

Facility Name & ID Number Manorcare at Palos Heights West

0041319 Report Period Beginning: 06/01/07 Ending: 05/31/08

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>47,580</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>47,580</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>12,963</u>	<u>5,803</u>	<u>24,234</u>	<u>43,000</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>12,963</u>	<u>5,803</u>	<u>24,234</u>	<u>43,000</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.37%

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 21,098

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 Fiscal Year: 5/31

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	334,351	17,490	9,533	361,374	3,588	364,962		364,962		1
2	Food Purchase		230,555		230,555		230,555	(902)	229,653		2
3	Housekeeping		19,574	129,433	149,007		149,007		149,007		3
4	Laundry		18,427	86,188	104,615		104,615		104,615		4
5	Heat and Other Utilities			201,444	201,444	8,229	209,673		209,673		5
6	Maintenance	45,183	25,908	107,245	178,336		178,336		178,336		6
7	Other (specify):* Medical Waste			680	680		680		680		7
8	TOTAL General Services	379,534	311,954	534,523	1,226,011	11,817	1,237,828	(902)	1,236,926		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	3,316,832	315,522	125,512	3,757,866	6,651	3,764,517		3,764,517		10
10a	Therapy	917,097	10,873	351,585	1,279,555		1,279,555		1,279,555		10a
11	Activities	94,450	5,102	14,400	113,952		113,952	(26)	113,926		11
12	Social Services	90,985			90,985		90,985		90,985		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,419,364	331,497	505,897	5,256,758	6,651	5,263,409	(26)	5,263,383		16
	C. General Administration										
17	Administrative	87,148		608,795	695,943	(128,425)	567,518		567,518		17
18	Directors Fees										18
19	Professional Services			61,818	61,818		61,818	(61,207)	611		19
20	Dues, Fees, Subscriptions & Promotions			105,203	105,203		105,203	(23,906)	81,297		20
21	Clerical & General Office Expenses	404,930	61,016	816,471	1,282,417		1,282,417	(351,651)	930,766		21
22	Employee Benefits & Payroll Taxes			978,157	978,157	84,123	1,062,280		1,062,280		22
23	Inservice Training & Education			790	790		790		790		23
24	Travel and Seminar			10,441	10,441		10,441		10,441		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			191,710	191,710		191,710		191,710		26
27	Other (specify):*							(61)	(61)		27
28	TOTAL General Administration	492,078	61,016	2,773,385	3,326,479	(44,302)	3,282,177	(436,825)	2,845,352		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,290,976	704,467	3,813,805	9,809,248	(25,834)	9,783,414	(437,753)	9,345,661		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: 06/01/07 Ending: 05/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			397,246	397,246	25,347	422,593		422,593			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,384	6,384	487	6,871		6,871			32
33	Real Estate Taxes			327,838	327,838		327,838	24,125	351,963			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			60,759	60,759		60,759		60,759			35
36	Other (specify):*											36
37	TOTAL Ownership			792,227	792,227	25,834	818,061	24,125	842,186			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		657,964	125	658,089		658,089		658,089			39
40	Barber and Beauty Shops			18,853	18,853		18,853		18,853			40
41	Coffee and Gift Shops	23,669			23,669		23,669		23,669			41
42	Provider Participation Fee			71,175	71,175		71,175		71,175			42
43	Other (specify):* IV Ther/Xray/Lab		46,850	197,417	244,267		244,267		244,267			43
44	TOTAL Special Cost Centers	23,669	704,814	287,570	1,016,053		1,016,053		1,016,053			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,314,645	1,409,281	4,893,602	11,617,528		11,617,528	(413,628)	11,203,900			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: 06/01/07

Ending: 05/31/08

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(902)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,220)	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(210)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(137)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(61)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(30,265)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(61,207)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(310,604)	21		24
25	Fund Raising, Advertising and Promotional	(23,906)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	24,125	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,241)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (413,628)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (413,628)		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		51
						52

Manorcare at Palos Heights West

ID# 0041319

Report Period Beginning: 06/01/07

Ending: 05/31/08

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,215)	21	1
2	Activity Income	(26)	11	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				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	(1,241)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning:

06/01/07

Ending:

05/31/08

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	(902)	0	0	0	0	0	0	0	0	0	0	(902)	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	(902)	0	0	0	0	0	0	0	0	0	0	(902)	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	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(26)	0	0	0	0	0	0	0	0	0	0	(26)	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	(26)	0	0	0	0	0	0	0	0	0	0	(26)	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	(61,207)	0	0	0	0	0	0	0	0	0	0	(61,207)	19
20	Fees, Subscriptions & Promotions	(23,906)	0	0	0	0	0	0	0	0	0	0	(23,906)	20
21	Clerical & General Office Expenses	(351,651)	0	0	0	0	0	0	0	0	0	0	(351,651)	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):*	(61)	0	0	0	0	0	0	0	0	0	0	(61)	27
28	TOTAL General Administration	(436,825)	0	0	0	0	0	0	0	0	0	0	(436,825)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(437,753)	0	0	0	0	0	0	0	0	0	0	(437,753)	29

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Palos Heights West

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Report Period Beginning:

06/01/07 Ending:

Summary B

05/31/08

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	24,125	0	0	0	0	0	0	0	0	0	0	24,125	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	24,125	0	24,125	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)	(413,628)	0	(413,628)	45									

Facility Name & ID Number Manorcare at Palos Heights West

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Report Period Beginning:

06/01/07

Ending:

05/31/08

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	\$ 608,795	HCR Manor Care, Inc.	100.00%	\$ 608,795	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V	10a Therapy Management	56,839	Heartland Management Services	100.00%	56,839		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 665,634			\$ 665,634	\$ *	14

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

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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.

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0041319

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Facs.	\$ 59,848	\$ 227	10,674,304	\$ 227	1
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	370 Nurs. Facs.	1,061,370	3,361	10,674,304	3,361	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	371 Nurs. Facs.	497,772	1,888	10,674,304	1,888	3
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	372 Nurs. Facs.	2,002,556	6,341	10,674,304	6,341	4
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	373 Nurs. Facs.	0	0	10,674,304	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	374 Nurs. Facs.	2,100,636	6,651	10,674,304	6,651	6
7	17	Gen & Admin - Direct	Accumulated Cost	2,813,673,080	375 Nurs. Facs.	41,222,846	156,388	10,674,304	156,388	7
8	17	Gen & Admin - Pooled	Accumulated Cost	3,371,307,314	376 Nurs. Facs.	102,324,370	323,982	10,674,304	323,982	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	377 Nurs. Facs.	7,830,100	29,705	10,674,304	29,705	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,371,307,314	378 Nurs. Facs.	17,187,062	54,418	10,674,304	54,418	10
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	379 Nurs. Facs.	0	0	10,674,304	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,371,307,314	380 Nurs. Facs.	8,005,430	25,347	10,674,304	25,347	12
13										13
14										14
15		Interest				3,167,921			487	15
16		Non Nursing Home Allocations				23,250,237				16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 208,710,148	\$ 608,308		\$ 608,795	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		0.0625	\$ 7,392	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7	Home Office other Int.										487	7								
8	Interest Income / Expense Other										(1,008)	8								
9	TOTAL Facility Related						\$ 118,340	\$ 118,340			\$ 6,871	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			\$ 6,871	15								

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

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

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

Facility Name & ID Number Manorcare at Palos Heights West# 0041319 Report Period Beginning: 06/01/07Ending: 05/31/08

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	301,695	1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	325,820	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	24,125	3														
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	327,715	4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	123	5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	351,963	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:																			
2003	<u>308,373</u>	<u>8</u>	<table border="1"> <thead> <tr> <th colspan="2">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2007 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </tbody> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2007 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
2004	<u>320,228</u>	<u>9</u>																	
2005	<u>313,371</u>	<u>10</u>																	
2006	<u>321,670</u>	<u>11</u>																	
2007	<u>327,715</u>	<u>12</u>																	
Line 2: \$325,820 = \$160,835 for 1st half of 2007 + \$164,985 for 2nd half of 2006																			
Line 4: \$327,715 = \$160,835 for Jan - June 2008 + \$166,880 for 2nd half 2007																			
Line 5: Worsek & Vihon invoice - 2005 Specific Objections - Filing Fees																			

NOTES:

- Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 2545495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>327,714.56</u>	\$ <u>327,714.56</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>327,714.56</u>	\$ <u>327,714.56</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

06/01/07 Ending:

05/31/08

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

Facility Name & ID Number **Manorcare at Palos Heights West**# **0041319**

Report Period Beginning:

06/01/07

Ending:

05/31/08**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	\$ 133,628		\$ 133,628	\$	\$ 1,616,092	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Current Year Depreciation				144,741		144,741		793,858	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				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:

06/01/07

Ending:

05/31/08

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	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	electrical work	2006	904						41
42	drywall / access panels	2006	1,044						42
43	12 doors	2006	4,495						43
44	4 simplex locks	2007	2,128						44
45	Renov - General overhead & interest	2007	29,772						45
46	Renov - Carpentry & Subcontr	2007	8,370						46
47	Renov - resilient flooring	2007	88,568						47
48	Renov - Carpeting & Pads	2007	10,156						48
49	Renov - Wallcovering	2007	110,905						49
50	renov - basic electrical	2007	8,735						50
51	electrical for lighting	2007	1,692						51
52	3 roof top units	2007	29,952						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)		\$ 6,747,291	\$ 278,369		\$ 278,369	\$	\$ 2,409,950	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: 06/01/07 Ending: 05/31/08

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	\$ 1,694,741	\$ 118,877	\$ 118,877	\$		\$ 1,370,451	71
72	Current Year Purchases	155,338						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			25,347	25,347			74
75	TOTALS	\$ 1,850,079	\$ 118,877	\$ 144,224	\$ 25,347		\$ 1,370,451	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)	\$ 9,302,370	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 397,246	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 422,593	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,347	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,780,401	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 60,759 Description: O2 Concentrators, Wheelchairs, geri chairs, Elec Beds, Etc
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	3713 hrs	\$ 137,393	4,501	\$ 226,873	\$ 2,644	8,214	\$ 366,910	1
2	Licensed Speech and Language Development Therapist	10a	4270 hrs	157,964	540	27,200	832	4,810	185,996	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	10a	6108 visits	225,936	358	18,049	7,397	6,466	251,382	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				657,964		657,964	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					197,417		197,417	13
14	TOTAL			\$ 521,293	5,399	\$ 272,122	\$ 866,254	19,490	\$ 1,659,669	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: 06/01/07Ending: 05/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 05/31/08

(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	\$ 18,297	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (686,643))	1,970,645		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,974		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,992,916	\$	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	6,747,291		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,850,079		16
17	Accumulated Depreciation (book methods)	(3,780,401)		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)	\$ 5,521,969	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,514,885	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 77,012	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	454,156		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	327,715		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>	162,857		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,021,740	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	118,340		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	8,140		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 126,480	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,148,220	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,366,665	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,514,885	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,898,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,898,665	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,391,858	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)	\$ 2,391,858	17
B. Transfers (Itemize):			
18	Change in Interdivision	(3,923,858)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3,923,858)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,366,665	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare at Palos Heights West

0041319

Report Period Beginning: 06/01/07

Ending: 05/31/08

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	\$ 10,035,634	1
2	Discounts and Allowances for all Levels	(896,157)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,139,477	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,862,406	6
7	Oxygen	1,520	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,863,926	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	1,276	12
13	Barber and Beauty Care	24,306	13
14	Non-Patient Meals	902	14
15	Telephone, Television and Radio	9,220	15
16	Rental of Facility Space		16
17	Sale of Drugs	699,058	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	183,726	19
20	Radiology and X-Ray	81,751	20
21	Other Medical Services	2,796	21
22	Laundry	2,738	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,005,773	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	<u>Purchase Discount</u>	210	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 210	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,009,386	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,226,011	31
32	Health Care	5,256,758	32
33	General Administration	3,326,479	33
B. Capital Expense			
34	Ownership	792,227	34
C. Ancillary Expense			
35	Special Cost Centers	944,878	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)*	\$ 11,617,528	40
41	Income before Income Taxes (line 30 minus line 40)**	2,391,858	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,391,858	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:

06/01/07

Ending:

05/31/08

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	1,800	1,928	\$ 73,514	\$ 38.13	1
2	Assistant Director of Nursing	2,685	2,875	93,502	32.52	2
3	Registered Nurses	39,740	42,564	1,390,813	32.68	3
4	Licensed Practical Nurses	28,443	30,465	736,963	24.19	4
5	CNAs & Orderlies	83,085	89,182	996,864	11.18	5
6	CNA Trainees					6
7	Licensed Therapist	14,091	15,161	560,844	36.99	7
8	Rehab/Therapy Aides	14,478	15,576	355,263	22.81	8
9	Activity Director	6,658	7,144	94,450	13.22	9
10	Activity Assistants					10
11	Social Service Workers	4,256	4,579	90,985	19.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,657	27,551	334,351	12.14	15
16	Dishwashers					16
17	Maintenance Workers	2,001	2,142	45,183	21.09	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	87,148	41.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,168	24,840	404,930	16.30	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	2,070	2,210	26,166	11.84	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,685	1,807	23,669	13.10	33
34	TOTAL (lines 1 - 33)	251,897	270,104	\$ 5,314,645 *	\$ 19.68	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	14,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,522	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)		\$ 19,922		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	500	\$ 34,572	10, 3	50
51	Licensed Practical Nurses	80	3,342	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	580	\$ 37,914		53

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. ICHA \$10,703
- (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 \$3417
- (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. \$ 79,760 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. \$ 902
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? NO
Attach invoices and a summary of services for all architect and appraisal fees.