



Facility Name & ID Number Manorcare of Palos Hts East

# 0049478 Report Period Beginning: 06/01/13 Ending: 05/31/14

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	184	Skilled (SNF)	184	67,160	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	184	TOTALS	184	67,160	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	6,653	3,073	50,328	60,054	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,653	3,073	50,328	60,054	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.42%

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 06/02/88

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 184 and days of care provided 42,837

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31 Fiscal Year: 5/31

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

**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	139,663	43,789	391,889	575,341		575,341		575,341		1
2	Food Purchase		389,796		389,796		389,796	(2,738)	387,058		2
3	Housekeeping	223,299	39,289	504	263,092		263,092		263,092		3
4	Laundry	80,893	31,168		112,061		112,061		112,061		4
5	Heat and Other Utilities			281,815	281,815	4,307	286,122		286,122		5
6	Maintenance	68,520	27,304	120,025	215,849		215,849		215,849		6
7	Other (specify):* <b>Med Waste</b>			1,772	1,772		1,772		1,772		7
8	<b>TOTAL General Services</b>	512,375	531,346	796,005	1,839,726	4,307	1,844,033	(2,738)	1,841,295		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			25,125	25,125		25,125		25,125		9
10	Nursing and Medical Records	5,560,358	442,597	135,834	6,138,789	18,774	6,157,563		6,157,563		10
10a	Therapy	4,285,233	19,930	61,093	4,366,256		4,366,256		4,366,256		10a
11	Activities	122,085	5,706	5,575	133,366		133,366	(86)	133,280		11
12	Social Services	275,585	61		275,646		275,646		275,646		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	10,243,261	468,294	227,627	10,939,182	18,774	10,957,956	(86)	10,957,870		16
	<b>C. General Administration</b>										
17	Administrative	177,183		1,142,954	1,320,137	(511,959)	808,178		808,178		17
18	Directors Fees										18
19	Professional Services			51,474	51,474	(7,406)	44,068	(44,068)			19
20	Dues, Fees, Subscriptions & Promotions			94,136	94,136		94,136	(27,041)	67,095		20
21	Clerical & General Office Expenses	559,356	113,387	269,697	942,440	7,406	949,846	(145,040)	804,806		21
22	Employee Benefits & Payroll Taxes			1,609,478	1,609,478	94,680	1,704,158		1,704,158		22
23	Inservice Training & Education			1,179	1,179		1,179		1,179		23
24	Travel and Seminar			1,204	1,204		1,204		1,204		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			426,660	426,660		426,660		426,660		26
27	Other (specify):*							(4,786)	(4,786)		27
28	<b>TOTAL General Administration</b>	736,539	113,387	3,596,782	4,446,708	(417,279)	4,029,429	(220,935)	3,808,494		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	11,492,175	1,113,027	4,620,414	17,225,616	(394,198)	16,831,418	(223,759)	16,607,659		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.

## 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	
	<b>D. Ownership</b>											
30	Depreciation			681,351	681,351	31,866	713,217		713,217			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,934,988	4,934,988	362,332	5,297,320	(4,970,740)	326,580			32
33	Real Estate Taxes			430,569	430,569		430,569		430,569			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,879	39,879		39,879		39,879			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			6,086,787	6,086,787	394,198	6,480,985	(4,970,740)	1,510,245			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,226,186		1,226,186		1,226,186		1,226,186			39
40	Barber and Beauty Shops			27,264	27,264		27,264		27,264			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,036	206,036		206,036		206,036			42
43	Other (specify):*		142,816	277,461	420,277		420,277		420,277			43
44	<b>TOTAL Special Cost Centers</b>		1,369,002	510,761	1,879,763		1,879,763		1,879,763			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	11,492,175	2,482,029	11,217,962	25,192,166		25,192,166	(5,194,499)	19,997,667			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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,738)	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	(99)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,786)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(35,189)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(141,104)	21		24
25	Fund Raising, Advertising and Promotional	(27,041)	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	(4,982,112)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (5,194,499)</b>		<b>\$</b>	<b>30</b>

**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>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (5,194,499)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY					
48		49		50	51
					52

Manorcare of Palos Hts East

ID# 0049478

Report Period Beginning: 06/01/13

Ending: 05/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	HCP Lease Interest	\$ (4,970,740)	32	1
2	Vending Income	(2,407)	21	2
3	Activity Income	(86)	11	3
4	Accounting / Collection Fees	(8,879)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(4,982,112)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Palos Hts East# 0049478

Report Period Beginning:

06/01/13

Ending:

05/31/14

## 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	(2,738)	0	0	0	0	0	0	0	0	0	0	(2,738)	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	<b>TOTAL General Services</b>	<b>(2,738)</b>	<b>0</b>	<b>(2,738)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(86)	0	0	0	0	0	0	0	0	0	0	(86)	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>(86)</b>	<b>0</b>	<b>(86)</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	(44,068)	0	0	0	0	0	0	0	0	0	0	(44,068)	19
20	Fees, Subscriptions & Promotions	(27,041)	0	0	0	0	0	0	0	0	0	0	(27,041)	20
21	Clerical & General Office Expenses	(145,040)	0	0	0	0	0	0	0	0	0	0	(145,040)	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):*	(4,786)	0	0	0	0	0	0	0	0	0	0	(4,786)	27
28	<b>TOTAL General Administration</b>	<b>(220,935)</b>	<b>0</b>	<b>(220,935)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(223,759)</b>	<b>0</b>	<b>(223,759)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Palos Hts East

# 0049478

Report Period Beginning:

06/01/13 Ending:

05/31/14

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	(4,970,740)	0	0	0	0	0	0	0	0	0	0	(4,970,740)	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>(4,970,740)</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>(4,970,740)</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)	(5,194,499)	0	0	0	0	0	0	0	0	0	0	(5,194,499)	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 Pg 6 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						1
2	V	Page 8						2
3	V							3
4	V	1-44						4
5	V	10a						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		\$ 12,654,796			\$ 12,654,796	\$ *	14

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

Facility Name &amp; ID Number

Manorcare of Palos Hts East

# 0049478

Report Period Beginning:

06/01/13

Ending:

05/31/14

## 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 West IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				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 Hts East

# 0049478

Report Period Beginning:

06/01/13

Ending:

05/31/14

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

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 Hts East

# 0049478

Report Period Beginning:

06/01/13

Ending: 05/31/14

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	702 NFs, HHs, & R	\$ 702,082	\$	24,046,212	\$ 4,307	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	357 NFs			24,046,212	0	2
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	48 NFs			24,046,212	0	3
4	10	Nursing - Pooled	Accumulated Cost	702 NFs, HHs, & R	421,070	303,971	24,046,212	2,583	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	357 NFs	2,331,970	10,787,378	24,046,212	16,191	5
6	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	48 NFs			24,046,212	0	6
7	17	Gen / Admin - Pooled	Accumulated Cost	702 NFs, HHs, & R	66,712,258	34,047,414	24,046,212	409,235	7
8	17	Gen / Admin - Direct to All SNFs	Accumulated Cost	357 NFs	18,712,683	6,531,152	24,046,212	129,925	8
9	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	48 NFs	1,887,403	1,136,236	24,046,212	91,835	9
10	22	Employee Benefits - Pooled	Accumulated Cost	702 NFs, HHs, & R	7,831,139		24,046,212	48,039	10
11	22	Empl Benefits - Direct to All SNFs	Accumulated Cost	357 NFs	6,717,577		24,046,212	46,641	11
12	22	Empl Benefits-Dir to MW Div SN	Accumulated Cost	48 NFs			24,046,212	0	12
13	30	Depreciation - Pooled	Accumulated Cost	702 NFs, HHs, & R	4,454,722		24,046,212	27,327	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	357 NFs	653,747		24,046,212	4,539	14
15	30	Depr - Direct to MW Div SNFs	Accumulated Cost	48 NFs			24,046,212	0	15
16									16
17	32	Pooled Interest	Accumulated Cost		25,923,280		24,046,212	159,023	17
18	32	Directly Assigned Interest	Not Allocated		18,563,246			203,309	18
19									19
20		H/O Costs Allocated to Non-SNFs & Oth Div			30,324,259				20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 185,235,436	\$ 52,806,151		\$ 1,142,954	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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Conv Sub Debentures		X	Various			\$ 3,102,852	\$ 3,102,852		0.0655	\$ 203,309	1					
2												2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6												6					
7	Pooled Interest										159,023	7					
8	Interest Expense / Interest Income										(35,752)	8					
9	<b>TOTAL Facility Related</b>						\$ 3,102,852	\$ 3,102,852			\$ 326,580	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>						\$ 3,102,852	\$ 3,102,852			\$ 326,580	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 2013 report.		\$	<u>379,803</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>435,224</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	55,421		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>375,642</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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ <u>494</u> For <u>2003</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<u>(494)</u>		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>430,569</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>297,240</u>	8		
	2010	<u>298,623</u>	9		
	2011	<u>380,092</u>	10		
	2012	<u>415,661</u>	11		
	2013	<u>426,533</u>	12		
<b>Line 2: \$435,224.05 = \$206,610.47 for 2nd half 2012 + \$228,613.58 for 1st half 2013</b>					
<b>Line 4: \$375,642.15 = \$197,919.65 for 2nd half of 2013 + \$177,722.50 for Jan-May 2014</b>					
<b>Line 6: (\$494.30) = Worssek &amp; Vihon LLP refund for 2003 RE Tax Rate Appeal</b>					
				<b>FOR BHF USE ONLY</b>	
				13	13
				14	14
				15	15
				16	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.**



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?       X   YES            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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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: 73,335 B. General Construction Type: Exterior Masonry Frame Steel 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).

---

---

---

---

---

---

---

---

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>1988</u>	<u>\$ 600,191</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 600,191</b>	<b>3</b>

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	144		1988	\$ 4,355,326	\$ 169,736		\$ 169,736	\$	\$ 3,681,894
5	30		1990	1,063,606					
6			1990	(10,000)					
7	10		2011						
8									
<b>Improvement Type**</b>									
9	Current Depreciation				294,839		294,839		3,581,171
10			1988	203,173					
11			1989	47,755					
12			1990	43,288					
13			1991	135,227					
14			1992	55,270					
15			1993	67,665					
16			1994	68,557					
17			1995	133,690					
18			1996	183,199					
19			1997	242,019					
20			1998	203,466					
21			1999	28,991					
22			2000	128,063					
23			2001	91,487					
24	LAUNDRY/KITCHEN EYE WASH		2002	2,250					
25	VINYL WALLCOVERING, PAINT, & CARPET		2002	9,566					
26	MAGNOLIA TREE		2002	550					
27	ROOFING		2002	7,686					
28	WALLCOVERING		2002	3,346					
29	DOOR - EMPLOYEE ENTERANCE		2002	1,487					
30	VCT FLOORING		2002	970					
31	WINDOW TREATMENTS		2002	3,633					
32	HAND RAILS		2002	4,716					
33	ELETRICAL WORK		2002	1,868					
34	DOOR - HOLLOW METAL		2003	1,026					
35	VCT FLOORING - ADDITIONAL		2003	16					
36			2003	3,486					

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Manorcare of Palos Hts East

# 0049478

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	WALLCOVERING	2003	\$ 124	\$		\$	\$	\$	37
38	CARPET	2003	9,521						38
39	KITCHEN DOORS	2003	3,140						39
40	CONSTRUCTION DEPARTMENT COST & INTEREST	2003	8,788						40
41	WALLCOVERING, BORDERS, & PAINTING	2003	88,476						41
42	CARPETING	2003	13,008						42
43	ELETRICAL WORK	2003	5,081						43
44	SIGNAGE	2003	3,423						44
45	SEALING & PATCHING PARKING LOT	2003	15,985						45
46	DUMPSTER GATE	2003	1,076						46
47	FENCE	2004	8,387						47
48	Electric to new rooftop exhaust fan	2004	1,079						48
49	Renov. - Construction Dept. Overhead Costs & Interest	2004	13,149						49
50	Renov. - Painting	2004	39,543						50
51	Renov. - Wallcovering & Corner Guards	2004	15,082						51
52	Renov. - Carpentry	2004	17,490						52
53	Renov. - Electrical	2004	1,934						53
54	Renov. - Doors	2004	2,947						54
55	Flooring	2004	3,635						55
56	Reconstruct - Move Walls, Plumbing, Elctric to enlarge resident ro	2004	853,768						56
57	Reconstruct - Architect & Engineering Costs	2004	77,920						57
58	Reconstruct - Construction Dept. Overheard Costs & Interest	2004	140,129						58
59	Reconstruct - Permit Fees	2004	24,199						59
60	Reconstruct - Millwork	2004	9,671						60
61	Reconstruct - Plumbing	2004	1,316						61
62	Reconstruct - Carpeting	2004	26,289						62
63	Reconstruct - Wallcovering & Corner Guards	2004	9,204						63
64	Reconstruct - Water & Sewer Work	2004	167						64
65	Concrete Pad at main entrance	2004	3,040						65
66	Prox Readers & Electric Strikes for Court Yard Doors	2005	3,970						66
67	Retirement 8-2004 - Door Alarm (asset # 179)	1989	(1,061)						67
68	Retirement 8-2004 - Door Alarm (asset #435)	1992	(1,218)						68
69		2005	11,265						69
70	TOTAL (lines 4 thru 69)		\$ 8,491,909	\$ 464,575		\$ 464,575	\$	\$ 7,263,065	70

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

Facility Name &amp; ID Number Manorcare of Palos Hts East

# 0049478

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 8,491,909	\$ 464,575		\$ 464,575	\$	\$ 7,263,065	1
2	EXTERIOR PAINTING	2005	18,189						2
3	3 HOLLOW METAL DOORS	2005	4,655						3
4	generator wiring	2006	4,073						4
5	emergency light	2006	924						5
6	wallcovering	2006	1,044						6
7	electrical	2006	2,240						7
8	kitchen door	2006	3,265						8
9	renov - wallcovering	2006	32,322						9
10	fire rated door	2006	12,592						10
11	kitchen wall / flooring	2006	17,880						11
12	kitchen wall / flooring	2006	4,950						12
13	roof replacement	2006	152,782						13
14	additional roof replacement	2006	13,210						14
15	flooring in shower stalls	2007	21,105						15
16	Electrical wrok in mechanical room	2007	4,246						16
17	12 resident room doors	2007	40,380						17
18	Renov - General Contractor	2009	591,269						18
19	Renov - Interest on Construction	2009	30,360						19
20	Trane Condensing Unit	2008	2,626						20
21	Wallcovering	2008	526						21
22	20 Receptacles	2008	5,600						22
23	2 Water Heaters	2008	7,500						23
24	4 Doors	2008	7,820						24
25	2 Water Heaters	2008	39,574						25
26	Renov - Elevator System	2008	67,498						26
27	Renov - Arch & Engineerng Cost, Permit Fees, Plan Reviews	2009	122,882						27
28	Renov - General Overhead Capital	2009	110,321						28
29	Renov - Resilient Flooring, Wallcovering & Corner Guards	2009	15,066						29
30	Fire Alarm Panel	2009	24,985						30
31	Resident Room Flooring	2009	37,952						31
32	Renov - Basic Electrical	2009	13,105						32
33	Concrete Ramp & Steps	2008	10,404						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,913,254	\$ 464,575		\$ 464,575	\$	\$ 7,263,065	34

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

Facility Name &amp; ID Number Manorcare of Palos Hts East

# 0049478

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 9,913,254	\$ 464,575		\$ 464,575	\$	\$ 7,263,065	1
2	Renov - Soil & Concrete Testing	2009	7,197						2
3	Renov - Gen Contractor - Site Prep	2009	96,739						3
4	Paving	2008	38,550						4
5	Concrete Ramp & Steps	2009	6,336						5
6	Renov - Legal Fees pertaining to Easement	2009	30,973						6
7	Renov - Resilient Flooring	2009	13,176						7
8	1st floor corridor handrail	2009	8,946						8
9	Renov - Carpeting & pads	2009	9,276						9
10	Renov - Wallcovering & corner guards	2009	57,481						10
11	steel entrance roof	2009	13,320						11
12	Room 229 flooring	2010	2,976						12
13	HM door	2011	1,725						13
14	pave, stripe, and sealcoat	2010	27,135						14
15	Addition - Arch & Engineering cost	2011	103,173						15
16	Addition - Landscape Design Consultant	2011	87,650						16
17	Addition - Soil Testing	2011	2,311						17
18	Addition - Concrete Testing	2011	2,881						18
19	Addition - Legal Fees, Permit Fees, Water & Sewer Fees	2011	36,870						19
20	Addition - Plan Reviews	2011	3,455						20
21	Addition - General Overhead Capital & Interest on Constr	2011	123,627						21
22	Addition - General Contractor	2011	931,924						22
23	Addition -Carpeting & Pads	2011	25,808						23
24	Addition - Wallcovering & Corner Guards	2011	15,850						24
25	Cold water line in Break Room	2011	1,950						25
26	remote annunciator panel	2011	6,330						26
27	Painting exterior handrails, 4 doors on W, N, E elevations	2011	5,108						27
28	Addition - Additional Concrete Testing	2011	27,129						28
29	door	2011	1,840						29
30	Addition - Landscaping	2011	3,500						30
31	Addition - Carpeting tiles	2011	956						31
32	exterior painting	2011	16,300						32
33	exterior HM Door	2011	2,785						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,626,528	\$ 464,575		\$ 464,575	\$	\$ 7,263,065	34

\*\*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	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	<b>Totals from Page 12C, Carried Forward</b>		\$ 11,626,528	\$ 464,575		\$ 464,575	\$	\$ 7,263,065	1
2	Ceiling in Heritage Corridor	2011	7,647						2
3	Renov - Accoustical Ceiling Tiles in all Mechanical Rooms	2011	61,498						3
4	CIRCUIT BREAKER UPDATE	2012	13,719						4
5	EXTERIOR PATIO	2012	15,737						5
6	HOT WATER HEATER	2012	8,840						6
7									7
8	2nd Flr Corridor, Lounge, & Nurses Station Renovations:								8
9	Carpentry on New Nurses' station in 2nd flr corridor	2012	158,060						9
10	Carpeting/ Wallcovering, Corner Guards for 2nd								10
11	flr corridor renovation of nurses' station and lounge	2012	20,484						11
12	Electrical for 2nd flr corridor renov nsg station, lounge	2012	36,560						12
13	Intrusion Detection System for 2nd flr corridor renov	2012	8,185						13
14	floor drain in kitchen	2013	5,198						14
15	kitchen ceiling	2013	17,307						15
16	new / upgraded dishwasher area	2013	30,900						16
17	stainless corners for kitchen area	2013	9,934						17
18	janitors closet replacemnt in kitchen	2013	13,818						18
19	2 ext doors - employee and svc doors	2013	12,829						19
20	smoke wall upgrades - tent lights on 2nd & 3rd floors, new access hatch to attic in								20
21	Arcadia Unit. Install 5 EZ path devices at dbl drs	2013	18,587						21
22	electrical upgrades - for new 120V EM recpt/feeds : Admin Ofc, BOM, 2nd flr DON Ofc,								22
23	2nd/3rd flr Med Rms and 2nd/3rd flr Kiosks	2014	5,946						23
24	corridor carpet - Heritage Unit	2014	2,498						24
25	Heritage Corridor / Lounge carpeting	2014	4,195						25
26	North East parking lot lighting electrical upgrades	2014	10,195						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,088,666	\$ 464,575		\$ 464,575	\$	\$ 7,263,065	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	\$ 3,113,600	\$ 216,776	\$ 216,776	\$		\$ 2,713,022	71
72	Current Year Purchases	103,322						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			31,866	31,866			74
75	TOTALS	\$ 3,216,922	\$ 216,776	\$ 248,642	\$ 31,866		\$ 2,713,022	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	Residents	1995 Goshen GHS		\$ 17,000	\$	\$	\$		\$ 17,000	76
77		Paratransit								77
78										78
79										79
80	TOTALS			\$ 17,000	\$	\$	\$		\$ 17,000	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)	\$ 15,922,779	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 681,351	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 713,217	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,866	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,993,087	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.

Facility Name & ID Number Manorcare of Palos Hts East

# 0049478

Report Period Beginning: 06/01/13

Ending: 05/31/14

**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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 39,879

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 Hts East # 0049478 Report Period Beginning: 06/01/13 Ending: 05/31/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	20216	hrs	\$ 853,104	547	\$ 31,493	\$ 2,759	20,763	\$ 887,356	1
2	Licensed Speech and Language Development Therapist	10a	8783	hrs	370,633			1,332	8,783	371,965	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	27397	hrs	1,156,132	6	355	15,839	27,403	1,172,326	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 3		# of prescripts				1,226,186		1,226,186	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Inhal Therapy</u>	10a	697		29,409				697	29,409	12
13	Other (specify): <u>IV Ther/Xray/Lab</u>	43, 2 & 3					277,461	142,816		420,277	13
14	TOTAL				\$ 2,409,278	553	\$ 309,309	\$ 1,388,932	57,646	\$ 4,107,519	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 Hts East

# 0049478

Report Period Beginning: 06/01/13

Ending:

05/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/14 (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	\$ 5,745	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (496,827) )	3,589,323		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,137		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>	\$ 3,601,205	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	600,191		13
14	Buildings, at Historical Cost	12,088,666		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,233,922		16
17	Accumulated Depreciation (book methods)	(9,993,087)		17
18	Deferred Charges	27,955,575		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>OMIT</u> )	43,276		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 33,928,543	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 37,529,748	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 231,229	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	977,137		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	375,642		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>	254,312		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,838,320	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	3,102,852		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			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>	\$ 3,102,852	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,941,172	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 32,588,576	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 37,529,748	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 33,069,517	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 33,069,517	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	4,581,396	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 4,581,396	17
	<b>B. Transfers (Itemize):</b>		
18	<b>Change in Interdivision</b>	(5,062,337)	18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ (5,062,337)	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 32,588,576	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 30,250,997	1
2	Discounts and Allowances for all Levels	(17,173,183)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 13,077,814</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,573,122	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 13,573,122</b>	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	7,193	12
13	Barber and Beauty Care	30,689	13
14	Non-Patient Meals	2,738	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,444,178	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	216,727	19
20	Radiology and X-Ray	312,702	20
21	Other Medical Services	108,225	21
22	Laundry	28	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 3,122,480</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	60	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 60</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Activity Income</u>	86	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 86</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 29,773,562</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,839,726	31
32	Health Care	10,939,182	32
33	General Administration	4,446,708	33
<b>B. Capital Expense</b>			
34	Ownership	6,086,787	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,673,727	35
36	Provider Participation Fee	206,036	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 25,192,166</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>4,581,396</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 4,581,396</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 897,533	44
45	Private Pay - Net Inpatient Revenue	980,538	45
46	Medicare - Net Inpatient Revenue	10,067,109	46
47	Other-(specify) <u>HOSPICE</u>	272,454	47
48	Other-(specify) <u>INSURANCE</u>	860,180	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 13,077,814</b>	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 Hts East

# 0049478

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	1,794	1,935	\$ 88,578	\$ 45.78	1
2	Assistant Director of Nursing	6,849	7,388	279,160	37.79	2
3	Registered Nurses	79,465	85,717	2,684,577	31.32	3
4	Licensed Practical Nurses	23,726	25,592	714,189	27.91	4
5	CNAs & Orderlies	131,097	141,608	1,733,007	12.24	5
6	CNA Trainees					6
7	Licensed Therapist	60,415	65,176	2,750,327	42.20	7
8	Rehab/Therapy Aides	53,797	58,036	1,534,906	26.45	8
9	Activity Director	9,557	10,312	122,085	11.84	9
10	Activity Assistants					10
11	Social Service Workers	11,829	12,758	275,585	21.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,605	11,417	139,663	12.23	15
16	Dishwashers					16
17	Maintenance Workers	2,893	3,120	68,520	21.96	17
18	Housekeepers	19,208	20,727	223,299	10.77	18
19	Laundry	7,291	7,869	80,893	10.28	19
20	Administrator	2,080	2,080	149,753	72.00	20
21	Assistant Administrator	950	950	27,430	28.87	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,578	29,931	559,356	18.69	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	3,664	3,955	60,847	15.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	452,798	488,571	\$ 11,492,175 *	\$ 23.52	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 25,125	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)	\$ 25,125		49

**C. CONTRACT NURSES**

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



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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Manorcare of Palos Hts East# 0049478

Report Period Beginning:

06/01/13

Ending:

05/31/14**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 \$2,957
- (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 \$5279
- (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. \$ 75,398 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. \$ 206,036  
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. \$ 2,738
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NO  
Attach invoices and a summary of services for all architect and appraisal fees.