



Facility Name & ID Number Manorcare of Highland Park

# 0050278 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	215	Skilled (SNF)	215	78,475	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	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	14,846	5,092	14,058	33,996	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,846	5,092	14,058	33,996	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.32%

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 03/10/97

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 06/15/01 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 208 and days of care provided 10,544

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	304,956	25,322	12,542	342,820	10,590	353,410		353,410		1
2	Food Purchase		230,846		230,846		230,846	(1,181)	229,665		2
3	Housekeeping	147,962	19,285	4,232	171,479		171,479		171,479		3
4	Laundry	41,337	8,546	976	50,859		50,859	(986)	49,873		4
5	Heat and Other Utilities			284,030	284,030	2,947	286,977		286,977		5
6	Maintenance	58,025	67,988	158,071	284,084		284,084		284,084		6
7	Other (specify):* <b>Medical Waste</b>			801	801		801		801		7
8	<b>TOTAL General Services</b>	552,280	351,987	460,652	1,364,919	13,537	1,378,456	(2,167)	1,376,289		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,000	22,000		22,000		22,000		9
10	Nursing and Medical Records	3,057,019	224,611	52,088	3,333,718	3,889	3,337,607		3,337,607		10
10a	Therapy	811,932	21,759	328,404	1,162,095		1,162,095		1,162,095		10a
11	Activities	125,750	3,307	4,564	133,621		133,621		133,621		11
12	Social Services	114,362		3,861	118,223		118,223		118,223		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,109,063	249,677	410,917	4,769,657	3,889	4,773,546		4,773,546		16
	<b>C. General Administration</b>										
17	Administrative	164,981		547,185	712,166	(173,002)	539,164		539,164		17
18	Directors Fees										18
19	Professional Services			20,083	20,083		20,083	(20,083)			19
20	Dues, Fees, Subscriptions & Promotions			90,319	90,319		90,319	(46,028)	44,291		20
21	Clerical & General Office Expenses	341,903	54,680	157,135	553,718		553,718	(86,955)	466,763		21
22	Employee Benefits & Payroll Taxes			872,790	872,790	87,921	960,711		960,711		22
23	Inservice Training & Education			10,447	10,447		10,447		10,447		23
24	Travel and Seminar			8,656	8,656		8,656		8,656		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			426,172	426,172		426,172		426,172		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	506,884	54,680	2,132,787	2,694,351	(85,081)	2,609,270	(153,066)	2,456,204		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,168,227	656,344	3,004,356	8,828,927	(67,655)	8,761,272	(155,233)	8,606,039		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 &amp; ID Number

Manorcare of Highland Park

#0050278

Report Period Beginning:

01/01/09

Ending:

12/31/09

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			244,112	244,112	23,508	267,620		267,620			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(6,621)	(6,621)	44,147	37,526		37,526			32
33	Real Estate Taxes			124,224	124,224		124,224		124,224			33
34	Rent-Facility & Grounds			1,222,772	1,222,772		1,222,772		1,222,772			34
35	Rent-Equipment & Vehicles			169,993	169,993		169,993		169,993			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,754,480	1,754,480	67,655	1,822,135		1,822,135			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			2,590	2,590		2,590		2,590			38
39	Ancillary Service Centers		354,850		354,850		354,850		354,850			39
40	Barber and Beauty Shops			8,350	8,350		8,350		8,350			40
41	Coffee and Gift Shops	10,252			10,252		10,252		10,252			41
42	Provider Participation Fee			117,712	117,712		117,712		117,712			42
43	Other (specify):* <b>IV XRAY LAB</b>		73,702	100,505	174,207		174,207		174,207			43
44	<b>TOTAL Special Cost Centers</b>	10,252	428,552	229,157	667,961		667,961		667,961			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,178,479	1,084,896	4,987,993	11,251,368		11,251,368	(155,233)	11,096,135			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,181)	2		4
5	Telephone, TV & Radio in Resident Rooms	(959)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(986)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(171)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(662)	21		18
19	Entertainment				19
20	Contributions	(375)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(20,083)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,344)	21		24
25	Fund Raising, Advertising and Promotional	(46,028)	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	(444)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (155,233)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (155,233)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

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

Manorcare of Highland Park

ID# 0050278

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (347)	21	1
2	Misc Income	(97)	21	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	<b>Total</b>	(444)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Highland Park# 0050278

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,181)	0	0	0	0	0	0	0	0	0	0	(1,181)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(986)	0	0	0	0	0	0	0	0	0	0	(986)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,167)</b>	<b>0</b>	<b>(2,167)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,083)	0	0	0	0	0	0	0	0	0	0	(20,083)	19
20	Fees, Subscriptions & Promotions	(46,028)	0	0	0	0	0	0	0	0	0	0	(46,028)	20
21	Clerical & General Office Expenses	(86,955)	0	0	0	0	0	0	0	0	0	0	(86,955)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(153,066)</b>	<b>0</b>	<b>(153,066)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(155,233)</b>	<b>0</b>	<b>(155,233)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Highland Park# 0050278

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(155,233)	0	0	0	0	0	0	0	0	0	0	(155,233)	45

**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
HCR 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	\$ 547,185	HCR Manor Care, Inc.	100.00%	\$ 547,185	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	31,726	Heartland Rehab Services, LLC	100.00%	31,726		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 578,911			\$ 578,911	\$ *	14

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Highland Park

# 0050278

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	2,857,768,524	359 Nurs. Fac.	\$ 2,826,629	\$ 1,585,087	10,706,601	\$ 10,590	1
2	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.			10,706,601	0	2
3	5	Utilities - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.			10,706,601	0	3
4	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	911,333		10,706,601	2,947	4
5	10	Nursing - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	632,689	715,152	10,706,601	2,370	5
6	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	469,810		10,706,601	1,519	6
7	17	General & Admin - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	36,564,185		10,706,601	149,260	7
8	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	69,554,530	79,745,671	10,706,601	224,923	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	8,673,677		10,706,601	61,079	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	8,300,418		10,706,601	26,842	10
11	30	Depreciation - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	146,326		10,706,601	1,060	11
12	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	6,941,685		10,706,601	22,448	12
13										13
14	32	Interest				21,122,019			44,147	14
15		Non-Nursing Home Allocations				25,797,439				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 547,185	25

Facility Name & ID Number

Manorcare of Highland Park

# 0050278

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	National City Bank, Trustee		X	Facility				\$ 1,733,736	\$ 1,733,736		2.5463	\$ 44,147	1							
2													2							
3													3							
4													4							
5													5							
<b>Working Capital</b>																				
6													6							
7													7							
8	Interest Income Other											(6,621)	8							
9	<b>TOTAL Facility Related</b>						\$ 1,733,736	\$ 1,733,736				\$ 37,526	9							
<b>B. Non-Facility Related*</b>																				
10													10							
11													11							
12													12							
13													13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 1,733,736	\$ 1,733,736				\$ 37,526	15							

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

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

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





Facility Name & ID Number Manorcare of Highland Park

# 0050278

Report Period Beginning:

01/01/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 73,108 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 3

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	3

Facility Name &amp; ID Number Manorcare of Highland Park

# 0050278

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	215		2001		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Building Improvements (Current Year Depreciation)					131,821		131,821		2,103,862	9
10	Civil Engineering Services		2001		3,332						10
11	Title Survey, environmental site assessment,professional serv		2001		26,933						11
12	Title Survey, environmental site assessment,professional serv		2001		5,937						12
13	Title Survey, environmental site assessment,professional serv		2001		11,541						13
14	Sinage		2001		2,234						14
15	Sinage		2002		10,967						15
16	Sidewalk		2003		3,496						16
17	Architect & Engineering Fees		2003		78,456						17
18	Developers Costs - Auto & Travel		2003		433						18
19	Developers Costs - Permits Fees		2003		1,195						19
20	Developers Cost - Plan Reviews		2003		6,013						20
21	Developers Costs - Overhead		2003		942,605						21
22	Interest		2003		83,525						22
23	Carpeting & Pads		2003		82,366						23
24	Wallcovering		2003		44,992						24
25	Cubicle Track - Material		2003		240						25
26	Carpentry Subcontractor		2003		905,757						26
27	HVAC		2003		4,180						27
28	Basic Electrical		2003		10,021						28
29	Building Demolition		2003		65,000						29
30	Site Clearing		2003		45,230						30
31	General Contractor		2003		324						31
32	Paving		2003		8,989						32
33	Landscaping		2003		31,494						33
34	Exterior Sign - Site		2003		583						34
35	Legal Fees		2003		44,751						35
36											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 &amp; ID Number Manorcare of Highland Park

# 0050278

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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			\$	\$		\$	\$	\$	37
38	VWC	2003	75						38
39	Freight on Carpet	2003	43						39
40	Carpet	2003	359						40
41	Flooring Installation	2003	843						41
42	Architect & Engineering	2003	471						42
43	Doors	2003	3,880						43
44	Concrete Pad	2004	885						44
45	Concrete Pad	2004	2,620						45
46	Lighting for Flagpole	2004	4,220						46
47	Exterior Lighting upgrade	2004	15,820						47
48	Exterior Lighting	2004	2,818						48
49	Sealing and Striping	2005	5,178						49
50	Doors	2005	19,400						50
51	Painting	2005	12,562						51
52	Painting	2005	16,809						52
53	Handrails	2005	14,245						53
54	Doors	2005	6,177						54
55	Doors Installed (10)	2006	16,151						55
56	Sidewalk	2007	4,725						56
57	Electrical Work for Light Fixture	2007	2,268						57
58	Door to Phone room	2007	2,208						58
59	Freight for Carpet	2007	758						59
60	Carpet	2008	14,399						60
61	HM Doors	2008	3,055						61
62	1008 Water Heater	2008	2,464						62
63	1008 Water Heater	2008	422						63
64	1008 Water Heater	2008	43,110						64
65	3 Door Restrictor	2008	6,631						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,623,190	\$ 131,821		\$ 131,821	\$	\$ 2,103,862	70

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

Facility Name & ID Number Manorcare of Highland Park

# 0050278

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 1,243,963	\$ 112,291	\$ 112,291	\$		\$ 837,611	71
72	Current Year Purchases	78,916						72
73	Fully Depreciated Assets							73
74				23,508	23,508			74
75	TOTALS	\$ 1,322,879	\$ 112,291	\$ 135,799	\$ 23,508		\$ 837,611	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)	\$ 3,946,069	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 244,112	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 267,620	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 23,508	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,941,473	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:	<u>1997</u>	<u>215</u>		\$ <u>1,222,772</u>	<u>15</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>215</u>		\$ <u>1,222,772</u>			7

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: \$ 169,993 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect.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

10. Effective dates of current rental agreement:

Beginning 06/15/01

Ending 06/15/16

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

Fiscal Year Ending Annual Rent

12. /2010 \$ 1,222,772

13. /2011 \$ 1,222,772

14. /2012 \$ 1,222,772

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	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	9185 hrs	\$ 361,334	1,032	\$ 70,582	\$ 2,675	10,217	\$ 434,591	1
2	Licensed Speech and Language Development Therapist	10a	1518 hrs	59,713	2	119	834	1,520	60,666	2
3	Licensed Recreational Therapist		hrs		355	24,292		355	24,292	3
4	Licensed Physical Therapist	10a	8408 hrs	331,133	2,885	197,341	18,250	11,293	546,724	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				393,675		393,675	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>IV Therapy</u>	43,2 & 10a				2,123	73,702		75,825	12
13	Other (specify): <u>X-Ray &amp; Lab</u>	43,3				100,505			100,505	13
14	<b>TOTAL</b>			\$ 752,180	4,274	\$ 394,962	\$ 489,136	23,385	\$ 1,636,278	14

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

Facility Name & ID Number Manorcare of Highland Park# 0050278Report Period Beginning: 01/01/09Ending: 12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 954	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (144,409) )	1,049,064		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,050,018	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,623,190		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,208,408		16
17	Accumulated Depreciation (book methods)	(2,941,473)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 890,125	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,940,143	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 169,434	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	320,301		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	119,314		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Payables</u>	1,452,003		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,061,052	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	8,098		42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 8,098	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,069,150	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (129,007)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,940,143	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,388,209)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,388,209)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,459,247)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,459,247)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	2,718,449	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>2,718,449</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(129,007)</b>	<b>24</b> *

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

Facility Name & ID Number Manorcare of Highland Park# 0050278Report Period Beginning: 01/01/09Ending: 12/31/09**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,931,281	1
2	Discounts and Allowances for all Levels	(3,090,785)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,840,496</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,385,711	6
7	Oxygen	209	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,385,920</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	347	12
13	Barber and Beauty Care	14,353	13
14	Non-Patient Meals	1,181	14
15	Telephone, Television and Radio	959	15
16	Rental of Facility Space		16
17	Sale of Drugs	465,286	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,927	19
20	Radiology and X-Ray	9,080	20
21	Other Medical Services	27,114	21
22	Laundry	986	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 565,233</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	375	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 375</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Misc Income</u>	97	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 97</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 9,792,121</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,364,919	31
32	Health Care	4,769,657	32
33	General Administration	2,694,351	33
<b>B. Capital Expense</b>			
34	Ownership	1,754,480	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	550,249	35
36	Provider Participation Fee	117,712	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 11,251,368</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(1,459,247)</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (1,459,247)</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number **Manorcare of Highland Park**

# **0050278**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,228	2,392	\$ 110,347	\$ 46.13	1
2	Assistant Director of Nursing	5,370	5,763	226,389	39.28	2
3	Registered Nurses	38,599	41,430	1,365,200	32.95	3
4	Licensed Practical Nurses	11,316	12,146	276,741	22.78	4
5	CNAs & Orderlies	75,707	81,453	1,078,342	13.24	5
6	CNA Trainees					6
7	Licensed Therapist	15,031	16,225	670,603	41.33	7
8	Rehab/Therapy Aides	4,081	4,405	141,329	32.08	8
9	Activity Director	8,331	8,961	125,750	14.03	9
10	Activity Assistants					10
11	Social Service Workers	5,409	5,818	114,362	19.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	19,626	21,360	304,956	14.28	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,213	2,379	58,025	24.39	17
18	Housekeepers	11,370	12,225	147,962	12.10	18
19	Laundry	3,479	3,744	41,337	11.04	19
20	Administrator	2,080	2,080	164,981	79.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,335	17,032	341,903	20.07	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					31
32	Other Health Care(specify)					32
33	Other(specify) <b>B&amp;B Hospitality</b>	649	700	10,252	14.65	33
34	TOTAL (lines 1 - 33)	220,824	238,113	\$ 5,178,479 *	\$ 21.75	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	22,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,864	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)		\$ 29,864		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	23	\$ 1,247	5,10,3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	78	2,025	5,10,3	52
53	TOTAL (lines 50 - 52)	101	\$ 3,272		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Barbara Beake	Administrator	0	\$ 74,131	Workers' Compensation Insurance	\$ 126,712	IDPH License Fee	\$ 3,292	
Brandon Davidson	Administrator	0	90,850	Unemployment Compensation Insurance	40,891	Advertising: Employee Recruitment	25,479	
				FICA Taxes	380,640	Health Care Worker Background Check	3,297	
				Employee Health Insurance	265,748	(Indicate # of checks performed <u>232</u> )		
				Employee Meals		<u>Patient Background Checks</u>	<u>148</u> 2,103	
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues/Subscriptions</u>	2,089	
				<u>401 K</u>	39,444	<u>Association Dues</u>	16,735	
				<u>Other Employee Benefits</u>	4,571	<u>Advertising</u>	37,324	
				<u>Tuition Program</u>	11,427			
				<u>SMSP Match</u>	2,699	<u>Less: Non -allowable Association Dues</u>	(8,704)	
				<u>Employee Uniforms</u>	658	<u>Less: Public Relations Expense</u>	( )	
				<u>Home Office Allocation</u>	87,921	<u>Non-allowable advertising</u>	(37,324)	
						<u>Yellow page advertising</u>	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 164,981	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 44,291
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees			\$ 547,185				Out-of-State Travel	\$
							In-State Travel	8,656
							<u>Includes travel expense to the Home Office in Toledo, OH for regional meetings</u>	
							Seminar Expense	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	\$ 8,656
Vendor/Payee	Type		Amount					
Elvidge Kelley	Legal Fees		\$ 1,478					
Foote, Meyers & Flowers LLC	Legal Fees		15,263					
Hartford Meiers, Inc	Legal Fees		720					
Collection Fees	Collection Fees		125					
MPRO	Collection Fees		1,185					
Rossmann & Co	Collection Fees		513					
United Collection	Collection Fees		799					
<u>(all above adjusted off via Page 5 line 22, therefore no invoices are attached)</u>								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)						\$		
			\$ 20,083					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Manorcare of Highland Park# 0050278Report Period Beginning: 01/01/09Ending: 12/31/09**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 \$8031
- (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 \$8704
- (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. \$ 57,989 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. \$ 117,712  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,181
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.