



Facility Name & ID Number Manor Care of Highland Park

# 0050278 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	18,814	3,456	16,807	39,077	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,814	3,456	16,807	39,077	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.80%

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 12,170

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL  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 Manor Care of Highland Park # 0050278 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

**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	400,328	30,926	3,707	434,961		434,961		434,961		1
2	Food Purchase		279,400		279,400		279,400	(2,247)	277,153		2
3	Housekeeping	201,921	28,194	4,125	234,240		234,240		234,240		3
4	Laundry	25,446	15,948	3,133	44,527		44,527	(509)	44,018		4
5	Heat and Other Utilities			249,258	249,258	2,558	251,816		251,816		5
6	Maintenance	80,041	20,301	183,190	283,532		283,532		283,532		6
7	Other (specify):* <b>Medical Waste</b>			781	781		781		781		7
8	<b>TOTAL General Services</b>	707,736	374,769	444,194	1,526,699	2,558	1,529,257	(2,756)	1,526,501		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			69,816	69,816		69,816		69,816		9
10	Nursing and Medical Records	3,494,554	245,674	107,158	3,847,386	16,144	3,863,530	(9)	3,863,521		10
10a	Therapy	1,028,535	21,348	364,694	1,414,577		1,414,577		1,414,577		10a
11	Activities	121,996	2,123	2,344	126,463		126,463		126,463		11
12	Social Services	159,700	140	428	160,268		160,268		160,268		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,804,785	269,285	544,440	5,618,510	16,144	5,634,654	(9)	5,634,645		16
	<b>C. General Administration</b>										
17	Administrative	87,160		647,621	734,781	(273,262)	461,519		461,519		17
18	Directors Fees										18
19	Professional Services			8,087	8,087		8,087	(6,304)	1,783		19
20	Dues, Fees, Subscriptions & Promotions			106,109	106,109		106,109	(68,876)	37,233		20
21	Clerical & General Office Expenses	534,368	68,854	391,324	994,546		994,546	(340,368)	654,178		21
22	Employee Benefits & Payroll Taxes			941,103	941,103	34,511	975,614		975,614		22
23	Inservice Training & Education			5,459	5,459		5,459		5,459		23
24	Travel and Seminar			8,672	8,672		8,672		8,672		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			573,612	573,612		573,612		573,612		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	621,528	68,854	2,681,987	3,372,369	(238,751)	3,133,618	(415,548)	2,718,070		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,134,049	712,908	3,670,621	10,517,578	(220,049)	10,297,529	(418,313)	9,879,216		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

Manor Care of Highland Park

#0050278

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

## 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			281,229	281,229	17,832	299,061		299,061			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(9,454)	(9,454)	202,217	192,763		192,763			32
33	Real Estate Taxes			128,174	128,174		128,174		128,174			33
34	Rent-Facility & Grounds			1,150,037	1,150,037		1,150,037		1,150,037			34
35	Rent-Equipment & Vehicles			75,139	75,139		75,139		75,139			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,625,125	1,625,125	220,049	1,845,174		1,845,174			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		419,706		419,706		419,706		419,706			39
40	Barber and Beauty Shops			10,174	10,174		10,174		10,174			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):* <b>IV, X-ray &amp; Lab</b>		51,405	108,422	159,827		159,827		159,827			43
44	<b>TOTAL Special Cost Centers</b>		471,111	236,309	707,420		707,420		707,420			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,134,049	1,184,019	5,532,055	12,850,123		12,850,123	(418,313)	12,431,810			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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (9)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,247)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,495)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(509)	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	(122)	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	(7,930)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,304)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(289,219)	21		24
25	Fund Raising, Advertising and Promotional	(68,876)	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 See attached pg 5A	(41,602)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (418,313)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (418,313)		37

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

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

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

**BHF USE ONLY**

48		49		50		51		52	
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Manor Care of Highland ParkID# 0050278Report Period Beginning: 01/01/2011Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Wages - Marketing	\$ (32,701)	21	1
2	Employee benefits - Marketing	(8,387)	21	2
3	HCP Lease Interest		32	3
4	Vending Income	(514)	21	4
5	Misc. Income		21	5
6	Acitivity Income		11	6
7	Loss on Disposal of Fixed Assets		36	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>	(41,602)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Care of Highland Park# 0050278

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

## 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	(2,247)	0	0	0	0	0	0	0	0	0	0	(2,247)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(509)	0	0	0	0	0	0	0	0	0	0	(509)	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>(2,756)</b>	<b>0</b>	<b>(2,756)</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	(9)	0	0	0	0	0	0	0	0	0	0	(9)	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>(9)</b>	<b>0</b>	<b>(9)</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	(6,304)	0	0	0	0	0	0	0	0	0	0	(6,304)	19
20	Fees, Subscriptions & Promotions	(68,876)	0	0	0	0	0	0	0	0	0	0	(68,876)	20
21	Clerical & General Office Expenses	(340,368)	0	0	0	0	0	0	0	0	0	0	(340,368)	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>(415,548)</b>	<b>0</b>	<b>(415,548)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(418,313)</b>	<b>0</b>	<b>(418,313)</b>	<b>29</b>									

## STATE OF ILLINOIS

Facility Name & ID Number Manor Care of Highland Park# 0050278

Report Period Beginning:

01/01/2011 Ending:

Summary B

12/31/2011

## 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)	(418,313)	0	0	0	0	0	0	0	0	0	0	(418,313)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Health Care	Toledo	Nursing Staff
		See PG6-Supp for list of related nursing homes in Illinois				

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	\$ 647,621	HCR Manor Care Services, LLC	100.00%	\$ 647,621	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	6,134,049	Heartland Employment Services, LLC	100.00%	6,134,049		4
5	V							5
6	V	10a Therapy Management	25,607	Heartland Rehab Services, LLC	100.00%	25,607		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 6,807,277			\$ 6,807,277	\$ *	14

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

Facility Name &amp; ID Number

Manor Care of Highland Park

# 0050278

Report Period Beginning:

01/01/2011

Ending: 12/31/2011

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15								15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights West IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights IL, LLC	Palos Heights				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				26
27			Manor Care of South Holland IL, LLC	South Holland				27
28			Manor Care of Westmont IL, LLC	Westmont				28
29			Manor Care of Wilmette IL, LLC	Wilmette				29
30			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				30



Facility Name & ID Number Manor Care of Highland Park # 0050278 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

## 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 Manor Care of Highland Park# 0050278

Report Period Beginning:

01/01/2011Ending: 2/31/2011

## 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 Services, LLC

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	5	Utilities - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	\$ 775,999	\$ 12,413,321	\$ 2,558	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs		12,413,321	0	2
3	5	Utilities - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs		12,413,321	0	3
4	5	Utilities - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs		12,413,321	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	485,056	352,684	12,413,321	1,599
6	10	Nursing - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	12,413,321	14,545
7	10	Nursing - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs		12,413,321	0	7
8	10	Nursing - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs		12,413,321	0	8
9	17	General & Administrative - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	71,430,003	38,287,220	12,413,321	235,493
10	17	General & Administrative - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	12,413,321	87,886
11	17	General & Administrative - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	12,413,321	27,546
12	17	General & Administrative - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	12,413,321	23,434
13	22	Employee Benefits - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	2,952,374		12,413,321	9,733
14	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		12,413,321	24,778
15	22	Employee Benefits - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs			12,413,321	0
16	22	Employee Benefits - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs			12,413,321	0
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs, & Re	4,719,938		12,413,321	15,561
18	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		12,413,321	2,271
19	30	Depreciation - Direct to Central Division	Accumulated Cost	803,363,605	92 NFs			12,413,321	0
20	30	Depreciation - Direct to Midwest Division	Accumulated Cost	474,102,184	48 NFs			12,413,321	0
21	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		12,413,321	86,850
22	32	Directly Assigned Interest	Not Allocated			18,851,990			115,367
23		H/O Costs Allocated to Non-SNFs and Other Divisions				32,615,916			
24									
25	TOTALS					\$ 195,623,363	\$ 61,082,869	\$ 647,621	25

Facility Name & ID Number

Manor Care of Highland Park

# 0050278

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

**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										
										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	Various		X	Facility				\$ 1,733,736	\$ 1,733,736		0.0665	\$ 115,367	1						
2													2						
3													3						
4													4						
5													5						
<b>Working Capital</b>																			
6													6						
7	Home Office Pooled Interest											86,850	7						
8	Interest Income Other											(9,454)	8						
9	<b>TOTAL Facility Related</b>						\$ 1,733,736	\$ 1,733,736				\$ 192,763	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				\$ 192,763	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2010 report.		\$	<b>121,524</b>		<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>124,849</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,325</b>		<b>3</b>
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>124,849</b>		<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>128,174</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<b>105,168</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2007	<b>114,405</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2010 \$ <b>13</b>
	2008	<b>119,314</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2009	<b>121,524</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
	2010	<b>124,849</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>

**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 Manor Care of Highland Park

# 0050278

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

**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 Manor Care of Highland Park

# 0050278

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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			\$	\$		\$	\$	4	
5									5	
6									6	
7									7	
8									8	
<b>Improvement Type**</b>										
9	Building Improvements (Current Year Depreciation)				138,308		138,308		2,373,968	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 Manor Care of Highland Park

# 0050278

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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	VWC	2003	\$ 75	\$		\$	\$	\$	37
38	Freight on Carpet	2003	43						38
39	Carpet	2003	359						39
40	Flooring Installation	2003	843						40
41	Architect & Engineering	2003	471						41
42	Doors	2003	3,880						42
43	Concrete Pad	2004	885						43
44	Concrete Pad	2004	2,620						44
45	Lighting for Flagpole	2004	4,220						45
46	Exterior Lighting upgrade	2004	15,820						46
47	Exterior Lighting	2004	2,818						47
48	Sealing and Striping	2005	5,178						48
49	Doors	2005	19,400						49
50	Painting	2005	12,562						50
51	Painting	2005	16,809						51
52	Handrails	2005	14,245						52
53	Doors	2005	6,177						53
54	Doors Installed (10)	2006	16,151						54
55	Sidewalk	2007	4,725						55
56	Electrical Work for Light Fixture	2007	2,268						56
57	Door to Phone room	2007	2,208						57
58	Freight for Carpet	2007	758						58
59	Carpet	2008	14,399						59
60	HM Doors	2008	3,055						60
61	1008 Water Heater	2008	2,464						61
62	1008 Water Heater	2008	422						62
63	1008 Water Heater	2008	43,110						63
64	3 Door Restrictor	2008	6,631						64
65	Install Electrical outlets	2010	4,733						65
66	Carpet for Res Rooms	2010	3,139						66
67	Carpeting Rms 128 & 129	2010	3,488						67
68	0310 Heritage Carpeting	2010	7,870						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,642,420	\$ 138,308		\$ 138,308	\$	\$ 2,373,968	70

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,642,420	\$ 138,308		\$ 138,308	\$	\$ 2,373,968	1
2	2010	5,674						2
3	2010	31,740						3
4	2010	18,326						4
5	2011	10,440						5
6	2011	2,814						6
7	2011	4,699						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		\$ 2,716,113	\$ 138,308		\$ 138,308	\$	\$ 2,373,968	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,390,216	\$ 142,921	\$ 142,921	\$		\$ 1,106,112	71
72	Current Year Purchases	185,581						72
73	Fully Depreciated Assets							73
74	Home Office			17,832	17,832			74
75	TOTALS	\$ 1,575,797	\$ 142,921	\$ 160,753	\$ 17,832		\$ 1,106,112	75

D. Vehicle Costs. (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)	\$ 4,291,910	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 281,229	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 299,061	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,832	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,480,080	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>1,150,037</u>	<u>15</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>215</u>		\$ <u>1,150,037</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: \$ 75,139 Description: O2 Concentrators, wheelchairs, gerichairs, electric 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. /2012 \$ 1,211,926

13. /2013 \$ 1,250,883

14. /2014 \$ 1,289,839

\* 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	10281 hrs	\$ 425,752	869	\$ 64,646	\$ 2,227	11,150	\$ 492,625	1
2	Licensed Speech and Language Development Therapist	10a	1361 hrs	56,365			478	1,361	56,843	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	8671 hrs	359,080	3,532	262,780	18,643	12,203	640,503	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				419,706		419,706	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					51,405		51,405	12
13	Other (specify): <u>X-ray &amp; Lab</u>	43, 3				108,422			108,422	13
14	<b>TOTAL</b>			\$ 841,197	4,401	\$ 435,848	\$ 492,459	24,714	\$ 1,769,504	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 Manor Care of Highland Park# 0050278Report Period Beginning: 01/01/2011Ending: 12/31/2011

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,692	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>396,665</u> )	1,570,393		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>	\$ 1,574,085	\$	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	2,716,113		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,575,797		16
17	Accumulated Depreciation (book methods)	(3,480,079)		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>	\$ 811,831	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,385,916	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 136,373	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	398,472		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	124,849		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>	294,403		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 954,097	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	921,567		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>	\$ 921,567	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,875,664	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 510,252	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,385,916	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(215,115)</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>(215,115)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,226,891)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,226,891)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in interdivision</b>	<b>1,952,258</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>1,952,258</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>510,252</b>	<b>24</b> *

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

Facility Name &amp; ID Number Manor Care of Highland Park

# 0050278

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,798,357	1
2	Discounts and Allowances for all Levels	(3,399,173)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,399,184	3
<b>B. Ancillary Revenue</b>			
4	Day Care	9	4
5	Other Care for Outpatients		5
6	Therapy	2,650,766	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,650,775	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	514	12
13	Barber and Beauty Care	13,319	13
14	Non-Patient Meals	2,247	14
15	Telephone, Television and Radio	1,495	15
16	Rental of Facility Space		16
17	Sale of Drugs	418,020	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,446	19
20	Radiology and X-Ray	28,779	20
21	Other Medical Services	53,944	21
22	Laundry	509	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 573,273	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,623,232	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,526,699	31
32	Health Care	5,618,510	32
33	General Administration	3,372,369	33
<b>B. Capital Expense</b>			
34	Ownership	1,625,125	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	589,707	35
36	Provider Participation Fee	117,713	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,850,123	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,226,891)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,226,891)	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 **Manor Care of Highland Park**

# **0050278**

Report Period Beginning: **01/01/2011**

Ending:

**12/31/2011**

**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	1,993	2,158	\$ 104,209	\$ 48.29	1
2	Assistant Director of Nursing	5,798	6,281	247,098	39.34	2
3	Registered Nurses	39,257	42,526	1,438,073	33.82	3
4	Licensed Practical Nurses	15,848	17,168	406,211	23.66	4
5	CNAs & Orderlies	95,016	103,143	1,289,622	12.50	5
6	CNA Trainees	113	122	1,458	11.95	6
7	Licensed Therapist	20,313	21,962	909,462	41.41	7
8	Rehab/Therapy Aides	3,514	3,799	119,073	31.34	8
9	Activity Director	7,843	8,505	121,996	14.34	9
10	Activity Assistants					10
11	Social Service Workers	5,959	6,462	159,700	24.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,506	27,654	400,328	14.48	15
16	Dishwashers					16
17	Maintenance Workers	3,418	3,708	80,041	21.59	17
18	Housekeepers	15,712	17,035	201,921	11.85	18
19	Laundry	1,815	1,969	25,446	12.92	19
20	Administrator	2,080	2,080	87,160	41.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,021	25,125	542,251	21.58	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)					33
34	TOTAL (lines 1 - 33)	267,206	289,697	\$ 6,134,049 *	\$ 21.17	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	69,816	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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)	\$	69,816		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	4	78	5,10,3	52
53	TOTAL (lines 50 - 52)	4	\$ 78		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 (Jan-Nov)	Administrator	0	\$ 85,660	Workers' Compensation Insurance	\$ 65,734	IDPH License Fee	\$ 1,922	
Tammy Wagner (Nov-Dec)	Administrator	0	1,500	Unemployment Compensation Insurance	70,402	Advertising: Employee Recruitment	4,635	
				FICA Taxes	432,748	Health Care Worker Background Check		
				Employee Health Insurance	311,936	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	18,426	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	4,962	
				401K	54,202	Association Dues	25,329	
				Other Employee Benefits & Marketing Adj	(1,459)	Advertising (Non-allowable)	28,679	
				Tuition Program	3,333	Advertising (Allowable)	22,156	
				SMSP Match	451	Less: Non-allowable Association Dues	(18,041)	
				Employee Uniforms	3,756	Less: Public Relations Expense	(22,156)	
				Home Office Allocation	34,511	Non-allowable advertising	(28,679)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 87,160	TOTAL (agree to Schedule V,	\$ 975,614	TOTAL (agree to Sch. V,	\$ 37,233	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
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
Home Office Costs			\$ 647,621				Out-of-State Travel	\$
							In-State Travel	8,672
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 647,621				Seminar Expense	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V,	
Foote Meyers Mielke & Flowers LLC	Legal Fees		\$ 3,804	TOTAL		\$	line 24, col. 8)	\$ 8,672
Littler Mendelson PC	Legal Fees		2,500					
United Collection Bureau Inc	Collection Fees		(109)					
Frances Hankin	Consulting Services		300					
MPRO	Consulting Services		1,410					
The Weissman Group	Mgmt Consulting Services		182					
(All above adjusted off via Page 5 line 22, therefore no invoices are attached.)								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 8,087					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Manor Care of Highland Park# 0050278Report Period Beginning: 01/01/2011 Ending: 12/31/2011**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 \$7,288
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes \$10,299 If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 57,581 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. \$ 117,713  
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. \$ 2,247
- (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?  
**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.