

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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> <small>Number City Zip Code</small></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%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </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 type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>06/01/11</u> to <u>05/31/12</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u> </td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </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) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
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) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Manorcare of Palos Heights West

0049353 Report Period Beginning: 06/01/11 Ending: 05/31/12

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	47,580	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	47,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,136	3,961	28,659	44,756	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,136	3,961	28,659	44,756	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.06%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 04/15/96

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/07/11 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 23,764

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31 Fiscal Year: 05/31

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

Facility Name & ID Number

Manorcare of Palos Heights West

0049353

Report Period Beginning:

06/01/11

Ending:

05/31/12

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	378,911	28,526	18,070	425,507		425,507		425,507		1
2	Food Purchase		340,374		340,374		340,374	(1,873)	338,501		2
3	Housekeeping		33,556	114,565	148,121		148,121		148,121		3
4	Laundry		44,222	111,996	156,218		156,218		156,218		4
5	Heat and Other Utilities			198,610	198,610	3,395	202,005		202,005		5
6	Maintenance	43,234	23,200	119,285	185,719		185,719		185,719		6
7	Other (specify):* Med Waste			1,685	1,685		1,685		1,685		7
8	TOTAL General Services	422,145	469,878	564,211	1,456,234	3,395	1,459,629	(1,873)	1,457,756		8
	B. Health Care and Programs										
9	Medical Director			14,955	14,955		14,955		14,955		9
10	Nursing and Medical Records	4,273,569	363,610	261,538	4,898,717	21,424	4,920,141		4,920,141		10
10a	Therapy	2,093,595	7,852	389,206	2,490,653		2,490,653		2,490,653		10a
11	Activities	82,410	2,395	3,819	88,624		88,624	(64)	88,560		11
12	Social Services	196,779			196,779		196,779		196,779		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,646,353	373,857	669,518	7,689,728	21,424	7,711,152	(64)	7,711,088		16
	C. General Administration										
17	Administrative	141,542		714,197	855,739	(217,409)	638,330		638,330		17
18	Directors Fees										18
19	Professional Services			55,085	55,085	(540)	54,545	(54,545)			19
20	Dues, Fees, Subscriptions & Promotions			85,932	85,932		85,932	(27,157)	58,775		20
21	Clerical & General Office Expenses	449,555	106,835	643,074	1,199,464	540	1,200,004	(551,246)	648,758		21
22	Employee Benefits & Payroll Taxes			1,250,217	1,250,217	45,798	1,296,015		1,296,015		22
23	Inservice Training & Education			2,047	2,047		2,047		2,047		23
24	Travel and Seminar			21,233	21,233		21,233		21,233		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			417,880	417,880		417,880		417,880		26
27	Other (specify):*										27
28	TOTAL General Administration	591,097	106,835	3,189,665	3,887,597	(171,611)	3,715,986	(632,948)	3,083,038		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,659,595	950,570	4,423,394	13,033,559	(146,792)	12,886,767	(634,885)	12,251,882		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:

06/01/11

Ending:

05/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			386,534	386,534	23,664	410,198		410,198			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,562,058	3,562,058	123,128	3,685,186	(3,564,093)	121,093			32
33	Real Estate Taxes			518,978	518,978		518,978		518,978			33
34	Rent-Facility & Grounds			600	600		600		600			34
35	Rent-Equipment & Vehicles			55,341	55,341		55,341		55,341			35
36	Other (specify):*											36
37	TOTAL Ownership			4,523,511	4,523,511	146,792	4,670,303	(3,564,093)	1,106,210			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		763,165	5,950	769,115		769,115		769,115			39
40	Barber and Beauty Shops			25,202	25,202		25,202		25,202			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			219,545	219,545		219,545		219,545			42
43	Other (specify):* IV Ther/Xray/Lab		101,061	227,826	328,887		328,887		328,887			43
44	TOTAL Special Cost Centers		864,226	478,523	1,342,749		1,342,749		1,342,749			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,659,595	1,814,796	9,425,428	18,899,819		18,899,819	(4,198,978)	14,700,841			45

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

Facility Name & ID Number Manorcare of Palos Heights West

0049353

Report Period Beginning: 06/01/11

Ending: 05/31/12

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,873)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(149)	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	(17,615)	21		18
19	Entertainment				19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(54,545)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(488,359)	21		24
25	Fund Raising, Advertising and Promotional	(27,157)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached 5a	(3,609,030)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,198,978)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (4,198,978)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Manorcare of Palos Heights West

ID# 0049353

Report Period Beginning: 06/01/11

Ending: 05/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Wages - Marketing	\$ (34,845)	21	1
2	P/R O/H Alloc - Mktg	(8,982)	21	2
3	HCP Lease Interest	(3,564,093)	32	3
4	Vending Income	(1,044)	21	4
5	Misc. Income	(2)	21	5
6	Activity Income	(64)	11	6
7	Loss on disposal of Fixed Asset		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	Total	(3,609,030)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

06/01/11

Ending:

05/31/12

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	(1,873)	0	0	0	0	0	0	0	0	0	0	(1,873)	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	(1,873)	0	(1,873)	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	(64)	0	0	0	0	0	0	0	0	0	0	(64)	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	(64)	0	(64)	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	(54,545)	0	0	0	0	0	0	0	0	0	0	(54,545)	19
20	Fees, Subscriptions & Promotions	(27,157)	0	0	0	0	0	0	0	0	0	0	(27,157)	20
21	Clerical & General Office Expenses	(551,246)	0	0	0	0	0	0	0	0	0	0	(551,246)	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	(632,948)	0	(632,948)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(634,885)	0	(634,885)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Palos Heights West

0049353

Report Period Beginning:

06/01/11 Ending:

05/31/12

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	(3,564,093)	0	0	0	0	0	0	0	0	0	0	(3,564,093)	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	(3,564,093)	0	0	0	0	0	0	0	0	0	0	(3,564,093)	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)	(4,198,978)	0	0	0	0	0	0	0	0	0	0	(4,198,978)	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 Svc	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Home Office Allocation	\$ 714,197	HCR Manor Care Services, LLC	100.00%	\$ 714,197	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	7,659,595	Heartland Employment Services, LLC	100.00%	7,659,595		4
5	V	10a Therapy Management	14,771	Heartland Rehabilitation Services, LLC	100.00%	14,771		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		\$ 8,388,563			\$ 8,388,563	\$ *	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:

06/01/11

Ending:

05/31/12

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			Manor Care - Highland Park	Highland Park				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 (East) IL, LLC	Palos Heights				24
25			Manor Care of South Holland IL, LLC	South Holland				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number

Manorcare of Palos Heights West

0049353

Report Period Beginning:

06/01/11

Ending:

05/31/12

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			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				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

Facility Name & ID Number Manorcare of Palos Heights West # 0049353 Report Period Beginning: 06/01/11 Ending: 05/31/12

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:

06/01/11

Ending: 05/31/12

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	731 NFs, HHs,Reha	\$ 775,999		16,472,975	\$ 3,395	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	353 NFs			16,472,975	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	92 NFs			16,472,975	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	48 NFs			16,472,975	0	4
5	10	Nursing - Pooled	Accumulated Cost	731 NFs, HHs,Reha	485,056	352,684	16,472,975	2,122	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	353 NFs	3,905,972	1,829,606	16,472,975	19,302	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	92 NFs			16,472,975	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	48 NFs			16,472,975	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	731 NFs, HHs,Reha	71,430,003	38,287,220	16,472,975	312,508	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	353 NFs	23,601,055	18,695,747	16,472,975	116,628	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	92 NFs	1,782,698	1,278,408	16,472,975	36,554	11
12	17	Gen/Admin-Direct to MW Div SNFs	Accumulated Cost	48 NFs	895,017	639,204	16,472,975	31,098	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	731 NFs, HHs,Reha	2,952,374		16,472,975	12,917	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	353 NFs	6,653,909		16,472,975	32,881	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	92 NFs			16,472,975	0	15
16	22	Empl Bnfts - Direct to MW Div SNFs	Accumulated Cost	48 NFs			16,472,975	0	16
17	30	Depreciation - Pooled	Accumulated Cost	731 NFs, HHs,Reha	4,719,938		16,472,975	20,650	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	353 NFs	609,966		16,472,975	3,014	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	92 NFs			16,472,975	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	48 NFs			16,472,975	0	20
21									21
22	32	Pooled Interest	Accumulated Cost		26,343,470		16,472,975	115,253	22
23	32	Directly Assigned Interest			18,851,990			7,875	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions			32,615,916				24
25	TOTALS				\$ 195,623,363	\$ 61,082,869		\$ 714,197	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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			
	A. Directly Facility Related																
	Long-Term																
1	Conv. Sub. Debentures		X	Various			\$ 118,340	\$ 118,340		0.0665	\$ 7,875	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7	Pooled Interest										115,253	7					
8	Interest Expense / Interest Income										(2,035)	8					
9	TOTAL Facility Related						\$ 118,340	\$ 118,340			\$ 121,093	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			\$ 121,093	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 2011 report.		\$	<u>203,989</u>		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.)		\$	<u>291,428</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>87,439</u>		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>427,539</u>		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.)		\$	<u>4,000</u>		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>518,978</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	<u>327,715</u>			8
	2008	<u>320,331</u>			9
	2009	<u>337,350</u>			10
	2010	<u>234,682</u>			11
	2011	<u>392,905</u>			12
Line 2: \$291,428.72 = \$106,204.64 for 2nd half 2010 + \$129,075.08 for 1st half 2011 + \$56,148 to adjust expense.					
Line 4: \$427,539.49 = \$263,829.49 for 2nd half 2011 = \$163,710 for Jan-May 2012					
Line 5: \$4,000 Urban Real Estate Research Invoice for 2011 RE Tax Appeal					
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Palos Heights West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049353

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>23-24-300-132-0000</u>	<u>See Attached</u>	\$ <u>392,904.57</u>	\$ <u>392,904.57</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>392,904.57</u></u>	\$ <u><u>392,904.57</u></u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	130			1996	\$ 5,345,094	\$ 133,627		\$ 133,627	\$	\$ 2,150,601	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					113,790		113,790		1,279,913	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:

06/01/11

Ending:

05/31/12

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	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	\$ 247,417		\$ 247,417	\$	\$ 3,430,514	70

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

Facility Name & ID Number Manorcare of Palos Heights West

0049353

Report Period Beginning:

06/01/11

Ending:

05/31/12

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	
1	Totals from Page 12A, Carried Forward		\$ 6,959,923	\$ 247,417		\$ 247,417	\$	\$ 3,430,514	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	flooring, 2nd flr dining	2010	6,420						6
7	curbs & flash in roof deck	2010	2,300						7
8	air vent grills	2010	13,475						8
9	carpeting	2010	2,633						9
10	frt carpeting	2010	161						10
11	3000 make up air unit	2010	26,578						11
12	additional air vent grills	2011	5,995						12
13	roof ventilator	2011	2,764						13
14	kitchen ceiling fans	2011	8,870						14
15	floor and wall tile 2 restrooms	2011	12,877						15
16	carpet install in Admin	2011	2,867						16
17	pave parking lot	2010	6,986						17
18	doors and frames	2011	49,214						18
19	Renov - Fire Sprinkler system	2011	51,784						19
20	Renov - Basic Electrical	2011	1,804						20
21	2000 sq. ft. of lower roof	2011	8,360						21
22	4 fire rated access hatch	2011	9,870						22
23	Renov - Carpentry	2011	36,225						23
24	Renov - Carpeting	2011	313						24
25	Renov - Wallcovering	2011	1,895						25
26	Revov - Basic Electrical	2011	4,802						26
27	HM door	2011	2,410						27
28	3 sets of exterior HM door	2011	22,905						28
29	countertop for 2nd flr nourishment	2012	3,055						29
30	3 insinkerators	2012	10,317						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,289,815	\$ 247,417		\$ 247,417	\$	\$ 3,430,514	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	\$ 2,214,518	\$ 139,117	\$ 139,117	\$		\$ 1,917,841	71
72	Current Year Purchases	142,239						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			23,664	23,664			74
75	TOTALS	\$ 2,356,757	\$ 139,117	\$ 162,781	\$ 23,664		\$ 1,917,841	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)	\$ 10,351,572	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 386,534	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 410,198	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 23,664	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,348,355	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 55,341 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Manorcare of Palos Heights West # 0049353 Report Period Beginning: 06/01/11 Ending: 05/31/12
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	12715 hrs	\$ 517,268	2,213	\$ 120,848	\$ 846	14,928	\$ 638,962	1
2	Licensed Speech and Language Development Therapist	10a	6767 hrs	275,307	(9)	(500)	426	6,758	275,233	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	9329 hrs	379,539	4,301	234,845	6,580	13,630	620,964	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				763,165		763,165	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Inhalation Therapist</u>	10a	1464	59,553	177	9,681		1,641	69,234	12
13	Other (specify): <u>IV Ther/Xray/Lab</u>	43, 2 & 3				227,826	101,061		328,887	13
14	TOTAL			\$ 1,231,667	6,682	\$ 592,700	\$ 872,078	36,957	\$ 2,696,445	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: 06/01/11

Ending:

05/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/12 (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	\$ 786	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (657,360))	3,191,538		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,289		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,197,613	\$	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	7,289,815		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,356,757		16
17	Accumulated Depreciation (book methods)	(5,348,355)		17
18	Deferred Charges	9,419,380		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)	\$ 14,422,597	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,620,210	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 318,839	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	468,290		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	427,539		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued Payables	172,078		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,386,746	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	118,340		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 118,340	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,505,086	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 16,115,124	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,620,210	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (33,015,399)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (33,015,399)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	339,135	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)	\$ 339,135	17
B. Transfers (Itemize):			
18	Change in Interdivision	48,791,388	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 48,791,388	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 16,115,124	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 19,354,635	1
2	Discounts and Allowances for all Levels	(7,548,029)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,806,606	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,302,050	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,302,050	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	1,044	12
13	Barber and Beauty Care	30,312	13
14	Non-Patient Meals	1,873	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	832,473	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,252	19
20	Radiology and X-Ray	71,154	20
21	Other Medical Services	105,252	21
22	Laundry	2,852	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,130,212	23
D. Non-Operating Revenue			
24	Contributions	20	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity & Miscellaneous Income	66	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 66	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,238,954	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,456,234	31
32	Health Care	7,689,728	32
33	General Administration	3,887,597	33
B. Capital Expense			
34	Ownership	4,523,511	34
C. Ancillary Expense			
35	Special Cost Centers	1,123,204	35
36	Provider Participation Fee	219,545	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,899,819	40
41	Income before Income Taxes (line 30 minus line 40)**	339,135	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 339,135	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,391,750	44
45	Private Pay - Net Inpatient Revenue	1,137,357	45
46	Medicare - Net Inpatient Revenue	8,171,986	46
47	Other-(specify)	189,843	47
48	Other-(specify)	915,670	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,806,606	49

* 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:

06/01/11

Ending:

05/31/12

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	1,786	1,928	\$ 85,897	\$ 44.55	1
2	Assistant Director of Nursing	3,127	3,374	117,407	34.80	2
3	Registered Nurses	64,562	69,669	2,331,289	33.46	3
4	Licensed Practical Nurses	12,823	13,837	349,382	25.25	4
5	CNAs & Orderlies	104,269	112,695	1,365,264	12.11	5
6	CNA Trainees					6
7	Licensed Therapist	30,276	32,669	1,329,025	40.68	7
8	Rehab/Therapy Aides	23,565	25,428	764,570	30.07	8
9	Activity Director	5,842	6,309	82,410	13.06	9
10	Activity Assistants					10
11	Social Service Workers	7,596	8,202	196,779	23.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,009	29,204	378,911	12.97	15
16	Dishwashers					16
17	Maintenance Workers	1,787	1,928	43,234	22.42	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	90,390	43.46	20
21	Assistant Administrator	1,281	1,281	51,152	39.93	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,505	23,550	405,728	17.23	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	1,775	1,917	24,330	12.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	309,283	334,071	\$ 7,615,768 *	\$ 22.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	14,955	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)		\$ 14,955		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	153	\$ 10,733	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	153	\$ 10,733		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Manorcare of Palos Heights West# 0049353Report Period Beginning: 06/01/11Ending: 05/31/12**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 \$4,354
- (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 \$10560
- (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. \$ 71,333 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? YES
If YES, give effective date of lease. 04/07/11
- (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. \$ 219,545
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. \$ 1,873
- (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.