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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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

<p>I. IDPH Facility ID Number: <u>0027433</u></p> <p>Facility Name: <u>Manorcare at Arlington Heights</u></p> <p>Address: <u>715 West Central Road</u> <u>Arlington Heights</u> <u>60005</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 392-2020</u> Fax # <u>(708) 392-3250</u></p> <p>IDPA ID Number: <u>520886946001</u></p> <p>Date of Initial License for Current Owners: <u>11/01/81</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Craig Dekany, Reimb. Manager</u> Telephone Number: <u>(419) 252-5740</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/99</u> to <u>05/31/00</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Barry Lazarus</u></td> </tr> <tr> <td></td> <td>(Title) <u>VP of Reimbursement</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Barry Lazarus</u>		(Title) <u>VP of Reimbursement</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) <u>()</u> Fax # <u>()</u>																																						

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Manorcare at Arlington Heights

0027433 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

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	151	Skilled (SNF)	151	55,266	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	151	TOTALS	151	55,266	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		841	10,450	11,291	8
9	SNF/PED					9
10	ICF	11,117	26,156	1,386	38,659	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,117	26,997	11,836	49,950	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.38%

D. How many bed-hold days during this year were paid by Public Aid? 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)
N/A

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 11 / 01 / 81

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11 / 01 / 81 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 36 and days of care provided 5752

Medicare Intermediary Blue Cross of Maryland

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12 / 31 / 00 Fiscal Year: 05 / 31 / 00

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

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	385,073	31,032	29,846	445,951	2,746	448,697	0	448,697		1
2	Food Purchase		203,982		203,982		203,982	(422)	203,560		2
3	Housekeeping	162,838	19,522	612	182,972		182,972	0	182,972		3
4	Laundry	45,363	12,537	1,276	59,176		59,176	(475)	58,701		4
5	Heat and Other Utilities			137,309	137,309	17,732	155,041	0	155,041		5
6	Maintenance	55,797	13,707	50,679	120,183		120,183	0	120,183		6
7	Other (specify):*			382	382		382	0	382		7
8	PLEASE REMOVE DECIMALS	649,071	280,780	220,104	1,149,955	20,478	1,170,433	(897)	#VALUE!		8
	B. Health Care and Programs										
9	Medical Director			30,797	30,797		30,797	0	30,797		9
10	Nursing and Medical Records	2,343,337	223,501	9,693	2,576,531	25,231	2,601,762	0	2,601,762		10
10a	Therapy	385,153	11,182	99,881	496,216		496,216	0	496,216		10a
11	Activities	61,705	829	2,298	64,832		64,832	0	64,832		11
12	Social Services	81,211	48		81,259	3,869	85,128	0	85,128		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Programs	2,871,406	235,560	142,669	3,249,635	29,100	3,278,735		3,278,735		16
	C. General Administration										
17	Administrative	196,168		411,852	608,020	(102,397)	505,623	0	505,623		17
18	Directors Fees							0			18
19	Professional Services			10,028	10,028	(6,697)	3,331	(3,331)			19
20	Dues, Fees, Subscriptions & Promotions			62,244	62,244		62,244	(23,535)	38,709		20
21	Clerical & General Office Expenses	231,891	10,805	776,441	1,019,137		1,019,137	(721,851)	297,286		21
22	Employee Benefits & Payroll Taxes			664,215	664,215	1,999	666,214	0	666,214		22
23	Inservice Training & Education			4,121	4,121		4,121	0	4,121		23
24	Travel and Seminar			6,662	6,662		6,662	0	6,662		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			122,183	122,183		122,183	0	122,183		26
27	Other (specify):*							0			27
28	PLEASE REMOVE DECIMALS	428,059	10,805	2,057,746	2,496,610	(107,095)	2,389,515	(748,717)	#VALUE!		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,948,536	527,145	2,420,520	6,896,201	(57,517)	6,838,684	(749,614)	#VALUE!		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

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			435,785	435,785	30,617	466,402	(73,582)	392,820		30
31	Amortization of Pre-Op. & Org.			103	103		103	0	103		31
32	Interest			20,011	20,011	26,900	46,911	(11,865)	35,046		32
33	Real Estate Taxes			334,435	334,435		334,435	0	334,435		33
34	Rent-Facility & Grounds			25,000	25,000		25,000	0	25,000		34
35	Rent-Equipment & Vehicles			54,991	54,991		54,991	0	54,991		35
36	Other (specify):*							0			36
37	TOTAL Ownership			870,325	870,325	57,517	927,842	(85,447)	842,395		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		301,191	5,200	306,391		306,391	0	306,391		39
40	Barber and Beauty Shops		20,595		20,595		20,595	0	20,595		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			82,900	82,900		82,900	0	82,900		42
43	Other (specify):*		131,525	0	131,525		131,525	0	131,525		43
44	TOTAL Special Cost Centers		453,311	88,100	541,411		541,411		541,411		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,948,536	980,456	3,378,945	8,307,937	0	8,307,937	(835,061)	#VALUE!		45

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

Print Preview

x

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Manorcare at Arlington Heights**

0027433

Report Period Beginning: **06 / 01 / 99**

Ending: **15 / 31 / 00**

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(422)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,326)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(475)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,865)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17,595)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(73,582)	30		15
16	Personal Expenses (Including Transportation)	(2,053)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,331)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(693,627)	21		24
25	Fund Raising, Advertising and Promotional	(23,535)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (835,061)		\$	30

OHF USE ONLY						
48		49	50	51	52	

Print Preview

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (835,061)		37

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

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

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

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Arlington Heights

0027433 Report Period Beginning:

06 / 01 / 99

Ending: 05 / 31 / 00 Summary A

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

Print Summary		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	(422)	0	0	0	0	0	0	0	0	0	0	(422)	2
3		Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4		Laundry	(475)	0	0	0	0	0	0	0	0	0	0	(475)	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	(897)	0	0	0	0	0	0	0	0	0	0	(897)	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	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		Nurse Aide 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	0	0	0	0	0	0	0	0	0	0	0	0	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	(3,331)	0	0	0	0	0	0	0	0	0	0	(3,331)	19
20		Fees, Subscriptions & Promotions	(23,535)	0	0	0	0	0	0	0	0	0	0	(23,535)	20
21		Clerical & General Office Expenses	(721,851)	0	0	0	0	0	0	0	0	0	0	(721,851)	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	(748,717)	0	0	0	0	0	0	0	0	0	0	(748,717)	28
29		TOTAL Operating Expense (sum of lines 8,16 & 28)	(749,614)	0	0	0	0	0	0	0	0	0	0	(749,614)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Arlington Heights

0027433

Report Period Beginning:

06 / 01 / 99 Ending:

05 / 31 / 00

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

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(73,582)	0	0	0	0	0	0	0	0	0	0	(73,582)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,865)	0	0	0	0	0	0	0	0	0	0	(11,865)	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	(85,447)	0	0	0	0	0	0	0	0	0	0	(85,447)	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)	(85,061)	0	0	0	0	0	0	0	0	0	0	(85,061)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

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.

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Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06 / 01 / 99 Ending: 5 / 31 / 00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

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

Name of Related Organization HCR ManorCare, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252 - 5500
 Fax Number (419) 254 - 5494

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost 100,182,693	357 Nurs. Fac.	\$ 388,478	\$ 221,496	384,952	\$ 1,493	1
2	5	Utilities	Accumulated Cost 100,182,693	357 Nurs. Fac.	4,614,666		384,952	17,732	2
3	10	Nursing	Accumulated Cost 100,182,693	357 Nurs. Fac.	6,247,503	4,177,723	384,952	24,006	3
4	17	General & Administrative	Accumulated Cost 100,182,693	357 Nurs. Fac.	80,443,795	26,746,978	384,952	309,105	4
5	22	Employee Benefits	Accumulated Cost 100,182,693	357 Nurs. Fac.	520,233		384,952	1,999	5
6	30	Depreciation	Accumulated Cost 100,182,693	357 Nurs. Fac.	7,968,019		384,952	30,617	6
7	32	Interest	Direct Allocated 1		26,900		1	26,900	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	TOTALS				\$ 100,209,594	\$ 31,146,197		\$ 411,852	25

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Northwest Community						\$ 901,783	\$ 895,532			\$ 9,368	1
2	Debt Discount						(53,707)	(52,784)			10,251	2
3	Conv. Sub. Debentures		X	Facility			849,637	849,637			26,900	3
4												4
5												5
	Working Capital											
6												6
7											392	7
8											(11,865)	8
9	TOTAL Facility Related						\$ 1,697,713	\$ 1,692,385			\$ 35,046	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,697,713	\$ 1,692,385			\$ 35,046	15

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

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

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Facility Name & ID Number Manorcare at Arlington Heights

0027433 Report Period Beginning:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,403 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1973</u>	<u>\$ 111,118</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 111,118	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

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Facility Name & ID Number Manorcare at Arlington Heights

0027433

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	151		1973	1969	\$ 2,165,884	\$ 75,643		\$ 75,643	\$	\$ 1,818,716	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Current Year Depreciation					160,892		160,892		1,029,546	9
10				1976	8,839						10
11				1978	23,518						11
12				1979	43,635						12
13				1980	3,940						13
14				1981	30,085						14
15				1982	90,702						15
16				1984	63,182						16
17				1985	24,863						17
18				1986	19,944						18
19				1987	105,148						19
20				1988	23,991						20
21				1989	51,409						21
22				1990	58,556						22
23				1991	222,698						23
24				1992	767,104						24
25				1993	52,576						25
26				1994	623,228						26
27				1995	44,468						27
28		UPGRADE LAUNDRY ROOM, STAIRWELL & SHOWER		1996	2,927						28
29		TILE		1996	12,870						29
30		INSTALL BASE COVE / REPLACE CEILING TILE		1996	7,736						30
31		REPLACE ROOF FAN		1996	1,370						31
32		CAPITALIZED LABOR		1996	7,272						32
33		TOILETS / PLUMBING		1996	2,194						33
34		ELECTRICAL WORK		1996	1,315						34
35		WALLVINYL		1996	1,281						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 236,535		\$ 236,535	\$	\$ 2,848,262	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Number Manorcare at Arlington Heights

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		GAZEBO		1996	2,014						9
10		SPRINKLER SYSTEM		1996	3,035						10
11		WALLCOVERINGS		1996	6,966						11
12		INSTALL ROOFTOP CHILLER		1996	15,766						12
13		FLOOR TILE & INSTALLATION		1996	24,364						13
14		NURSE STATION RENOVATION		1996	20,477						14
15		WALK-IN COOLER & INSTALLATION		1996	19,089						15
16		RENOVATE BATHROOM		1996	11,624						16
17		INSTALL SHELVING		1996	2,931						17
18		A/C REPAIR		1996	1,891						18
19		PIPING - LAUNDRY ROOM		1996	2,013						19
20		CARPETING		1996	7,261						20
21		RENOVATIONS		1996	7,896						21
22		CORPORATE OVERHEAD		1997	10,516						22
23		INSTALL CARPET		1997	3,794						23
24		INSTALL CABINETS / COUNTERTOPS / DOORS		1997	3,964						24
25		NURSES STATION RENOVATION		1997	6,871						25
26		REPLACE WATER LINE		1997	1,743						26
27		NURSES CALL SYSTEM		1997	23,581						27
28		INSTALL CEILING TILE		1997	7,443						28
29		HVAC		1997	15,227						29
30		POWER GENERATOR		1997	3,088						30
31		RETIREMENTS		1987	(62,983)						31
32		RETIREMENTS		1992	(18,208)						32
33		GENERATOR / SWITCHGEAR		1997	33,312						33
34		WALLCOVERINGS		1997	2,460						34
35		INSTALL CABINETS		1997	8,800						35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Number Manorcare at Arlington Heights

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9		REMOVE & INSTALL FENCE		1997	5,250						9
10		REFRIGERATOR / FREEZER REPAIRS		1997	2,830						10
11		FACILITY PLAN ALLOC.		1997	5,965						11
12		REAR EXIT FRAME & DOOR		1997	2,761						12
13		ELECTRICAL		1997	12,876						13
14		SIDELIGHT FRAME & DOOR		1997	6,005						14
15		SHOWER ROOM REHAB		1997	16,502						15
16		FRENCH DOORS		1997	4,230						16
17		LIGHTING		1997	4,323						17
18		INSTALL SHOWER / FAUCET		1997	2,600						18
19		KITCHEN WORK		1997	4,960						19
20		HVAC / DUCTWORK		1997	6,590						20
21		SPRINKLER SYSTEM		1997	22,285						21
22		DRYWALL REPAIRS		1997	4,257						22
23		BOND COPIES		1997	316						23
24		EXTERIOR LIGHTING		1997	18,355						24
25		INSTALL CEILING TILE		1997	15,372						25
26		CARPENTRY		1998	9,278						26
27		DOORS / WINDOWS		1998	8,177						27
28		PLUMBING		1998	18,843						28
29		PAINTING / WALLCOVERINGS		1998	61,387						29
30		CASEWORK		1998	7,069						30
31		CEILING / FLOORING		1998	7,397						31
32		DRYWALL / FINISH STUD		1998	13,861						32
33		CORPORATE OVERHEAD		1998	1,651						33
34		DEVELOPER COSTS		1998	2,153						34
35		GENERAL CONTRACTOR FEES		1998	7,789						35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Number Manorcare at Arlington Heights

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		ROOFING / SOFFIT REPAIRS		1998	932						9
10		EXTERIOR SIGN WORK		1998	1,040						10
11		PAINTING/WALLCOVERING		1998	1,526						11
12		PLUMBING		1998	9,100						12
13		ELECTRICAL		1998	16,773						13
14		DEVELOPERS		1998	5,555						14
15		FLOORING/CEILING		1998	45,000						15
16		HVAC		1998	5,885						16
17		DOOR/WINDOWS		1998	5,542						17
18		SIGN		1998	11,862						18
19		PLUMBING		1999	2,482						19
20		FLOORING/CEILING		1999	25,000						20
21		LIGHT FIXTURE		1999	2,990						21
22		HVAC		1999	3,230						22
23		ENGINEER FEES, EXPENSES		1999	998						23
24		NEW DOOR, KICKPLATE, HANDLES		1999	3,071						24
25		WALLCOVERING		1999	360						25
26		WALLCOVERING		1999	121						26
27		ADJ CONST COST FOR RETENTION		1999	(11,545)						27
28		VINYL WALLCOVERING		1999	495						28
29		VINYLIzed FABRIC		1999	68						29
30		WALLCOVERING		1999	459						30
31		COLD WATER PIPES		1999	2,412						31
32		WALLCOVERING		1999	2,296						32
33		WALLCOVERING		1999	112						33
34		CARPET		1999	3,833						34
35		DINING HVAC		1999	2,611						35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Number Manorcare at Arlington Heights

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		CABINETS		2000	6,835						9
10		WALCOVERING & FLOORING		1999	10,131						10
11		WALLCOVERING		1999	300						11
12		MJ ROST FREIGHT		2000	81						12
13		MED ROOM REMODEL		2000	11,690						13
14		MJ ROST FREIGHT (CARPET)		2000	128						14
15		LOBBY, RSTROOM, & DINING DECORATIONS		2000	2,215						15
16		FLOORING		2000	1,280						16
17		PAINTING & CERAMIC TILE INSTALLATION		2000	2,114						17
18		VWC REPAIR/VCT		1999	985						18
19		RENOVATION		2000	2,301						19
20		LOUNGE & DINING HVAC ADDTL COST		2000	116						20
21		WALLCOVERING		2000	125						21
22		WILLIAMSBURG LOUNGE & DINING RENOVATION		2000	3,255						22
23		WALLCOVERING FOR WILLIAMSBURG DINING		2000	374						23
24		ADDTL RENOVATION COST		2000	193						24
25		ROOF REPAIRS		2000	1,520						25
26		RETIREMENTS		2000	(116,092)						26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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.

Print Preview

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

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	
37	Purchased in Prior Years	\$ 1,099,912	\$ 125,668	\$ 125,668			\$ 696,141	37
38	Current Year Purchases	54,312						38
39	Fully Depreciated Assets	(109,343)						39
40	Home Office			30,617	30,617			40
41	TOTALS	\$ 1,044,881	\$ 125,668	\$ 156,285	\$ 30,617		\$ 696,141	41

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	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 362,203	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 392,820	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 30,617	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,544,403	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	STEP-UP BUILDING	\$ 2,281,050	\$ 73,582	\$ 1,367,404	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 2,281,050	\$ 73,582	\$ 1,367,404	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

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

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

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Northwest Community Healthcare

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5	Property				<u>25,000</u>	<u>Monthly</u>		5
6								6
7	TOTAL				\$ <u>25,000</u>			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: \$ 54,991 Description: _____
(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

* 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.

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XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

	1 2 3 4			
	Facility		Contract	Total
	Drop-outs	Completed		
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 Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

Print Preview

Facility Name & ID Number Manorcare at Arlington Heights

0027433 Report Period Beginning:

06 / 01 / 99 Ending: 05 / 31 / 00

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	7,133 hrs	\$ 129,038		\$ 13,138	\$ 1,565	7,133	\$ 143,741	1
2	Licensed Speech and Language Development Therapist	10a	1,221 hrs	28,433		9,634	10	1,221	38,077	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	9,107 hrs	227,682		21,502	9,607	9,107	258,791	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts			55,607	301,191		356,798	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Podiatry	39,3				5,200			5,200	13
14	TOTAL			\$ 385,153		\$ 105,081	\$ 312,373	17,461	\$ 802,607	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 nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number Manorcare at Arlington Heights

0027433

Report Period Beginning: 06 / 01 / 99

Ending: 05 / 31 / 00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05 / 31 / 00 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 126,072		1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 514,330)	1,507,935		3
4	Supply Inventory (priced at)	18,598		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,871		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,664,476	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	132,779		13
14	Buildings, at Historical Cost	7,240,273		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,044,353		16
17	Accumulated Depreciation (book methods)	(4,933,335)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	426		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	(475)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,484,021	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,148,497	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 95,343	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	162,657		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,105		31
32	Accrued Real Estate Taxes(Sch.IX-B)	318,871		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	56,700		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 664,676	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	842,748		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 842,748	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,507,424	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,641,073	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,148,497	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,989,138	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,989,138	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	358,935	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)	\$ 358,935	17
B. Transfers (Itemize):			
18	INTERDIVISION	(6,707,000)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (6,707,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,641,073	24 *

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Arlington Heights

0027433

Report Period Beginning: 06 / 01 / 99

Ending: 05 / 31 / 00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,535,655	1
2	Discounts and Allowances for all Levels	(1,707,342)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,828,313	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,483,059	6
7	Oxygen	(1,074)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,481,985	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,053	12
13	Barber and Beauty Care	16,075	13
14	Non-Patient Meals	422	14
15	Telephone, Television and Radio	7,326	15
16	Rental of Facility Space		16
17	Sale of Drugs	306,914	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,180	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,264	21
22	Laundry	475	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 344,709	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,865	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,865	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)	\$ 8,666,872	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,149,955	31
32	Health Care	3,249,635	32
33	General Administration	2,496,610	33
B. Capital Expense			
34	Ownership	870,325	34
C. Ancillary Expense			
35	Special Cost Centers	541,411	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,307,937	40
41	Income before Income Taxes (line 30 minus line 40)**	358,935	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 358,935	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.

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Facility Name & ID Number Manorcare at Arlington Heights

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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	3,834	4,443	\$ 116,130	\$ 26.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,328	33,076	649,691	19.64	3
4	Licensed Practical Nurses	19,706	23,724	392,019	16.52	4
5	Nurse Aides & Orderlies	86,131	102,915	1,157,805	11.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	16,761	19,172	329,567	17.19	7
8	Rehab/Therapy Aides	5,061	5,673	55,586	9.80	8
9	Activity Director					9
10	Activity Assistants	6,252	7,062	61,705	8.74	10
11	Social Service Workers	3,188	3,676	81,211	22.09	11
12	Dietician	26,526	32,618	385,073	11.81	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,770	4,898	55,797	11.39	17
18	Housekeepers	15,719	18,016	162,838	9.04	18
19	Laundry	3,787	4,872	45,363	9.31	19
20	Administrator	3,984	4,256	196,168	46.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,078	17,929	231,891	12.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,688	2,744	27,692	10.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	238,813	285,074	\$ 3,948,536 *	\$ 13.85	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
35	Dietary Consultant	\$	35
36	Medical Director		36
37	Medical Records Consultant	Monthly 1,225	10,5 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	Monthly 3,869	12,5 45
46	Other(specify)		46
47	Dietary	Monthly 1,253	1,5 47
48	Administrative	Monthly 350	17,5 48
49	TOTAL (lines 35 - 48)	\$ 6,697	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	Nurse Aides		52
53	TOTAL (lines 50 - 52)	\$	53

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	6 Amount of Expense Amortized Per Year								
					5 FY1997	6 FY1998	7 FY1999	8 FY2000	9 FY2001	10 FY2002	11 FY2003	12 FY2004	13 FY2005
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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Facility Name & ID Number Manorcare at Arlington Heights

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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 5619
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 78,546 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 of Public Aid during this cost report period. \$ 82,900
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 of Public Aid, 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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 422
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? YES
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.