		FOR BHF USE					

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0050278

Facility Name: Manorcare of Highland Park

Address: 2773 Skokie Valley Road (Number) | Highland Park (City) | 60035 (Zip Code)

County: Lake

Telephone Number: 847-266-9266 **Fax #** 547-266-9240

HFS ID Number:

Date of Initial License for Current Owners: 06/15/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Raymond Lewis **Telephone Number:** 419-252-5783
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 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.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	215	Skilled (SNF)	215	78,475	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,648	3,040	12,292	32,980	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,648	3,040	12,292	32,980	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.03%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 06/15/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 208 and days of care provided 8,925

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	343,511	24,452	3,022	370,985	9,535	380,520		380,520			1
2	Food Purchase		225,477		225,477		225,477	(1,449)	224,028			2
3	Housekeeping	167,543	22,031	6,914	196,488		196,488		196,488			3
4	Laundry	24,449	13,800	1,258	39,507		39,507	(482)	39,025			4
5	Heat and Other Utilities			201,165	201,165	2,571	203,736		203,736			5
6	Maintenance	54,205	30,252	200,710	285,167		285,167		285,167			6
7	Other (specify):* Medical Waste			819	819		819		819			7
8	TOTAL General Services	589,708	316,012	413,888	1,319,608	12,106	1,331,714	(1,931)	1,329,783			8
	B. Health Care and Programs											
9	Medical Director			48,115	48,115		48,115		48,115			9
10	Nursing and Medical Records	2,803,881	213,723	56,787	3,074,391	11,311	3,085,702		3,085,702			10
10a	Therapy	893,820	17,439	131,395	1,042,654		1,042,654		1,042,654			10a
11	Activities	116,669	2,028	5,912	124,609		124,609	(5)	124,604			11
12	Social Services	146,960	258	4,405	151,623		151,623		151,623			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,961,330	233,448	246,614	4,441,392	11,311	4,452,703	(5)	4,452,698			16
	C. General Administration											
17	Administrative	137,233		566,586	703,819	(159,857)	543,962		543,962			17
18	Directors Fees											18
19	Professional Services			12,539	12,539		12,539	(12,539)				19
20	Dues, Fees, Subscriptions & Promotions			91,876	91,876		91,876	(66,889)	24,987			20
21	Clerical & General Office Expenses	564,676	55,009	307,242	926,927		926,927	(215,119)	711,808			21
22	Employee Benefits & Payroll Taxes			873,952	873,952	43,439	917,391		917,391			22
23	Inservice Training & Education			8,704	8,704		8,704		8,704			23
24	Travel and Seminar			7,940	7,940		7,940		7,940			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			616,642	616,642		616,642		616,642			26
27	Other (specify):*											27
28	TOTAL General Administration	701,909	55,009	2,485,481	3,242,399	(116,418)	3,125,981	(294,547)	2,831,434			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,252,947	604,469	3,145,983	9,003,399	(93,001)	8,910,398	(296,483)	8,613,915			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare of Highland Park #0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			257,378	257,378	15,061	272,439		272,439			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,506)	(1,506)	77,940	76,434		76,434			32
33	Real Estate Taxes			123,734	123,734		123,734		123,734			33
34	Rent-Facility & Grounds			1,222,772	1,222,772		1,222,772		1,222,772			34
35	Rent-Equipment & Vehicles			104,789	104,789		104,789		104,789			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,707,167	1,707,167	93,001	1,800,168		1,800,168			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,657	2,657		2,657		2,657			38
39	Ancillary Service Centers		325,909		325,909		325,909		325,909			39
40	Barber and Beauty Shops			10,965	10,965		10,965		10,965			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**		55,581	76,580	132,161		132,161		132,161			43
44	**TOTAL Special Cost Centers**		381,490	207,915	589,405		589,405		589,405			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,252,947	985,959	5,061,065	11,299,971		11,299,971	(296,483)	11,003,488			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 Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,449)	2		4
5	Telephone, TV & Radio in Resident Rooms	(76)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(482)	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	(103)	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				18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,539)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(213,744)	21		24
25	Fund Raising, Advertising and Promotional	(66,889)	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	(201)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (296,483)		$	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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (296,483)		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

Manorcare of Highland Park

ID# 0050278

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (196)	21	1
2	Activity Income	(5)	11	2
3				3
4				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	**Total**	(201)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Highland Park # 0050278 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,449)	0	0	0	0	0	0	0	0	0	0	(1,449)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(482)	0	0	0	0	0	0	0	0	0	0	(482)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,931)	0	0	0	0	0	0	0	0	0	0	(1,931)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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**	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	(12,539)	0	0	0	0	0	0	0	0	0	0	(12,539)	19
20	Fees, Subscriptions & Promotions	(66,889)	0	0	0	0	0	0	0	0	0	0	(66,889)	20
21	Clerical & General Office Expenses	(215,119)	0	0	0	0	0	0	0	0	0	0	(215,119)	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**	(294,547)	0	0	0	0	0	0	0	0	0	0	(294,547)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(296,483)	0	0	0	0	0	0	0	0	0	0	(296,483)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Highland Park # 0050278 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(296,483)	0	0	0	0	0	0	0	0	0	0	(296,483)	45

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, Inc	100	Health Care & Retirement Corporation of America (see H.O. Cost Report)	Toledo			

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 566,586	HCR Manor Care, Inc	100.00%	$ 566,586	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	20,147	Heartland Rehab Services, LLC	100.00%	20,147		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 586,733			$ 586,733	$ *	14

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St
City / State / Zip Code: Tpledo, OH 43604-2617
Phone Number: (419-252-5500
Fax Number: (419-254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary -Direct to All SNFs	Accumulated Cost	2917243659	353 NFs	$ 2,652,139	$ 1,448,591	10,488,458	$ 9,535	1
2	1	Dietary - Direct to Central Divisio	Accumulated Cost	692663974	92 NFs	0	0	10,488,458	0	2
3	1	Dietary - Pooled	Accumulated Cost	3335641627	727 NFs, HHs &Reh	0	0	10,488,458	0	3
4	5	Utilities -Direct to All SNFs	Accumulated Cost	2917243659	353 NFs	0	0	10,488,458	0	4
5	5	Utilities - Direct to Central Divisio	Accumulated Cost	692663974	92 NFs	0	0	10,488,458	0	5
6	5	Utilities - Pooled	Accumulated Cost	3335641627	727 NFs, HHs &Reh	817,551	0	10,488,458	2,571	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2917243659	353 NFs	2,699,818	1,331,445	10,488,458	9,707	7
8	10	Nursing - Direct to Central Divisio	Accumulated Cost	692663974	92 NFs	0	0	10,488,458	0	8
9	10	Nursing - Pooled	Accumulated Cost	3335641627	727 NFs, HHs &Reh	510,057	376,446	10,488,458	1,604	9
10	17	General & Administrative - Direct	Accumulated Cost	2917243659	353 NFs	24,740,566	19,625,790	10,488,458	88,951	10
11	17	General & Administrative - Direct	Accumulated Cost	692663974	92 NFs	1,871,124	5,027,701	10,488,458	28,333	11
12	17	General & Administrative - Poole	Accumulated Cost	3335641627	727 NFs, HHs &Reh	92,052,254	34,999,867	10,488,458	289,445	12
13	22	Employee Benefits - Direct to All SNFs		2917243659	353 NFs	7,290,309	0	10,488,458	26,211	13
14	22	Employee Benefits - Direct to Central Division SNFs		692663974	92 NFs	0	0	10,488,458	0	14
15	22	Employee Benefits - Pooled		3335641627	727 NFs, HHs &Reh	5,479,146	0	10,488,458	17,228	15
16	30	Depreciation - Direct to All SNFs		2917243659	353 NFs	285,954	0	10,488,458	1,028	16
17	30	Depreciation - Direct to Central Division SNFs		692,663,974	92 NFs	0	0	10,488,458	0	17
18	30	Depreciation - Pooled		3335641627	727 NFs, HHs &Reh	4,462,801	0	10,488,458	14,033	18
19										19
20	32	Interest				12,736,052			77,940	20
21		Non Central Division Nursing Home Allocations				29,513,406				21
22										22
23										23
24										24
25	TOTALS					$ 185,111,177	$ 62,809,840		$ 566,586	25

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	National City Bank, Trestee		X	Facility			$ 1,733,736	$ 1,733,736		4.4955	$ 77,970	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interst Income Other										(1,506)	8
9	TOTAL Facility Related						$ 1,733,736	$ 1,733,736			$ 76,464	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			$ 76,464	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.)**

Facility Name & ID Number Manorcare of Highland Park **#** 0050278 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 119,314	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.)		$ 121,524	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,210	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 121,524	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.		$ 123,734	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	105,615	8
	2006	105,168	9
	2007	114,405	10
	2008	119,314	11
	2009	121,524	12

Line 2: $60,762.17 for 1st half of 2009 paid May 10 + 60762.18 for 2nd half of 2009 paid Aug 10

Line 4: 60,762.17 estimate for 1st half 2010 and 60,762.18 estimate for 2nd half 2010

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Highland Park COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0050278

CONTACT PERSON REGARDING THIS REPORT Raymond Lewis

TELEPHONE 419-252-5783 FAX #: 419-254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-401-005	See attached	$ 121,524.35	$ 121,524.35
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,524.35	$ 121,524.35

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 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.

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					131,798		131,798		2,235,660	9
10	Civil Engineering Services			2001	3,332						10
11	Title Survey, environmental site assessment,professional serv			2001	26,933						11
12	Title Survey, environmental site assessment,professional serv			2001	5,937						12
13	Title Survey, environmental site assessment,professional serv			2001	11,541						13
14	Sinage			2001	2,234						14
15	Sinage			2002	10,967						15
16	Sidewalk			2003	3,496						16
17	Architect & Engineering Fees			2003	78,456						17
18	Developers Costs - Auto & Travel			2003	433						18
19	Developers Costs - Permits Fees			2003	1,195						19
20	Developers Cost - Plan Reviews			2003	6,013						20
21	Developers Costs - Overhead			2003	942,605						21
22	Interest			2003	83,525						22
23	Carpeting & Pads			2003	82,366						23
24	Wallcovering			2003	44,992						24
25	Cubicle Track - Material			2003	240						25
26	Carpentry Subcontractor			2003	905,757						26
27	HVAC			2003	4,180						27
28	Basic Electrical			2003	10,021						28
29	Building Demolition			2003	65,000						29
30	Site Clearing			2003	45,230						30
31	General Contractor			2003	324						31
32	Paving			2003	8,989						32
33	Landscaping			2003	31,494						33
34	Exterior Sign - Site			2003	583						34
35	Legal Fees			2003	44,751						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	VWC	2003	75						38
39	Freight on Carpet	2003	43						39
40	Carpet	2003	359						40
41	Flooring Installation	2003	843						41
42	Architect & Engineering	2003	471						42
43	Doors	2003	3,880						43
44	Concrete Pad	2004	885						44
45	Concrete Pad	2004	2,620						45
46	Lighting for Flagpole	2004	4,220						46
47	Exterior Lighting upgrade	2004	15,820						47
48	Exterior Lighting	2004	2,818						48
49	Sealing and Striping	2005	5,178						49
50	Doors	2005	19,400						50
51	Painting	2005	12,562						51
52	Painting	2005	16,809						52
53	Handrails	2005	14,245						53
54	Doors	2005	6,177						54
55	Doors Installed (10)	2006	16,151						55
56	Sidewalk	2007	4,725						56
57	Electrical Work for Light Fixture	2007	2,268						57
58	Door to Phone room	2007	2,208						58
59	Freight for Carpet	2007	758						59
60	Carpet	2008	14,399						60
61	HM Doors	2008	3,055						61
62	1008 Water Heater	2008	2,464						62
63	1008 Water Heater	2008	422						63
64	1008 Water Heater	2008	43,110						64
65	3 Door Restrictor	2008	6,631						65
66	Install Electrical outlets	2010	4,733						66
67	Carpet for Res Rooms	2010	3,139						67
68	Carpeting Rms 128 & 129	2010	3,488						68
69	0310 Heritage Carpeting	2010	7,870						69
70	TOTAL (lines 4 thru 69)		$ 2,642,420	$ 131,798		$ 131,798	$	$ 2,235,660	70

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,642,420	$ 131,798		$ 131,798	$	$ 2,235,660	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									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	TOTAL (lines 1 thru 33)		$ 2,698,160	$ 131,798		$ 131,798	$	$ 2,235,660	34

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 1,322,879	$ 125,580	$ 125,580	$		$ 963,191	71
72	Current Year Purchases	67,337						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			15,061	15,061			74
75	TOTALS	$ 1,390,216	$ 125,580	$ 140,641	$ 15,061		$ 963,191	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,088,376	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 257,378	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 272,439	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,061	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,198,851	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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		$ 1,222,772	15	10	3
4	Additions							4
5								5
6								6
7	TOTAL		215		$ 1,222,772 **			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: [X] YES [ ] NO Terms: *

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.	/2011	$ 1,222,772
13.	/2012	$ 1,222,772
14.	/2013	$ 1,222,772

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 104,789 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	8082	hrs	$ 329,429	460	$ 31,470	$ 4,290	8,542	$ 365,189	1
2	Licensed Speech and Language Development Therapist	10a	1546	hrs	54,187				1,546	54,187	2
3	Licensed Recreational Therapist			hrs		356	24,342	907	356	25,249	3
4	Licensed Physical Therapist	10a	10371	hrs	434,149	743	50,805	12,242	11,114	497,196	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				325,909		325,909	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43,2 & 10a					2,884	55,581		58,465	12
13	Other (specify): X-Ray, Lab	43,3					76,580			76,580	13
14	TOTAL				$ 817,765	1,559	$ 186,081	$ 398,929	21,558	$ 1,402,775	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.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 141,404	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	762,150		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)**	$ 903,554	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,698,160		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,390,216		16
17	Accumulated Depreciation (book methods)	(3,198,851)		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)**	$ 889,525	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,793,079	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 122,627	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	351,566		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,311		31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,524		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	328,309		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 972,337	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	996,797		40
41	Bonds Payable			41
42	Deferred Compensation	39,060		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,035,857	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,008,194	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (215,115)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,793,079	$	48

*(See instructions.)

Facility Name & ID Number Manorcare of Highland Park # 0050278 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (129,007)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (129,007)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,133,253)	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)**	$ (2,133,253)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	2,047,145	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,047,145	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (215,115)	24 *

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

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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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,354,975	1
2	Discounts and Allowances for all Levels	(3,014,176)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,340,799	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,367,519	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,367,519	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	196	12
13	Barber and Beauty Care	12,025	13
14	Non-Patient Meals	1,449	14
15	Telephone, Television and Radio	76	15
16	Rental of Facility Space		16
17	Sale of Drugs	350,928	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,217	19
20	Radiology and X-Ray	14,700	20
21	Other Medical Services	38,327	21
22	Laundry	482	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 458,400	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)**	$ 9,166,718	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,319,608	31
32	Health Care	4,441,392	32
33	General Administration	3,242,399	33
	B. Capital Expense		
34	Ownership	1,707,167	34
	C. Ancillary Expense		
35	Special Cost Centers	471,692	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)***	$ 11,299,971	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,133,253)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,133,253)	43

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

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

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

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

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,929	2,091	$ 99,164	$ 47.42	1
2	Assistant Director of Nursing	4,683	5,076	196,157	38.64	2
3	Registered Nurses	32,048	34,734	1,171,999	33.74	3
4	Licensed Practical Nurses	12,091	13,104	304,037	23.20	4
5	CNAs & Orderlies	75,317	81,930	1,029,338	12.56	5
6	CNA Trainees					6
7	Licensed Therapist	16,906	18,479	761,814	41.23	7
8	Rehab/Therapy Aides	3,991	4,362	132,006	30.26	8
9	Activity Director	7,263	7,885	116,669	14.80	9
10	Activity Assistants					10
11	Social Service Workers	5,937	6,425	146,960	22.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	20,896	22,768	343,511	15.09	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,041	2,218	54,205	24.44	17
18	Housekeepers	13,033	14,148	167,543	11.84	18
19	Laundry	1,787	1,940	24,449	12.60	19
20	Administrator	2,080	2,080	137,233	65.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,348	28,393	567,862	20.00	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)	226,350	245,633	$ 5,252,947 *	$ 21.39	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	48,115	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)		$ 48,115		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	17	368	5,10,3	52
53	TOTAL (lines 50 - 52)	17	$ 368		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Beake	Administrator	0	$ 65,465
Brandon Davidson	Administrator	0	71,768
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 137,233

B. Administrative - Other

Description	Amount
Management Fees	$ 566,586
TOTAL (agree to Schedule V, line 17, col. 3)	$ 566,586
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Foote Meyers Mielke	Legal Fees	$ 7,752
Lamiline Inc.	Legal Fees	2,071
Collection Fees	Collection Fees	696
MPRO	Collection Fees	580
United Collection	Collection Fees	1,440
(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.)		$ 12,539

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,208
Unemployment Compensation Insurance	48,416
FICA Taxes	370,209
Employee Health Insurance	330,644
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	40,379
Other Employee Benefits	4,123
Tuition Program	4,378
SMSP Match	6,185
Employee Uniforms	6,410
Home Office Allocation	43,439
TOTAL (agree to Schedule V, line 22, col.8)	$ 917,391

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	$ 5,799
Advertising: Employee Recruitment	5,285
Health Care Worker Background Check	1,914
(Indicate # of checks performed 68)	
Patient Background Checks 233	2,330
Dues/Subscriptions	1,628
Association Dues	19,222
Advertising	55,698
Less: Non-allowable Association Dues	(11,191)
Less: Public Relations Expense	( )
Non-allowable advertising	(55,698)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,987

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,940
Includes travel expense to the Home	
Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,940

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare of Highland Park # 0050278 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare of Highland Park # 0050278 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 $8031**

(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 $11191**

(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. $ **58,359** 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. $ **1,449**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.