

		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0049353</u></p> <p>Facility Name: <u>Manorcare of Palos Heights West</u></p> <p>Address: <u>11860 Southwest Highway</u> <u>Palos Heights</u> <u>60463</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 361-4555</u> Fax # <u>(708) 361-3777</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>04/15/96</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Garv Geise</u> Telephone Number: <u>(419) 252-5731</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/09</u> to <u>05/31/10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.																												
	<input checked="" type="checkbox"/> Limited Liability Co.																												
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Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____																												

Facility Name & ID Number Manorcare of Palos Heights West

0049353 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	130	Skilled (SNF)	130	47,450	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	130	TOTALS	130	47,450	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	11,550	5,051	26,359	42,960	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,550	5,051	26,359	42,960	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.54%

D. How many bed-hold days during this year were paid by the Department?

1 (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 22,653

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.

Facility Name & ID Number Manorcare of Palos Heights West # 0049353 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	332,394	28,208	5,403	366,005	11,406	377,411		377,411		1
2	Food Purchase		271,513		271,513		271,513	(1,029)	270,484		2
3	Housekeeping		21,542	134,915	156,457		156,457		156,457		3
4	Laundry		17,541	89,164	106,705		106,705		106,705		4
5	Heat and Other Utilities			205,014	205,014	3,174	208,188		208,188		5
6	Maintenance	47,052	20,244	101,851	169,147		169,147		169,147		6
7	Other (specify):* Med Waste			1,082	1,082		1,082		1,082		7
8	TOTAL General Services	379,446	359,048	537,429	1,275,923	14,580	1,290,503	(1,029)	1,289,474		8
	B. Health Care and Programs										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	3,629,245	354,477	140,607	4,124,329	4,189	4,128,518		4,128,518		10
10a	Therapy	1,424,540	6,707	165,408	1,596,655		1,596,655		1,596,655		10a
11	Activities	63,654	5,038	7,972	76,664		76,664	(10)	76,654		11
12	Social Services	171,944	15		171,959		171,959		171,959		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,289,383	366,237	327,187	5,982,807	4,189	5,986,996	(10)	5,986,986		16
	C. General Administration										
17	Administrative	177,246		544,796	722,042	(141,792)	580,250		580,250		17
18	Directors Fees										18
19	Professional Services			52,564	52,564		52,564	(52,564)			19
20	Dues, Fees, Subscriptions & Promotions			51,429	51,429		51,429	(26,257)	25,172		20
21	Clerical & General Office Expenses	374,789	51,138	425,590	851,517		851,517	(323,520)	527,997		21
22	Employee Benefits & Payroll Taxes			1,147,328	1,147,328	94,692	1,242,020		1,242,020		22
23	Inservice Training & Education			600	600		600		600		23
24	Travel and Seminar			1,430	1,430		1,430		1,430		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			330,721	330,721		330,721		330,721		26
27	Other (specify):*										27
28	TOTAL General Administration	552,035	51,138	2,554,458	3,157,631	(47,100)	3,110,531	(402,341)	2,708,190		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,220,864	776,423	3,419,074	10,416,361	(28,331)	10,388,030	(403,380)	9,984,650		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 of Palos Heights West

#0049353

Report Period Beginning:

06/01/09

Ending:

05/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			394,879	394,879	25,318	420,197		420,197			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(4,536)	(4,536)	3,013	(1,523)		(1,523)			32
33	Real Estate Taxes			213,160	213,160		213,160		213,160			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			119,153	119,153		119,153		119,153			35
36	Other (specify):*											36
37	TOTAL Ownership			722,656	722,656	28,331	750,987		750,987			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		776,498		776,498		776,498		776,498			39
40	Barber and Beauty Shops			22,818	22,818		22,818		22,818			40
41	Coffee and Gift Shops	9,710			9,710		9,710		9,710			41
42	Provider Participation Fee			71,175	71,175		71,175		71,175			42
43	Other (specify):* IV Ther/Xray/Lab		72,191	295,813	368,004		368,004		368,004			43
44	TOTAL Special Cost Centers	9,710	848,689	389,806	1,248,205		1,248,205		1,248,205			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,230,574	1,625,112	4,531,536	12,387,222		12,387,222	(403,380)	11,983,842			45

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

Manorcare of Palos Heights West

ID# 0049353

Report Period Beginning: 06/01/09

Ending: 05/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,113)	21	1
2	Miscellaneous Income	(74)	21	2
3	Activity Income	(10)	11	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	(1,197)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Palos Heights West# 0049353

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	(1,029)	0	0	0	0	0	0	0	0	0	0	(1,029)	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	(1,029)	0	(1,029)	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	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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	(10)	0	(10)	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	(52,564)	0	0	0	0	0	0	0	0	0	0	(52,564)	19
20	Fees, Subscriptions & Promotions	(26,257)	0	0	0	0	0	0	0	0	0	0	(26,257)	20
21	Clerical & General Office Expenses	(323,520)	0	0	0	0	0	0	0	0	0	0	(323,520)	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	TOTAL General Administration	(402,341)	0	(402,341)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(403,380)	0	(403,380)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Palos Heights West# 0049353

Report Period Beginning:

06/01/09

Ending:

05/31/10

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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(403,380)	0	0	0	0	0	0	0	0	0	0	(403,380)	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
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	\$ 544,795	HCR Manor Care, Inc.	100.00%	\$ 544,795	\$	1
2	V	Pg 8						2
3	V							3
4	V	10a Therapy Management	45,788	Heartland Therapy Management	100.00%	45,788		4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 590,583			\$ 590,583	\$ *	14

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

Facility Name & ID Number Manorcare of Palos Heights West # 0049353 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 Palos Heights West

0049353

Report Period Beginning:

06/01/09

Ending: 05/31/10

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 Street

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 to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	\$ 2,826,629	\$ 1,585,087	11,531,241	\$ 11,406	1
2	1	Dietary - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			11,531,241	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs,HHs, Rehab			11,531,241	0	3
4	5	Utilities - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs			11,531,241	0	4
5	5	Utilities - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			11,531,241	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	911,333		11,531,241	3,174	6
7	10	Nursing - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	11,531,241	2,553	7
8	10	Nursing - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			11,531,241	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	469,810		11,531,241	1,636	9
10	17	Gen/Admin - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	35,518,981		11,531,241	143,321	10
11	17	Gen/Admin - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	1,045,204		11,531,241	17,435	11
12	17	Gen/Admin - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	69,554,530	79,745,671	11,531,241	242,247	12
13	22	Empl Bnfts -Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	6,239,311		11,531,241	25,176	13
14	22	Empl Bnfts -Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	2,434,366		11,531,241	40,607	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	8,300,418		11,531,241	28,909	15
16	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714		11,531,241	414	16
17	30	Deprec - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	43,612		11,531,241	727	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	6,941,685		11,531,241	24,177	18
19										19
20	32	Directly Assigned Interest				21,122,019			3,013	20
21		Non Central Div Nrsg Hm				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 544,795	25

Facility Name & ID Number

Manorcare of Palos Heights West

0049353

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	Conv. Sub. Debentures		X	Various				\$ 118,340	\$ 118,340		0.0255	\$ 3,013	1							
2													2							
3													3							
4													4							
5													5							
Working Capital																				
6													6							
7													7							
8	Interest Income / Expense Other										(4,536)	8								
9	TOTAL Facility Related										\$ 118,340	\$ 118,340	\$ (1,523)	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	\$ (1,523)	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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.	\$	320,331	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.)	\$	332,656	2
3. Under or (over) accrual (line 2 minus line 1).	\$	12,325	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	204,231	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.)	\$	1,950	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 \$ 5,346 For 2006 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(5,346)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	213,160	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	313,371	8
	2006	321,670	9
	2007	327,715	10
	2008	320,331	11
	2009	233,595	12

Line 2: \$332,656.16 = \$176,182.19 for 1st half of 2009 + \$153,476.97 for 2nd half of 2008

Line 4: \$204,231.42,987 = \$146,818.49 for Jan - May 2010 + \$57,412.93 for 2nd half of 2009

Line 5: \$1,950 = Worsek & Vihon Invoices. \$159 for 2007 RE Tax Appeal + \$1,791 for 2006 RE Tax Appeal

Line 6: \$5,346.31 refund for 2006 RE Tax Appeal

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

Facility Name & ID Number Manorcare of Palos Heights West

0049353

Report Period Beginning:

06/01/09

Ending:

05/31/10

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1996</u>	<u>\$ 705,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 705,000	3

Facility Name & ID Number Manorcare of Palos Heights West

0049353

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	130			1996	\$ 5,345,094	\$ 133,627		\$ 133,627	\$	\$ 1,883,347	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					125,486		125,486		1,042,290	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 of Palos Heights West

0049353

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	Consulting for PT Expansion	2008	4,847						53
54	Bathroom floor and toilets	2007	7,106						54
55	door frame and flooring	2008	4,542						55
56	fire doors	2008	6,260						56
57	fire dampers	2009	12,600						57
58	Renov - Arch & engineering cost	2009	2,479						58
59	Renov - resilient flooring	2009	885						59
60	Renov - Wallcovering	2009	7,534						60
61	Renov - General overhead & interest	2009	9,308						61
62	Renov -Interest on Const	2009	868						62
63	Renov - Carpentry & Subcontr	2009	69,237						63
64	Renov - Carpentry & Subcontr	2009	41,772						64
65	UL-263 Ceiling	2009	4,540						65
66	2 rooftop replacements	2009	25,017						66
67	water heater	2009	845						67
68	water heater	2009	1,293						68
69	water heater	2009	13,500						69
70	TOTAL (lines 4 thru 69)		\$ 6,959,923	\$ 259,113		\$ 259,113	\$	\$ 2,925,637	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,959,923	\$ 259,113		\$ 259,113	\$	\$ 2,925,637	1
2	10tib RTU	2010	16,605						2
3	Install PTAC	2010	1,661						3
4	flooring	2010	3,078						4
5	Parking lot paving	2009	13,669						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,994,936	\$ 259,113		\$ 259,113	\$	\$ 2,925,637	34

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

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	\$ 1,993,924	\$ 135,766	\$ 135,766	\$		\$ 1,638,485	71
72	Current Year Purchases	30,814						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			25,318	25,318			74
75	TOTALS	\$ 2,024,738	\$ 135,766	\$ 161,084	\$ 25,318		\$ 1,638,485	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)	\$ 9,724,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 394,879	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 420,197	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,318	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,564,122	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

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? _____

16. Rental Amount for movable equipment: \$ 119,153 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

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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	8380 hrs	\$ 323,625	420	\$ 19,637	\$ 1,368	8,800	\$ 344,630	1
2	Licensed Speech and Language Development Therapist	10a	4094 hrs	156,624	123	5,755	20	4,217	162,399	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	5012 hrs	215,986	1,382	64,666	5,319	6,394	285,971	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescripts				776,498		776,498	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					72,191		72,191	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3				295,813			295,813	13
14	TOTAL			\$ 696,235	1,925	\$ 385,871	\$ 855,396	19,411	\$ 1,937,502	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 Palos Heights West

0049353

Report Period Beginning: 06/01/09

Ending: 05/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/10 (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	\$ 12,907	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (863,144))	2,065,565		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,977		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,082,449	\$	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	6,994,936		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,024,738		16
17	Accumulated Depreciation (book methods)	(4,564,122)		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)	\$ 5,160,552	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,243,001	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 222,958	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	541,296		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	204,231		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>	30,410		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 998,895	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	118,340		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	44,247		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 162,587	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,161,482	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,081,519	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,243,001	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,152,272	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,152,272	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,421,471	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)	\$ 4,421,471	17
	B. Transfers (Itemize):		
18	Change in Interdivison	(4,492,224)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4,492,224)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,081,519	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Palos Heights West

0049353

Report Period Beginning: 06/01/09

Ending: 05/31/10

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	\$ 16,690,557	1
2	Discounts and Allowances for all Levels	(6,502,687)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,187,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,315,430	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,315,430	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	1,113	12
13	Barber and Beauty Care	26,590	13
14	Non-Patient Meals	1,029	14
15	Telephone, Television and Radio	8,432	15
16	Rental of Facility Space		16
17	Sale of Drugs	814,929	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	223,926	19
20	Radiology and X-Ray	108,229	20
21	Other Medical Services	118,388	21
22	Laundry	2,683	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,305,319	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>Miscellaneous Income</u>	74	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 74	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,808,693	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,275,923	31
32	Health Care	5,982,807	32
33	General Administration	3,157,631	33
B. Capital Expense			
34	Ownership	722,656	34
C. Ancillary Expense			
35	Special Cost Centers	1,177,030	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)*	\$ 12,387,222	40
41	Income before Income Taxes (line 30 minus line 40)**	4,421,471	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,421,471	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 of Palos Heights West**

0049353

Report Period Beginning:

06/01/09

Ending:

05/31/10

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	1,751	1,893	\$ 78,406	\$ 41.42	1
2	Assistant Director of Nursing	4,219	4,560	157,639	34.57	2
3	Registered Nurses	43,449	46,959	1,571,894	33.47	3
4	Licensed Practical Nurses	23,777	25,697	641,722	24.97	4
5	CNAs & Orderlies	92,124	99,690	1,153,613	11.57	5
6	CNA Trainees					6
7	Licensed Therapist	19,176	20,758	849,911	40.94	7
8	Rehab/Therapy Aides	19,856	21,495	574,629	26.73	8
9	Activity Director	4,885	5,271	63,654	12.08	9
10	Activity Assistants					10
11	Social Service Workers	7,854	8,524	171,944	20.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,350	27,432	332,394	12.12	15
16	Dishwashers					16
17	Maintenance Workers	1,929	2,087	47,052	22.55	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	158,776	76.33	20
21	Assistant Administrator	463	463	18,470	39.89	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,594	20,387	374,789	18.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,929	2,078	25,971	12.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	654	707	9,710	13.73	33
34	TOTAL (lines 1 - 33)	268,090	290,081	\$ 6,230,574 *	\$ 21.48	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	13,200	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,488	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)		\$ 15,688		49

C. CONTRACT NURSES

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

Facility Name & ID Number Manorcare of Palos Heights West# 0049353Report Period Beginning: 06/01/09Ending: 05/31/10**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 \$4,750
- (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 \$5377
- (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. \$ 79,022 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. \$ 1,029
- (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.