

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 0041319

Facility Name: Manorcare at Palos Heights West

Address: 11860 Southwest Highway Palos Heights 60463
 Number City Zip Code

County: Cook

Telephone Number: (708) 361-4555 **Fax #** (708) 361-3777

HFS ID Number: 520886946016

Date of Initial License for Current Owners: 04/15/96

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input 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 _____	<input checked="" 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 _____	

In the event there are further questions about this report, please contact:
Name: Gary Geise **Telephone Number:** (419)252-5731

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/05 to 05/31/06 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Barry A. Lazarus</u>	
	(Title) <u>Vice President, Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number Manorcare at Palos Heights West

0041319 Report Period Beginning: 06/01/05 Ending: 05/31/06

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	<u>130</u>	Skilled (SNF)	<u>130</u>	<u>47,450</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>130</u>	TOTALS	<u>130</u>	<u>47,450</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>17,180</u>	<u>5,069</u>	<u>18,856</u>	<u>41,105</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>17,180</u>	<u>5,069</u>	<u>18,856</u>	<u>41,105</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.63%

D. How many bed-hold days during this year were paid by the Department? 0 (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 04/15/96

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 130 and days of care provided 15,887

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 5/31/06

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

Facility Name & ID Number Manorcare at Palos Heights West # 0041319 Report Period Beginning: 06/01/05 Ending: 05/31/06

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
	A. General Services										
1	Dietary	283,070	21,426	1,461	305,957	3,479	309,436		309,436		1
2	Food Purchase		193,681		193,681		193,681	(407)	193,274		2
3	Housekeeping	93,898	20,897	45,746	160,541		160,541		160,541		3
4	Laundry	25,322	13,179	33,750	72,251		72,251		72,251		4
5	Heat and Other Utilities			163,635	163,635	7,040	170,675		170,675		5
6	Maintenance	48,765	21,551	75,148	145,464		145,464		145,464		6
7	Other (specify):* Medical Waste			841	841		841		841		7
8	TOTAL General Services	451,055	270,734	320,581	1,042,370	10,519	1,052,889	(407)	1,052,482		8
	B. Health Care and Programs										
9	Medical Director			19,350	19,350		19,350		19,350		9
10	Nursing and Medical Records	2,717,245	253,607	124,901	3,095,753	12,629	3,108,382		3,108,382		10
10a	Therapy		9,548	906,146	915,694		915,694	(99,345)	816,349		10a
11	Activities	55,695	3,061	7,780	66,536		66,536		66,536		11
12	Social Services	86,356		77	86,433		86,433		86,433		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,859,296	266,216	1,058,254	4,183,766	12,629	4,196,395	(99,345)	4,097,050		16
	C. General Administration										
17	Administrative	95,102		423,601	518,703	(95,487)	423,216		423,216		17
18	Directors Fees										18
19	Professional Services			10,438	10,438		10,438	(10,438)			19
20	Dues, Fees, Subscriptions & Promotions			82,933	82,933		82,933	(25,083)	57,850		20
21	Clerical & General Office Expenses	275,080	65,452	284,919	625,451		625,451	(249,418)	376,033		21
22	Employee Benefits & Payroll Taxes			643,424	643,424	52,470	695,894		695,894		22
23	Inservice Training & Education			1,445	1,445		1,445		1,445		23
24	Travel and Seminar			9,359	9,359		9,359		9,359		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			145,752	145,752		145,752		145,752		26
27	Other (specify):* Pers Purch							(5)	(5)		27
28	TOTAL General Administration	370,182	65,452	1,601,871	2,037,505	(43,017)	1,994,488	(284,944)	1,709,544		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,680,533	602,402	2,980,706	7,263,641	(19,869)	7,243,772	(384,696)	6,859,076		29

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

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

Facility Name & ID Number Manorcare at Palos Heights West #0041319 Report Period Beginning: 06/01/05 Ending: 05/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	D. Ownership										
30	Depreciation			327,499	327,499	19,869	347,368	347,368			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			7,319	7,319		7,319	7,319			32
33	Real Estate Taxes			313,956	313,956		313,956	313,956			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			97,746	97,746		97,746	97,746			35
36	Other (specify):*										36
37	TOTAL Ownership			746,520	746,520	19,869	766,389	766,389			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			159	159		159	159			38
39	Ancillary Service Centers		412,828		412,828		412,828	412,828			39
40	Barber and Beauty Shops		1,055	18,349	19,404		19,404	19,404			40
41	Coffee and Gift Shops	23,286			23,286		23,286	23,286			41
42	Provider Participation Fee			71,175	71,175		71,175	71,175			42
43	Other (specify):* IV Therapy, x-ray & lab		140,405	79,699	220,104		220,104	220,104			43
44	TOTAL Special Cost Centers	23,286	554,288	169,382	746,956		746,956	746,956			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,703,819	1,156,690	3,896,608	8,757,117		8,757,117	(384,696)	8,372,421		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 West

0041319

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	OHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(407)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,978)	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	(118)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(19,203)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,438)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(218,336)	21		24
25	Fund Raising, Advertising and Promotional	(25,083)	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	(1,783)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (285,351)		\$	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)	(99,345)	10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (99,345)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (384,696)		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	Exceptional 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		52

Manorcare at Palos Heights West

ID# 0041319

Report Period Beginning: 06/01/05

Ending: 05/31/06

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (1,210)	21	1
2	Misc. Income	(469)	21	2
3	Late Charges	(104)	21	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	Total	(1,783)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning:

06/01/05

Ending:

05/31/06

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(407)	0	0	0	0	0	0	0	0	0	0	(407)	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	TOTAL General Services	(407)	0	0	0	0	0	0	0	0	0	0	(407)	8
	B. Health Care and Programs													
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	(99,345)	0	0	0	0	0	0	0	0	0	0	(99,345)	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	TOTAL Health Care and Programs	(99,345)	0	0	0	0	0	0	0	0	0	0	(99,345)	16
	C. General Administration													
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	(10,438)	0	0	0	0	0	0	0	0	0	0	(10,438)	19
20	Fees, Subscriptions & Promotions	(25,083)	0	0	0	0	0	0	0	0	0	0	(25,083)	20
21	Clerical & General Office Expenses	(249,418)	0	0	0	0	0	0	0	0	0	0	(249,418)	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):*	(5)	0	0	0	0	0	0	0	0	0	0	(5)	27
28	TOTAL General Administration	(284,944)	0	0	0	0	0	0	0	0	0	0	(284,944)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(384,696)	0	0	0	0	0	0	0	0	0	0	(384,696)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning:

06/01/05 Ending:

Summary B

05/31/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(384,696)	0	0	0	0	0	0	0	0	0	0	(384,696)	45

Facility Name & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning:

06/01/05

Ending:

05/31/06

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Home Office Allocation	\$ 423,601	HCR Manor Care, Inc.	100.00%	\$ 423,601	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a Therapy Management	14,518	Heartland Management Services	100.00%	14,518		6
7	V							7
8	V	10a Therapy PT, OT, & ST	871,526	Heartland Rehab Services	100.00%	772,181	(99,345)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,309,645			\$ 1,210,300	\$ * (99,345)	14

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

Facility Name & ID Number Manorcare at Palos Heights West # 0041319 Report Period Beginning: 06/01/05 Ending: 05/31/06

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 West

0041319

Report Period Beginning: 06/01/05

Ending: 05/31/06

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	\$ 1,107,111	\$ 591,572	7,861,626	\$ 3,479	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	0	7,861,626	0		2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	267,575	7,861,626	841		3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	2,395,925	7,861,626	6,199		4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	771,372	565,963	7,861,626	2,424	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	3,944,092	2,235,491	7,861,626	10,205	6
7	17	Gen & Adm - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	24,791,565	22,717,176	7,861,626	77,903	7
8	17	Gen & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	96,702,974	43,044,715	7,861,626	250,211	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	6,363,513	7,861,626	19,996		9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	12,550,855	7,861,626	32,474		10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	0	7,861,626	0		11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	7,679,242	7,861,626	19,869		12
13										13
14	32	Interest				7,118,315		0		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 163,692,539	\$ 69,154,917		\$ 423,601	25

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			
A. Directly Facility Related																				
Long-Term																				
1	National City Bank		X	To fund fixed assets		04/2003	\$ 118,340	\$ 118,340		6.2464	\$ 7,392	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8	Interest Income /Expense Other										(73)	8								
9	TOTAL Facility Related						\$ 118,340	\$ 118,340			\$ 7,319	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 118,340	\$ 118,340			\$ 7,319	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Palos Heights West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041319

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 2005 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 2005.

(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>23-24-300-132-0000</u>	<u>See Attached</u>	<u>\$ 313,370.73</u>	<u>\$ 313,370.73</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 313,370.73	\$ 313,370.73

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 at Palos Heights West

0041319 Report Period Beginning:

06/01/05 Ending:

05/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,653 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

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	<u>Facility</u>		<u>1996</u>	<u>\$ 705,000</u>	1
2					2
3	TOTALS			\$ 705,000	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130			1996	\$ 5,345,094	\$ 133,627		\$ 133,627	\$	\$ 1,348,837	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Current Year Depreciation				97,319		97,319		560,209	9
10				1996	398,017						10
11				1997	165,442						11
12				1998	67,765						12
13				1999	27,686						13
14				2000	74,134						14
15				2001	129,144						15
16		VINYL WALLCOVERING & BORDERS		2002	1,250						16
17		CARPET, VINYL WALLCOVERING & BORDERS		2002	64,471						17
18		FLOORING IN PUBIC RESTROOM		2003	2,125						18
19		WALLCOVERING & PAINTING		2003	9,129						19
20		DOORS		2003	3,109						20
21		WINDOW TREATMENTS		2003	2,527						21
22		CONSTRUCTION DEPT. COST & INTEREST		2004	12,658						22
23		WALLCOVERING & PAINTING		2004	39,469						23
24		TV ANTENNA JACKS & COAX WIRING		2004	3,140						24
25		DOORS		2004	1,020						25
26		Sealcoat & Restripe Parking Lot		2004	2,280						26
27		Renov. - General Overhead & Interest		2004	3,752						27
28		Renov. - Painting		2004	35,265						28
29		Renov. - Wallcovering & Corner Guards		2004	6,697						29
30		Renov. - Carpentry		2004	4,180						30
31		Dorrs		2004	4,483						31
32		Ceramic Tile		2005	2,990						32
33		Wallcovering & Painting		2005	8,452						33
34		Carpet		2005	5,362						34
35		FABRICS / CURTAINS		2005	3,914						35
36		Fire Rated Door		2005	1,150						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 at Palos Heights West**

0041319

Report Period Beginning:

06/01/05

Ending:

05/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Shower Floors	2005	\$ 9,945	\$		\$	\$	\$	37
38 Ceramic Tile / Bathrooms	2005	10,800						38
39 Painting	2005	3,859						39
40 1 new Rated Door	2005	1,260						40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 6,450,569	\$ 230,946		\$ 230,946	\$	\$ 1,909,046	70

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

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

0041319

Report Period Beginning:

06/01/05

Ending:

05/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 6,450,569	\$ 230,946		\$ 230,946	\$	\$ 1,909,046	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,450,569	\$ 230,946		\$ 230,946	\$	\$ 1,909,046	34

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

Facility Name & ID Number Manorcare at Palos Heights West # 0041319 Report Period Beginning: 06/01/05 Ending: 05/31/06

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	\$ 1,554,115	\$ 96,553	\$ 96,553	\$		\$ 1,155,142	71
72	Current Year Purchases	69,402						72
73	Fully Depreciated Assets							73
74	Home Office Depr			19,869	19,869			74
75	TOTALS	\$ 1,623,517	\$ 96,553	\$ 116,422	\$ 19,869		\$ 1,155,142	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				\$	\$	\$	\$		\$	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)		\$ 8,779,086	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 327,499	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 347,368	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 19,869	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,064,188	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	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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 97,746 Description: O2 Concentrators, Wheelchairs, Gerichairs, 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	N/A		\$ _____	\$ _____	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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	hrs	\$	7,309	\$ 346,452	\$	7,309	\$ 346,452	1
2	Licensed Speech and Language Development Therapist	10a	hrs		1,601	75,889		1,601	75,889	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		8,124	385,084		8,124	385,084	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 prescrpts				412,828		412,828	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P -Inhal/X-ray & Lab	10a & 43, 3			7	345	79,699	7	80,044	13
14	TOTAL			\$	17,041	\$ 807,770	\$ 492,527	17,041	\$ 1,300,297	14

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

Facility Name & ID Number Manorcare at Palos Heights West# 0041319Report Period Beginning: 06/01/05

Ending:

05/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/06

(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	\$ (13,778)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>327,659</u>)	2,330,317		3
4	Supply Inventory (priced at <u>03/31/06</u>)	45,103		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,456		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,365,098	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	705,000		13
14	Buildings, at Historical Cost	6,450,569		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,623,517		16
17	Accumulated Depreciation (book methods)	(3,064,188)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,714,898	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,079,996	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 139,682	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	259,715		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	286,440		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	136,087		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 821,924	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	118,340		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	70		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 118,410	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 940,334	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 7,139,662	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,079,996	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,553,258	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,553,258	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,207,875	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)	\$ 1,207,875	17
B. Transfers (Itemize):			
18	Change in Interdivision	(621,471)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (621,471)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,139,662	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning: 06/01/05

Ending: 05/31/06

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,868,287	1
2	Discounts and Allowances for all Levels	(1,811,475)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,056,812	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,323,715	6
7	Oxygen	(170)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,323,545	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	1,215	12
13	Barber and Beauty Care	18,364	13
14	Non-Patient Meals	407	14
15	Telephone, Television and Radio	9,978	15
16	Rental of Facility Space		16
17	Sale of Drugs	461,484	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	47,993	19
20	Radiology and X-Ray	41,843	20
21	Other Medical Services		21
22	Laundry	2,778	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 584,062	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	Misc. Income	469	28
28a	Late Charges	104	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 573	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,964,992	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,042,370	31
32	Health Care	4,183,766	32
33	General Administration	2,037,505	33
B. Capital Expense			
34	Ownership	746,520	34
C. Ancillary Expense			
35	Special Cost Centers	675,781	35
36	Provider Participation Fee	71,175	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,757,117	40
41	Income before Income Taxes (line 30 minus line 40)**	1,207,875	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,207,875	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 & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning:

06/01/05

Ending:

05/31/06

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	1,557	1,662	\$ 56,020	\$ 33.71	1
2	Assistant Director of Nursing	3,014	3,216	96,911	30.13	2
3	Registered Nurses	31,762	33,893	974,751	28.76	3
4	Licensed Practical Nurses	27,016	28,829	642,172	22.28	4
5	CNAs & Orderlies	80,392	85,950	917,683	10.68	5
6	CNA Trainees	32	32	347	10.84	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,312	5,692	55,695	9.78	9
10	Activity Assistants					10
11	Social Service Workers	4,139	4,439	86,356	19.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,485	27,100	283,070	10.45	15
16	Dishwashers					16
17	Maintenance Workers	2,189	2,345	48,765	20.80	17
18	Housekeepers	10,383	10,985	93,898	8.55	18
19	Laundry	2,949	3,145	25,322	8.05	19
20	Administrator	2,080	2,080	73,396	35.29	20
21	Assistant Administrator					21
22	Other Administrative	17,955	19,018	296,786	15.61	22
23	Office Manager					23
24	Clerical					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	2,335	2,501	29,361	11.74	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,798	1,925	23,286	12.10	33
34	TOTAL (lines 1 - 33)	218,398	232,812	\$ 3,703,819 *	\$ 15.91	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	19,350	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,900	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)		\$ 23,250		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,009	\$ 79,616	10,3	50
51	Licensed Practical Nurses	126	4,369	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,135	\$ 83,985		53

Facility Name & ID Number Manorcare at Palos Heights West

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 \$7320
- (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 \$2305
- (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. \$ 62,959 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. \$ 71,175
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. \$ 407
- (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.