



Facility Name & ID Number Manorcare of Palos Hts West

# 0049353 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	130	Skilled (SNF)	130	47,450	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,818	3,914	26,517	42,249	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,818	3,914	26,517	42,249	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.04%

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 20,909

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: 5/31

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

Facility Name &amp; ID Number

Manorcare of Palos Hts West

# 0049353

Report Period Beginning:

06/01/13

Ending:

05/31/14

**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	118,770	31,684	301,938	452,392		452,392	452,392			1
2	Food Purchase		259,930		259,930		259,930	(3,980)	255,950		2
3	Housekeeping		31,720	134,849	166,569		166,569		166,569		3
4	Laundry		35,365	89,310	124,675		124,675		124,675		4
5	Heat and Other Utilities			222,142	222,142	3,086	225,228		225,228		5
6	Maintenance	44,482	18,454	144,547	207,483		207,483		207,483		6
7	Other (specify):* <b>Med Waste</b>			1,516	1,516		1,516		1,516		7
8	<b>TOTAL General Services</b>	163,252	377,153	894,302	1,434,707	3,086	1,437,793	(3,980)	1,433,813		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,068	22,068		22,068		22,068		9
10	Nursing and Medical Records	4,012,338	365,987	223,637	4,601,962	13,452	4,615,414		4,615,414		10
10a	Therapy	2,228,194	8,266	12,303	2,248,763		2,248,763		2,248,763		10a
11	Activities	67,503	3,256	6,909	77,668		77,668	(95)	77,573		11
12	Social Services	211,227			211,227		211,227		211,227		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	6,519,262	377,509	264,917	7,161,688	13,452	7,175,140	(95)	7,175,045		16
	<b>C. General Administration</b>										
17	Administrative	167,510		681,040	848,550	(228,911)	619,639		619,639		17
18	Directors Fees										18
19	Professional Services			184,407	184,407	(2,941)	181,466	(181,466)			19
20	Dues, Fees, Subscriptions & Promotions			64,930	64,930		64,930	(15,201)	49,729		20
21	Clerical & General Office Expenses	394,383	99,170	518,035	1,011,588	2,941	1,014,529	(389,889)	624,640		21
22	Employee Benefits & Payroll Taxes			1,023,017	1,023,017	67,841	1,090,858		1,090,858		22
23	Inservice Training & Education			1,022	1,022		1,022		1,022		23
24	Travel and Seminar			5,115	5,115		5,115		5,115		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			337,670	337,670		337,670		337,670		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	561,893	99,170	2,815,236	3,476,299	(161,070)	3,315,229	(586,556)	2,728,673		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	7,244,407	853,832	3,974,455	12,072,694	(144,532)	11,928,162	(590,631)	11,337,531		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			332,093	332,093	22,833	354,926		354,926			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,477,895	3,477,895	121,699	3,599,594	(3,511,262)	88,332			32
33	Real Estate Taxes			441,102	441,102		441,102		441,102			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,461	39,461		39,461		39,461			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			4,290,551	4,290,551	144,532	4,435,083	(3,511,262)	923,821			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		708,038	1,820	709,858		709,858		709,858			39
40	Barber and Beauty Shops			19,653	19,653		19,653		19,653			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			200,714	200,714		200,714		200,714			42
43	Other (specify):* <b>IV Ther/EKG/XRay/Lab</b>		114,911	152,694	267,605		267,605		267,605			43
44	<b>TOTAL Special Cost Centers</b>		822,949	374,881	1,197,830		1,197,830		1,197,830			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,244,407	1,676,781	8,639,887	17,561,075		17,561,075	(4,101,893)	13,459,182			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 Hts West

# 0049353

Report Period Beginning: 06/01/13

Ending: 05/31/14

**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	(3,980)	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	(44)	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	(1,875)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(162,331)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(387,189)	21		24
25	Fund Raising, Advertising and Promotional	(15,201)	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	(3,531,273)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (4,101,893)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48		49		50	51
					52

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>\$ (4,101,893)</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>

Manorcare of Palos Hts West

ID# 0049353

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	\$ (3,511,262)	32	1
2	Vending Income	(781)	21	2
3	Activity Income	(95)	11	3
4	Accounting / Collection Fees	(19,135)	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>	(3,531,273)		49

## STATE OF ILLINOIS

Summary A

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

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	(3,980)	0	0	0	0	0	0	0	0	0	0	(3,980)	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>(3,980)</b>	<b>0</b>	<b>(3,980)</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	(95)	0	0	0	0	0	0	0	0	0	0	(95)	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>(95)</b>	<b>0</b>	<b>(95)</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	(181,466)	0	0	0	0	0	0	0	0	0	0	(181,466)	19
20	Fees, Subscriptions & Promotions	(15,201)	0	0	0	0	0	0	0	0	0	0	(15,201)	20
21	Clerical & General Office Expenses	(389,889)	0	0	0	0	0	0	0	0	0	0	(389,889)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(586,556)</b>	<b>0</b>	<b>(586,556)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(590,631)</b>	<b>0</b>	<b>(590,631)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Palos Hts West

# 0049353

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	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(3,511,262)	0	0	0	0	0	0	0	0	0	0	(3,511,262)	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>(3,511,262)</b>	<b>0</b>	<b>(3,511,262)</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)	(4,101,893)	0	0	0	0	0	0	0	0	0	0	(4,101,893)	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:	
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	\$ 681,040	HCR Manor Care Services, LLC	100.00%	\$ 681,040	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	7,244,407	Heartland Employment Services, LLC	100.00%	7,244,407		4
5	V	10a Therapy Management	13,894	Heartland Rehabilitation Services, LLC	100.00%	13,894		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		\$ 7,939,341			\$ 7,939,341	\$ *	14

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

Facility Name &amp; ID Number

Manorcare of Palos Hts West

# 0049353

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 Decatur IL, LLC	Decatur				2
3			Heartland of Galesburg IL, LLC	Galesburg				3
4			Heartland of Henry IL, LLC	Henry				4
5			Heartland of Macomb IL, LLC	Macomb				5
6			Heartland of Moline IL, LLC	Moline				6
7			Heartland of Normal IL, LLC	Normal				7
8			Heartland of Paxton IL, LLC	Paxton				8
9			Heartland of Peoria IL, LLC	Peoria				9
10			Heartland-Riverview of East Peoria IL, LLC	East Peoria				10
11			Manor Care at Arlington Heights	Arlington Heights				11
12			Manor Care of Elgin IL, LLC	Elgin				12
13			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Manor Care - Highland Park	Highland Park				14
15			Manor Care of Hinsdale IL, LLC	Hinsdale				15
16			Manor Care of Homewood IL, LLC	Homewood				16
17			Manor Care of Kankakee IL, LLC	Kankakee				17
18			Manor Care of Libertyville IL, LLC	Libertyville				18
19			Manor Care of Naperville IL, LLC	Naperville				19
20			Manor Care of Northbrook IL, LLC	Northbrook				20
21			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (East) 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 West

# 0049353

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

Facility Name & ID Number Manorcare of Palos Hts West # 0049353 Report Period Beginning: 06/01/13 Ending: 05/31/14

## 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 Hts West

# 0049353

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	3,919,925,578	702 NFs, HHs, & R	\$ 702,082	\$ 17,229,876	\$ 3,086	1	
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs		17,229,876	0	2	
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs		17,229,876	0	3	
4	10	Nursing - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	421,070	303,971	17,229,876	1,851	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	2,331,970	10,787,378	17,229,876	11,601	5
6	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			17,229,876	0	6
7	17	Gen / Admin - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	66,712,258	34,047,414	17,229,876	293,232	7
8	17	Gen / Admin - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	18,712,683	6,531,152	17,229,876	93,095	8
9	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	494,203,074	48 NFs	1,887,403	1,136,236	17,229,876	65,802	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	7,831,139		17,229,876	34,421	10
11	22	Empl Benefits - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	6,717,577		17,229,876	33,420	11
12	22	Empl Benefits-Dir to MW Div SN	Accumulated Cost	494,203,074	48 NFs			17,229,876	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & R	4,454,722		17,229,876	19,581	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	653,747		17,229,876	3,252	14
15	30	Depr - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			17,229,876	0	15
16										16
17	32	Pooled Interest	Accumulated Cost	3,919,925,578		25,923,280		17,229,876	113,945	17
18	32	Directly Assigned Interest	Not Allocated			18,563,246			7,754	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	\$ 681,040		25

Facility Name & ID Number

Manorcare of Palos Hts West

# 0049353

Report Period Beginning:

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**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			\$ 118,340	\$ 118,340		0.0655	\$ 7,754						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6																	
7	Pooled Interest										113,945						
8	Interest Expense / Interest Income										(33,367)						
9	<b>TOTAL Facility Related</b>						\$ 118,340	\$ 118,340			\$ 88,332						
<b>B. Non-Facility Related*</b>																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 118,340	\$ 118,340			\$ 88,332						

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.)

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## 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>392,605</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>449,895</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>57,290</u>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>384,055</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>		\$	<u>167</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. <b>TOTAL REFUND \$ <u>410</u> For <u>2003</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<u>(410)</u>	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>441,102</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>337,350</u>	8	<b>FOR BHF USE ONLY</b>	
	2010	<u>234,682</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>392,905</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>429,673</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>440,911</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>Line 2: \$449,895.08 = \$213,575.13 for 2nd half 2012 + \$236,319.95 for 1st half of 2013</b>					
<b>Line 4: \$384,054.70 = \$302,591.37 for 2nd half 2013 + \$182,463.33 for Jan-May 2014</b>					
<b>Line 5: Worssek &amp; Vihon LLP invoices for 2012 RE Tax Appeal Specific Objections</b>					
<b>Line 6: (\$409.88) = Worssek &amp; Vihon LLP refund for 2003 RE Tax Appeal Rate Objections</b>					

## NOTES:

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



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 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: 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).

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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>1996</u>	<u>\$ 705,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 705,000</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	Accumulated Depreciation
4	130		1996	\$ 5,345,094	\$ 133,627		\$ 133,627	\$ 2,417,856
5								
6								
7								
8								
<b>Improvement Type**</b>								
9	<b>Current Year Depreciation</b>				87,367		87,367	1,450,703
10			1996	398,017				
11			1997	165,442				
12			1998	67,765				
13			1999	27,686				
14			2000	74,134				
15			2001	129,144				
16	VINYL WALLCOVERING & BORDERS		2002	1,250				
17	CARPET, VINYL WALLCOVERING & BORDERS		2002	64,471				
18	FLOORING IN PUBIC RESTROOM		2003	2,125				
19	WALLCOVERING & PAINTING		2003	9,129				
20	DOORS		2003	3,109				
21	WINDOW TREATMENTS		2003	2,527				
22	CONSTRUCTION DEPT. COST & INTEREST		2004	12,658				
23	WALLCOVERING & PAINTING		2004	39,469				
24	TV ANTENNA JACKS & COAX WIRING		2004	3,140				
25	DOORS		2004	1,020				
26	Sealcoat & Restripe Parking Lot		2004	2,280				
27	Renov. - General Overhead & Interest		2004	3,752				
28	Renov. - Painting		2004	35,265				
29	Renov. - Wallcovering & Corner Guards		2004	6,697				
30	Renov. - Carpentry		2004	4,180				
31	Dorrs		2004	4,483				
32	Ceramic Tile		2005	2,990				
33	Wallcovering & Painting		2005	8,452				
34	Carpet		2005	5,362				
35	FABRICS / CURTAINS		2005	3,914				
36			2005	1,150				

\*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 West

# 0049353

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**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	\$ 220,994		\$ 220,994	\$	\$ 3,868,559	70

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

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## 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	\$ 220,994		\$ 220,994	\$	\$ 3,868,559	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 in corridors	2011	49,214						18
19	Renov - Fire Damper upgrade in bldg	2011	51,784						19
20	Renov - Basic Electrical for fire damper upgrade	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 1st & 2nd floor offices & copier rooms	2011	36,225						23
24	Renov - Carpeting 1st & 2nd floor offices & copier rooms	2011	313						24
25	Renov - Wallcovering 1st & 2nd floor offices & copier rooms	2011	1,895						25
26	Revov - Basic Electrical 1st & 2nd floor offices & copier rooms	2011	4,802						26
27	HM door at electrical room	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	Roofing membrane - main roof	2012	8,424						31
32	hot water heater	2012	17,985						32
33	vinyl flooring 14 baths on 2nd floor	2012	11,862						33
34	TOTAL (lines 1 thru 33)		\$ 7,328,086	\$ 220,994		\$ 220,994	\$	\$ 3,868,559	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	Totals from Page 12B, Carried Forward		\$ 7,328,086	\$ 220,994		\$ 220,994	\$	\$ 3,868,559	1
2	concrete sidewalk repairs around perimeter of facility	2012	9,920						2
3	electrical panel -kitchen	2012	1,665						3
4	fusible links in 80 fire dampers	2012	10,026						4
5	bathroom flooring in 19 resident rooms on 2nd floor	2012	16,485						5
6	ceiling mounted heater in lobby	2013	3,680						6
7	parking lot overlay	2013	8,121						7
8	roofing replacement	2013	8,658						8
9	elevator door upgrades	2014	5,400						9
10	elect upgrades-admin, HR, 1st flr DON ofcs. Med rms	2014	5,380						10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,397,421	\$ 220,994		\$ 220,994	\$	\$ 3,868,559	34

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

Facility Name & ID Number Manorcare of Palos Hts West

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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	\$ 2,416,255	\$ 111,099	\$ 111,099	\$		\$ 2,154,359	71
72	Current Year Purchases	62,914						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			22,833	22,833			74
75	TOTALS	\$ 2,479,169	\$ 111,099	\$ 133,932	\$ 22,833		\$ 2,154,359	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)	\$ 10,581,590	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 332,093	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 354,926	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,833	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,022,918	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	CIP	\$ 46,229	92
93			93
94			94
95		\$ 46,229	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.

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**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	<b>TOTAL</b>				\$			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: \$ 39,461

Description: O2 Concentratos, 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	<b>TOTAL</b>		\$	\$	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 West # 0049353 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	12758	hrs	\$ 539,954		\$	542	12,758	\$ 540,496	1
2	Licensed Speech and Language Development Therapist	10a	5773	hrs	244,316			115	5,773	244,431	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	9226	hrs	392,184			7,609	9,226	399,793	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				708,038		708,038	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Inhalation Therapy</u>	10a	1241		52,514				1,241	52,514	12
13	Other (specify): <u>IV Ther/Xray/Lab</u>	43, 2 & 3					152,694	114,911		267,605	13
14	TOTAL				\$ 1,228,968		\$ 152,694	\$ 831,215	28,998	\$ 2,212,877	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 West

# 0049353

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 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 695	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (515,471) )	2,101,410		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,338		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>	\$ 2,106,443	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	705,000		13
14	Buildings, at Historical Cost	7,397,421		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,479,169		16
17	Accumulated Depreciation (book methods)	(6,022,918)		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) <u>OMIT</u>	43,225		22
23	Other(specify): <u>CIP</u>	46,229		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 14,067,506	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 16,173,949	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 170,292	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	451,606		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	384,055		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>	156,971		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,162,924	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	118,340		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>	\$ 118,340	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,281,264	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 14,892,685	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 16,173,949	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 14,894,724	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,894,724	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(494,077)	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)	\$ (494,077)	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	492,038	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 492,038	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 14,892,685	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	\$ 17,487,216	1
2	Discounts and Allowances for all Levels	(9,404,935)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 8,082,281</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,185,054	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 7,185,054</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	781	12
13	Barber and Beauty Care	24,012	13
14	Non-Patient Meals	3,980	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,404,341	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	141,480	19
20	Radiology and X-Ray	144,818	20
21	Other Medical Services	78,573	21
22	Laundry	1,583	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,799,568</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Activity Income</u>	95	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 95</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 17,066,998</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,434,707	31
32	Health Care	7,161,688	32
33	General Administration	3,476,299	33
<b>B. Capital Expense</b>			
34	Ownership	4,290,551	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	997,116	35
36	Provider Participation Fee	200,714	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>\$ 17,561,075</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(494,077)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (494,077)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,562,141	44
45	Private Pay - Net Inpatient Revenue	1,508,989	45
46	Medicare - Net Inpatient Revenue	4,393,439	46
47	Other-(specify)	263,327	47
48	Other-(specify)	354,385	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 8,082,281</b>	<b>49</b>

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

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

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

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

Facility Name & ID Number Manorcare of Palos Hts West

# 0049353

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	2,048	2,203	\$ 94,589	\$ 42.94	1
2	Assistant Director of Nursing	2,578	2,773	98,820	35.64	2
3	Registered Nurses	59,826	64,357	2,037,539	31.66	3
4	Licensed Practical Nurses	16,207	17,435	458,845	26.32	4
5	CNAs & Orderlies	100,379	108,136	1,297,527	12.00	5
6	CNA Trainees					6
7	Licensed Therapist	31,918	34,333	1,453,122	42.32	7
8	Rehab/Therapy Aides	23,710	25,504	775,072	30.39	8
9	Activity Director	5,478	5,895	68,152	11.56	9
10	Activity Assistants					10
11	Social Service Workers	8,000	8,610	211,227	24.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,483	9,112	118,770	13.03	15
16	Dishwashers					16
17	Maintenance Workers	1,866	2,008	44,482	22.15	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	99,510	47.84	20
21	Assistant Administrator	1,624	1,624	67,351	41.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,090	21,918	394,383	17.99	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	1,793	1,930	25,018	12.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	286,080	307,918	\$ 7,244,407 *	\$ 23.53	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	22,068	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)		\$ 22,068		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	597	\$ 40,564	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	597	\$ 40,564		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 West# 0049353

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 \$4,092
- (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 \$1725
- (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. \$ 68,035 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. \$ 200,714  
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. \$ \_\_\_\_\_
- (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.