss on Disposal of Fixed Asset		36	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(761)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Palos Heights# 0033324 Report Period Beginning:06/01/04

Ending:

05/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(480)	0	0	0	0	0	0	0	0	0	0	(480)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(480)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(480)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,113)	0	0	0	0	0	0	0	0	0	0	(8,113)	19
20	Fees, Subscriptions & Promotions	(39,047)	0	0	0	0	0	0	0	0	0	0	(39,047)	20
21	Clerical & General Office Expenses	(232,667)	0	0	0	0	0	0	0	0	0	0	(232,667)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,496)	0	0	0	0	0	0	0	0	0	0	(1,496)	27
28	<b>TOTAL General Administration</b>	<b>(281,323)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(281,323)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(281,803)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(281,803)</b>	<b>29</b>



VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See						1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a						6
		Home Office Allocation	\$ 646,639	HCR Manor Care, Inc.	100.00%	\$ 646,639		
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 679,045			\$ 679,045	\$ *	14

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

Facility Name & ID Number      Manorcare at Palos Heights      #      0033324      Report Period Beginning:      06/01/04      Ending:      05/31/05

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 at Palos Heights # 0033324 Report Period Beginning: 06/01/04 Ending: 05/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization HCR Manor Care, Inc.  
 Street Address 333 North Summit St.  
 City / State / Zip Code Toledo, OH 43604-2617  
 Phone Number ( 419 ) 252-5500  
 Fax Number ( 419 ) 254-5495

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	\$		\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	1,043,233	571,891	8,888,887	3,278
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	223,707		8,888,887	841
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,139,042		8,888,887	6,721
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	12,987,607	8,226,246	8,888,887	48,829
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,252,260	1,199,059	8,888,887	7,076
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	16,611,639	15,056,893	8,888,887	62,454
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	75,121,310	43,509,256	8,888,887	236,027
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	3,924,545		8,888,887	14,755
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	11,662,215		8,888,887	36,642
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	0		8,888,887	0
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	7,114,804		8,888,887	22,355
13									13
14	32	Interest				10,002,527			207,661
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 143,082,889	\$ 68,563,345	\$	646,639

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/04 Ending: 05/31/05

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Conv. Sub. Debentures		X	Facility			\$ 3,102,852	\$ 3,102,852		6.6926	\$ 207,661	1								
2												2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6												6								
7												7								
8	Interest Income/Expense Other										(401)	8								
9	<b>TOTAL Facility Related</b>						\$ 3,102,852	\$ 3,102,852			\$ 207,260	9								
	<b>B. Non-Facility Related*</b>																			
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 3,102,852	\$ 3,102,852			\$ 207,260	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 at Palos Heights**# **0033324** Report Period Beginning: **06/01/04** Ending: **05/31/05****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>351,376</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>379,271</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>27,895</b>	<b>3</b>
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>364,405</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>392,300</b>	<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:				<b>FOR OHF USE ONLY</b>	
2000	<u>359,597</u>	<u>8</u>			
2001	<u>373,170</u>	<u>9</u>			
2002	<u>357,236</u>	<u>10</u>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$
2003	<u>371,926</u>	<u>11</u>			
2004	<u>386,223</u>	<u>12</u>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$
<b>Line 2: \$379,271 = \$185,963 for 1st half of 2004 + \$193,308 for 2nd half of 2003</b>			<b>15</b>	LESS REFUND FROM LINE 6	\$
<b>Line 4: \$364,405 = \$164,145 for Jan-May 2005 + \$200,260 for 2nd half of 2004</b>			<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Manorcare at Palos Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033324

CONTACT PERSON REGARDING THIS REPORT Gary Geise

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

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

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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>23-24-300-330-0000</u>	<u>See Attached</u>	\$ <u>537,017.76</u>	\$ <u>386,223.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>537,017.76</u>	\$ <u>386,223.00</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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,687 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).

---



---



---



---



---



---

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1988	\$ 600,191	1
2					2
3	TOTALS			\$ 600,191	3

Facility Name &amp; ID Number Manorcare at Palos Heights

# 0033324

Report Period Beginning:

06/01/04

Ending:

05/31/05

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	144		1988	\$ 4,355,326	\$ 148,860		\$ 148,860		\$ 2,211,253	4
5	30		1990	1,063,606						5
6			1990	(10,000)						6
7										7
8										8
<b>Improvement Type**</b>										
9	Current Year Depreciation (Adjustment is for 2 retired assets)				181,813		181,813	(2,279)	1,574,116	9
10			1988	203,173						10
11			1989	47,755						11
12			1990	43,288						12
13			1991	135,227						13
14			1992	55,270						14
15			1993	67,665						15
16			1994	68,557						16
17			1995	133,690						17
18			1996	183,199						18
19			1997	242,019						19
20			1998	203,466						20
21			1999	28,991						21
22			2000	128,063						22
23			2001	91,487						23
24	LAUNDRY/KITCHEN EYE WASH		2002	2,250						24
25	VINYL WALLCOVERING, PAINT, & CARPET		2002	9,566						25
26	MAGNOLIA TREE		2002	550						26
27	ROOFING		2002	7,686						27
28	WALLCOVERING		2002	3,346						28
29	DOOR - EMPLOYEE ENTERANCE		2002	1,487						29
30	VCT FLOORING		2002	970						30
31	WINDOW TREATMENTS		2002	3,633						31
32	HAND RAILS		2002	4,716						32
33	ELECTRICAL WORK		2002	1,868						33
34	DOOR - HOLLOW METAL		2003	1,026						34
35	VCT FLOORING - ADDITIONAL		2003	16						35
36	EXTERIOR PAINTING		2003	3,486						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

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number    Manorcare at Palos Heights

#    0033324

Report Period Beginning:

06/01/04

Ending:

05/31/05

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	WALLCOVERING	2003	\$ 124	\$		\$	\$	\$		37
38	CARPET	2003	9,521							38
39	KITCHEN DOORS	2003	3,140							39
40	CONSTRUCTION DEPARTMENT COST & INTEREST	2003	8,788							40
41	WALLCOVERING, BORDERS, & PAINTING	2003	88,476							41
42	CARPETING	2003	13,008							42
43	ELETRICAL WORK	2003	5,081							43
44	SIGNAGE	2003	3,423							44
45	SEALING & PATCHING PARKING LOT	2003	15,985							45
46	DUMPSTER GATE	2003	1,076							46
47	FENCE	2004	8,387							47
48	Electric to new rooftop exhaust fan	2004	1,079							48
49	Renov. - Construction Dept. Overhead Costs & Interest	2004	13,149							49
50	Renov. - Painting	2004	39,543							50
51	Renov. - Wallcovering & Corner Guards	2004	15,082							51
52	Renov. - Carpentry	2004	17,490							52
53	Renov. - Electrical	2004	1,934							53
54	Renov. - Doors	2004	2,947							54
55	Flooring	2004	3,635							55
56	Reconstruct - Move Walls, Plumbing, Electric to enlarge resident ro	2004	853,768							56
57	Reconstruct - Architect & Engineering Costs	2004	77,920							57
58	Reconstruct - Construction Dept. Overhead Costs & Interest	2004	140,129							58
59	Reconstruct - Permit Fees	2004	24,199							59
60	Reconstruct - Millwork	2004	9,671							60
61	Reconstruct - Plumbing	2004	1,316							61
62	Reconstruct - Carpeting	2004	26,289							62
63	Reconstruct - Wallcovering & Corner Guards	2004	9,204							63
64	Reconstruct - Water & Sewer Work	2004	167							64
65	Concrete Pad at main entrance	2004	3,040							65
66	Prox Readers & Electric Strikes for Court Yard Doors	2005	3,970							66
67	Retirement 8-2004 - Door Alarm (asset # 179)	1989	(1,061)							67
68	Retirement 8-2004 - Door Alarm (asset #435)	1992	(1,218)							68
69										69
70	TOTAL (lines 4 thru 69)		\$ 8,480,644	\$ 330,673		\$ 330,673	\$ (2,279)	\$ 3,785,369		70

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

Facility Name & ID Number    Manorcare at Palos Heights    #    0033324    Report Period Beginning:    06/01/04    Ending:    05/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,344,244	\$ 136,135	\$ 136,135			\$ 1,018,984	71
72	Current Year Purchases	492,888						72
73	Fully Depreciated Assets							73
74	Home Office Depr			22,355	22,355			74
75	TOTALS	\$ 1,837,132	\$ 136,135	\$ 158,490	\$ 22,355		\$ 1,018,984	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENTS	1995 GOSHEN GCH	1995	\$ 17,000					\$ 17,000	76
77		PARATRANSIT								77
78										78
79										79
80	TOTALS			\$ 17,000					\$ 17,000	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,934,967	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 466,808	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 489,163	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,355	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,821,353	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</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: \$ 87,578 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.  
 (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	2907	hrs	\$ 84,564	2,375	\$ 112,838	\$ 3,710	5,282	\$ 201,112	1	
2	Licensed Speech and Language Development Therapist	10a	1432	hrs	39,246	2,242	106,545	99	3,674	145,890	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	2928	hrs	103,383	6,594	313,344	12,662	9,522	429,389	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				559,432		559,432	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify): X-ray & Lab	43, 3					40,581			40,581	13	
14	<b>TOTAL</b>				\$ 227,193	11,211	\$ 573,308	\$ 575,903	18,478	\$ 1,376,404	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.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number      Manorcare at Palos Heights

#      0033324

Report Period Beginning:      06/01/04

Ending:

05/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of      05/31/05

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 12,472	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 252,077 )	2,016,334		3
4	Supply Inventory (priced at 03/31/05 )	45,280		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,043		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,081,129	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	600,191		13
14	Buildings, at Historical Cost	8,480,644		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,854,132		16
17	Accumulated Depreciation (book methods)	(4,821,353)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction In Progress</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,113,614	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 8,194,743	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 118,742	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	513,285		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	364,405		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Payables</u>	156,033		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,152,465	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	25,077		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 25,077	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,177,542	\$	46
47	<b>TOTAL EQUITY (page 18, line 24)</b>	\$ 7,017,201	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 8,194,743	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,962,250</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>5,962,250</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>3,355,485</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>3,355,485</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Changes in Interdivison</b>	<b>(2,300,534)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(2,300,534)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>7,017,201</b>	<b>24</b> *

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

Facility Name &amp; ID Number Manorcare at Palos Heights

# 0033324

Report Period Beginning: 06/01/04

Ending:

05/31/05

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,252,560	1
2	Discounts and Allowances for all Levels	(838,311)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,414,249	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,710,047	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,710,047	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,257	12
13	Barber and Beauty Care	44,569	13
14	Non-Patient Meals	480	14
15	Telephone, Television and Radio	95	15
16	Rental of Facility Space		16
17	Sale of Drugs	556,858	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,711	19
20	Radiology and X-Ray	43,409	20
21	Other Medical Services		21
22	Laundry	1,734	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 735,113	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	77	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 77	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc. Income	(1,671)	28
28a	Late Charges	181	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (1,490)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,857,996	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,307,155	31
32	Health Care	4,761,250	32
33	General Administration	2,614,393	33
<b>B. Capital Expense</b>			
34	Ownership	947,787	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	776,661	35
36	Provider Participation Fee	95,265	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,502,511	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	3,355,485	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 3,355,485	43

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

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

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

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

Facility Name &amp; ID Number Manorcare at Palos Heights

# 0033324

Report Period Beginning: 06/01/04

Ending:

05/31/05

## 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	1,965	2,129	\$ 87,410	\$ 41.06	1
2	Assistant Director of Nursing	5,483	5,941	177,513	29.88	2
3	Registered Nurses	30,253	32,775	858,798	26.20	3
4	Licensed Practical Nurses	39,261	42,534	886,436	20.84	4
5	CNAs & Orderlies	113,122	122,752	1,258,372	10.25	5
6	CNA Trainees					6
7	Licensed Therapist	7,240	7,752	243,251	31.38	7
8	Rehab/Therapy Aides	7,646	8,187	195,243	23.85	8
9	Activity Director	7,413	8,051	92,146	11.45	9
10	Activity Assistants					10
11	Social Service Workers	3,893	4,229	59,846	14.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,999	30,527	348,671	11.42	15
16	Dishwashers					16
17	Maintenance Workers	4,028	4,375	70,876	16.20	17
18	Housekeepers	16,088	17,467	162,612	9.31	18
19	Laundry	6,005	6,517	59,625	9.15	19
20	Administrator	2,080	2,080	82,556	39.69	20
21	Assistant Administrator	391	391	11,758	30.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,605	19,803	351,779	17.76	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	3,276	3,560	49,149	13.81	31
32	Other Health Care(specify)					32
33	Other(specify) B&B	14	16	155	9.69	33
34	TOTAL (lines 1 - 33)	294,762	319,086	\$ 4,996,196 *	\$ 15.66	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	11,200	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,904	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	17,104		49

## C. CONTRACT NURSES

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





Facility Name & ID Number Manorcare at Palos Heights# 0033324Report Period Beginning: 06/01/04Ending: 05/31/05**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 \$8582
- (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 \$2772
- (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. \$ 51,069 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 95,265  
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. \$ 480
- (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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.