

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0050278</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Manor Care of Highland Park</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>2773 Skokie Valley Road</u> <u>Highland Park</u> <u>60035</u>			
NumberCityZip Code			
County: <u>Lake</u>			
Telephone Number: <u>(847) 266-9266</u> Fax # <u>(547) 266-9240</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer (Signed) _____ (Date) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>	
Date of Initial License for Current Owners: <u>06/15/01</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☒ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____ ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>Garv Geise</u> Telephone Number: <u>(419) 252-5731</u>		MAIL TO: BUREAU OF HEALTH FINANCE	
Email Address: _____		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES	
		201 S. Grand Avenue East	
		Springfield, IL 62763-0001	
		Phone # (217) 782-1630	

Facility Name & ID Number Manor Care of Highland Park

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

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>215</u>	Skilled (SNF)	<u>215</u>	<u>78,475</u>	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	<u>215</u>	TOTALS	<u>215</u>	<u>78,475</u>	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	<u>18,814</u>	<u>3,456</u>	<u>16,807</u>	<u>39,077</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,814</u>	<u>3,456</u>	<u>16,807</u>	<u>39,077</u>	14

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

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 03/10/97

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 06/15/01 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 208 and days of care provided 12,170

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

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

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

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

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			281,229	281,229	17,832	299,061		299,061			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(9,454)	(9,454)	202,217	192,763		192,763			32
33	Real Estate Taxes			128,174	128,174		128,174		128,174			33
34	Rent-Facility & Grounds			1,150,037	1,150,037		1,150,037		1,150,037			34
35	Rent-Equipment & Vehicles			75,139	75,139		75,139		75,139			35
36	Other (specify):*											36
37	TOTAL Ownership			1,625,125	1,625,125	220,049	1,845,174		1,845,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		419,706		419,706		419,706		419,706			39
40	Barber and Beauty Shops			10,174	10,174		10,174		10,174			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):* IV, X-ray & Lab		51,405	108,422	159,827		159,827		159,827			43
44	TOTAL Special Cost Centers		471,111	236,309	707,420		707,420		707,420			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,134,049	1,184,019	5,532,055	12,850,123		12,850,123	(418,313)	12,431,810			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$ (9)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,247)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,495)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(509)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(122)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,930)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,304)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(289,219)	21		24
25	Fund Raising, Advertising and Promotional	(68,876)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached pg 5A	(41,602)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (418,313)		\$	30

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

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

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

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

Report Period Beginning:

Ending:

ID#

0050278

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (32,701)	21	1
2	Employee benefits - Marketing	(8,387)	21	2
3	HCP Lease Interest		32	3
4	Vending Income	(514)	21	4
5	Misc. Income		21	5
6	Acitivity Income		11	6
7	Loss on Disposal of Fixed Assets		36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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16				16
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(41,602)		49

STATE OF ILLINOIS

Summary A

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

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,247)	0	0	0	0	0	0	0	0	0	0	(2,247)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(509)	0	0	0	0	0	0	0	0	0	0	(509)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,756)	0	0	0	0	0	0	0	0	0	0	(2,756)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(9)	0	0	0	0	0	0	0	0	0	0	(9)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(9)	0	0	0	0	0	0	0	0	0	0	(9)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,304)	0	0	0	0	0	0	0	0	0	0	(6,304)	19
20	Fees, Subscriptions & Promotions	(68,876)	0	0	0	0	0	0	0	0	0	0	(68,876)	20
21	Clerical & General Office Expenses	(340,368)	0	0	0	0	0	0	0	0	0	0	(340,368)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(415,548)	0	0	0	0	0	0	0	0	0	0	(415,548)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(418,313)	0	0	0	0	0	0	0	0	0	0	(418,313)	29

Summary B

12/31/2011

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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

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

VII. RELATED PARTIES

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

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

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 Geneva IL, LLC	Geneva				1
2			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				2
3			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				3
4			Arden Courts of Northbrook IL, LLC	Northbrook				4
5			Arden Courts of Palos Heights IL, LLC	Palos Heights				5
6			Arden Courts of South Holland IL, LLC	South Holland				6
7								7
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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manor Care of Highland Park # 0050278 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities - Pooled	Accumulated Cost	731 NFs, HHs, & Re	\$ 775,999	\$	12,413,321	\$ 2,558	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	353 NFs			12,413,321	0	2
3	5	Utilities - Direct to Central Division	Accumulated Cost	92 NFs			12,413,321	0	3
4	5	Utilities - Direct to Midwest Division	Accumulated Cost	48 NFs			12,413,321	0	4
5	10	Nursing - Pooled	Accumulated Cost	731 NFs, HHs, & Re	485,056	352,684	12,413,321	1,599	5
6	10	Nursing - Direct to All SNFs	Accumulated Cost	353 NFs	3,905,972	1,829,606	12,413,321	14,545	6
7	10	Nursing - Direct to Central Division	Accumulated Cost	92 NFs			12,413,321	0	7
8	10	Nursing - Direct to Midwest Division	Accumulated Cost	48 NFs			12,413,321	0	8
9	17	General & Administrative - Pooled	Accumulated Cost	731 NFs, HHs, & Re	71,430,003	38,287,220	12,413,321	235,493	9
10	17	General & Administrative - Direct to All SNFs	Accumulated Cost	353 NFs	23,601,055	18,695,747	12,413,321	87,886	10
11	17	General & Administrative - Direct to Central Division	Accumulated Cost	92 NFs	1,782,698	1,278,408	12,413,321	27,546	11
12	17	General & Administrative - Direct to Midwest Division	Accumulated Cost	48 NFs	895,017	639,204	12,413,321	23,434	12
13	22	Employee Benefits - Pooled	Accumulated Cost	731 NFs, HHs, & Re	2,952,374		12,413,321	9,733	13
14	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	353 NFs	6,653,909		12,413,321	24,778	14
15	22	Employee Benefits - Direct to Central Division	Accumulated Cost	92 NFs			12,413,321	0	15
16	22	Employee Benefits - Direct to Midwest Division	Accumulated Cost	48 NFs			12,413,321	0	16
17	30	Depreciation - Pooled	Accumulated Cost	731 NFs, HHs, & Re	4,719,938		12,413,321	15,561	17
18	30	Depreciation - Direct to All SNFs	Accumulated Cost	353 NFs	609,966		12,413,321	2,271	18
19	30	Depreciation - Direct to Central Division	Accumulated Cost	92 NFs			12,413,321	0	19
20	30	Depreciation - Direct to Midwest Division	Accumulated Cost	48 NFs			12,413,321	0	20
21	32	Pooled Interest	Accumulated Cost		26,343,470		12,413,321	86,850	21
22	32	Directly Assigned Interest	Not Allocated		18,851,990			115,367	22
23		H/O Costs Allocated to Non-SNFs and Other Divisions			32,615,916				23
24									24
25	TOTALS				\$ 195,623,363	\$ 61,082,869		\$ 647,621	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		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Various		X	Facility			\$ 1,733,736	\$ 1,733,736		0.0665	\$ 115,367	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Pooled Interest										86,850	7	
8	Interest Income Other										(9,454)	8	
9	TOTAL Facility Related						\$ 1,733,736	\$ 1,733,736			\$ 192,763	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,733,736	\$ 1,733,736			\$ 192,763	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

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

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>Manor Care of Highland Park</u>	COUNTY	<u>Lake</u>
FACILITY IDPH LICENSE NUMBER	<u>0050278</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Gary Geise</u>		
TELEPHONE	(419) 252-5731	FAX #:	(419) 254-5495

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

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: 73,108

B. General Construction Type: Exterior Masonary Frame Steel, Fire Resistant Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	N/A			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Manor Care of Highland Park

0050278

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	215				\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvements (Current Year Depreciation)					138,308		138,308		2,373,968
10	Civil Engineering Services			2001	3,332					
11	Title Survey, environmental site assessment,professional serv			2001	26,933					
12	Title Survey, environmental site assessment,professional serv			2001	5,937					
13	Title Survey, environmental site assessment,professional serv			2001	11,541					
14	Sinage			2001	2,234					
15	Sinage			2002	10,967					
16	Sidewalk			2003	3,496					
17	Architect & Engineering Fees			2003	78,456					
18	Developers Costs - Auto & Travel			2003	433					
19	Developers Costs - Permits Fees			2003	1,195					
20	Developers Cost - Plan Reviews			2003	6,013					
21	Developers Costs - Overhead			2003	942,605					
22	Interest			2003	83,525					
23	Carpeting & Pads			2003	82,366					
24	Wallcovering			2003	44,992					
25	Cubicle Track - Material			2003	240					
26	Carpentry Subcontractor			2003	905,757					
27	HVAC			2003	4,180					
28	Basic Electrical			2003	10,021					
29	Building Demolition			2003	65,000					
30	Site Clearing			2003	45,230					
31	General Contractor			2003	324					
32	Paving			2003	8,989					
33	Landscaping			2003	31,494					
34	Exterior Sign - Site			2003	583					
35	Legal Fees			2003	44,751					
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manor Care of Highland Park

0050278

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 VWC	2003	\$ 75	\$		\$	\$	\$	37
38 Freight on Carpet	2003	43						38
39 Carpet	2003	359						39
40 Flooring Installation	2003	843						40
41 Architect & Engineering	2003	471						41
42 Doors	2003	3,880						42
43 Concrete Pad	2004	885						43
44 Concrete Pad	2004	2,620						44
45 Lighting for Flagpole	2004	4,220						45
46 Exterior Lighting upgrade	2004	15,820						46
47 Exterior Lighting	2004	2,818						47
48 Sealing and Striping	2005	5,178						48
49 Doors	2005	19,400						49
50 Painting	2005	12,562						50
51 Painting	2005	16,809						51
52 Handrails	2005	14,245						52
53 Doors	2005	6,177						53
54 Doors Installed (10)	2006	16,151						54
55 Sidewalk	2007	4,725						55
56 Electrical Work for Light Fixture	2007	2,268						56
57 Door to Phone room	2007	2,208						57
58 Freight for Carpet	2007	758						58
59 Carpet	2008	14,399						59
60 HM Doors	2008	3,055						60
61 1008 Water Heater	2008	2,464						61
62 1008 Water Heater	2008	422						62
63 1008 Water Heater	2008	43,110						63
64 3 Door Restrictor	2008	6,631						64
65 Install Electrical outlets	2010	4,733						65
66 Carpet for Res Rooms	2010	3,139						66
67 Carpeting Rms 128 & 129	2010	3,488						67
68 0310 Heritage Carpeting	2010	7,870						68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,642,420	\$ 138,308		\$ 138,308	\$	\$ 2,373,968	70

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,642,420	\$ 138,308		\$ 138,308	\$	\$ 2,373,968	1
2 Carpeting	2010	5,674						2
3 Drainage Pipe to Generator	2010	31,740						3
4 Asphalt Seal & Strip	2010	18,326						4
5 BI 261 FLOOR SINK	2011	10,440						5
6 BI 268 PAINTING & FLOORING	2011	2,814						6
7 LI 262 PATIO INSTALLATION SW CRN	2011	4,699						7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,716,113	\$ 138,308		\$ 138,308	\$	\$ 2,373,968	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,390,216	\$ 142,921	\$ 142,921	\$		\$ 1,106,112	71
72	Current Year Purchases	185,581						72
73	Fully Depreciated Assets							73
74	Home Office			17,832	17,832			74
75	TOTALS	\$ 1,575,797	\$ 142,921	\$ 160,753	\$ 17,832		\$ 1,106,112	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 4,291,910
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 281,229
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 299,061
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 17,832
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 3,480,080

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☒ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1997	215		\$ 1,150,037	15	10	3
4	Additions							4
5								5
6								6
7	TOTAL		215		\$ 1,150,037			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☒ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☒ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 75,139
- Description: 02 Concentrators, wheelchairs, gerichairs, electric beds, etc.
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 06/15/01

Ending 06/15/16

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$ 1,211,926
13.	/2013	\$ 1,250,883
14.	/2014	\$ 1,289,839

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

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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	10281 hrs	\$ 425,752	869	\$ 64,646	\$ 2,227	11,150	\$ 492,625	1
2	Licensed Speech and Language Development Therapist	10a	1361 hrs	56,365			478	1,361	56,843	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	8671 hrs	359,080	3,532	262,780	18,643	12,203	640,503	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				419,706		419,706	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV Therapy	43, 2					51,405		51,405	12
13	Other (specify): X-ray & Lab	43, 3				108,422			108,422	13
14	TOTAL			\$ 841,197	4,401	\$ 435,848	\$ 492,459	24,714	\$ 1,769,504	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,692	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 396,665)	1,570,393		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,574,085	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,716,113		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,575,797		16
17	Accumulated Depreciation (book methods)	(3,480,079)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 811,831	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,385,916	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 136,373	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	398,472		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	124,849		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	294,403		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 954,097	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	921,567		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 921,567	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,875,664	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 510,252	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,385,916	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (215,115)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (215,115)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,226,891)	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)	\$ (1,226,891)	17
	B. Transfers (Itemize):		
18	Change in interdivision	1,952,258	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,952,258	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 510,252	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.

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

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

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,993	2,158	\$ 104,209	\$ 48.29	1
2	Assistant Director of Nursing	5,798	6,281	247,098	39.34	2
3	Registered Nurses	39,257	42,526	1,438,073	33.82	3
4	Licensed Practical Nurses	15,848	17,168	406,211	23.66	4
5	CNAs & Orderlies	95,016	103,143	1,289,622	12.50	5
6	CNA Trainees	113	122	1,458	11.95	6
7	Licensed Therapist	20,313	21,962	909,462	41.41	7
8	Rehab/Therapy Aides	3,514	3,799	119,073	31.34	8
9	Activity Director	7,843	8,505	121,996	14.34	9
10	Activity Assistants					10
11	Social Service Workers	5,959	6,462	159,700	24.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,506	27,654	400,328	14.48	15
16	Dishwashers					16
17	Maintenance Workers	3,418	3,708	80,041	21.59	17
18	Housekeepers	15,712	17,035	201,921	11.85	18
19	Laundry	1,815	1,969	25,446	12.92	19
20	Administrator	2,080	2,080	87,160	41.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,021	25,125	542,251	21.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	267,206	289,697	\$ 6,134,049 *	\$ 21.17	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	69,816	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 69,816		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	4	78	5,10,3	52
53	TOTAL (lines 50 - 52)	4	\$ 78		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Barbara Beake (Jan-Nov)	Administrator	0	\$ 85,660
Tammy Wagner (Nov-Dec)	Administrator	0	1,500
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,160
B. Administrative - Other			
Description			Amount
Home Office Costs		\$	647,621
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 647,621
C. Professional Services			
Vendor/Payee	Type		Amount
Foote Meyers Mielke & Flowers LLC	Legal Fees	\$	3,804
Littler Mendelson PC	Legal Fees		2,500
United Collection Bureau Inc	Collection Fees		(109)
Frances Hankin	Consulting Services		300
MPRO	Consulting Services		1,410
The Weissman Group	Mgmt Consulting Services		182
(All above adjusted off via Page 5 line 22, therefore no invoices are attached.)			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,087
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	65,734
Unemployment Compensation Insurance			70,402
FICA Taxes			432,748
Employee Health Insurance			311,936
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401K			54,202
Other Employee Benefits & Marketing Adj			(1,459)
Tuition Program			3,333
SMSP Match			451
Employee Uniforms			3,756
Home Office Allocation			34,511
TOTAL (agree to Schedule V, line 22, col.8)			\$ 975,614
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,922
Advertising: Employee Recruitment			4,635
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			18,426
Dues & Subscriptions			4,962
Association Dues			25,329
Advertising (Non-allowable)			28,679
Advertising (Allowable)			22,156
Less: Non-allowable Association Dues			(18,041)
Less: Public Relations Expense			(22,156)
Non-allowable advertising			(28,679)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 37,233
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			8,672
Seminar Expense			
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	8,672

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

IHCA \$7,288
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes \$10,299

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5-10 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 57,581

Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 117,713

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 2,247
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

No

Attach invoices and a summary of services for all architect and appraisal fees.