

Facility Name & ID Number ManorCare at Arlington Heights# 0027433 Report Period Beginning: 06/01/02 Ending: 05/31/03

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>151</u>	Skilled (SNF)	<u>151</u>	<u>55,115</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>151</u>	TOTALS	<u>151</u>	<u>55,115</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	Private Pay	4 Other		
8	SNF	<u>2,556</u>	<u>7,532</u>	<u>24,062</u>	<u>34,150</u>	8
9	SNF/PED					9
10	ICF	<u>5,273</u>	<u>5,992</u>	<u>1,105</u>	<u>12,370</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,829</u>	<u>13,524</u>	<u>25,167</u>	<u>46,520</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.41%

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/AF. 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 111 and days of care provided 20,682Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/03 Fiscal Year: 05/31/03

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

Facility Name & ID Number ManorCare at Arlington Heights # 0027433 Report Period Beginning: 06/01/02 Ending: 05/31/03**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	410,116	33,323	1,182	444,621	3,426	448,047		448,047		1
2	Food Purchase		194,665		194,665		194,665	(3,741)	190,924		2
3	Housekeeping	197,942	20,967	1,239	220,148		220,148		220,148		3
4	Laundry	29,889	25,263	529	55,681		55,681		55,681		4
5	Heat and Other Utilities			163,177	163,177	13,958	177,135		177,135		5
6	Maintenance	56,726	18,262	52,057	127,045		127,045		127,045		6
7	Other (specify):* Med Waste			1,196	1,196		1,196		1,196		7
8	TOTAL General Services	694,673	292,480	219,380	1,206,533	17,384	1,223,917	(3,741)	1,220,176		8
	B. Health Care and Programs										
9	Medical Director			54,410	54,410		54,410		54,410		9
10	Nursing and Medical Records	3,014,577	218,231	30,072	3,262,880	71,781	3,334,661	(2,794)	3,331,867		10
10a	Therapy	800,207	4,209	90,138	894,554		894,554		894,554		10a
11	Activities	68,204	3,278	5,365	76,847		76,847	(485)	76,362		11
12	Social Services	98,159	27	540	98,726		98,726		98,726		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,981,147	225,745	180,525	4,387,417	71,781	4,459,198	(3,279)	4,455,919		16
	C. General Administration										
17	Administrative	92,658		617,911	710,569	(285,591)	424,978		424,978		17
18	Directors Fees										18
19	Professional Services			31,401	31,401	(13,203)	18,198	(18,198)			19
20	Dues, Fees, Subscriptions & Promotions			73,522	73,522		73,522	(15,848)	57,674		20
21	Clerical & General Office Expenses	381,235	49,152	95,518	525,905	864	526,769	(43,581)	483,188		21
22	Employee Benefits & Payroll Taxes			962,455	962,455	106,928	1,069,383		1,069,383		22
23	Inservice Training & Education			3,263	3,263		3,263		3,263		23
24	Travel and Seminar			10,589	10,589		10,589		10,589		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			168,590	168,590		168,590		168,590		26
27	Other (specify):*										27
28	TOTAL General Administration	473,893	49,152	1,963,249	2,486,294	(191,002)	2,295,292	(77,627)	2,217,665		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,149,713	567,377	2,363,154	8,080,244	(101,837)	7,978,407	(84,647)	7,893,760		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 at Arlington Heights #0027433 Report Period Beginning: 06/01/02 Ending: 05/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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
	D. Ownership										
30	Depreciation			330,507	330,507	67,609	398,116		398,116		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			19,924	19,924	34,228	54,152		54,152		32
33	Real Estate Taxes			348,486	348,486		348,486	(46,419)	302,067		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			52,190	52,190		52,190		52,190		35
36	Other (specify):*										36
37	TOTAL Ownership			751,107	751,107	101,837	852,944	(46,419)	806,525		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		543,778	96,940	640,718		640,718		640,718		39
40	Barber and Beauty Shops			20,746	20,746		20,746		20,746		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			82,673	82,673		82,673		82,673		42
43	Other (specify):*		135,296		135,296		135,296		135,296		43
44	TOTAL Special Cost Centers		679,074	200,359	879,433		879,433		879,433		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,149,713	1,246,451	3,314,620	9,710,784		9,710,784	(131,066)	9,579,718		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 at Arlington Heights

0027433

Report Period Beginning: 06/01/02

Ending: 05/31/03

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	(3,741)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,413)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,749)	21		10
11	Discounts, Allowances, Rebates & Refunds	(6)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,267)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,794)	10		16
17	Non-Care Related Fees	(1,027)	21		17
18	Fines and Penalties				18
19	Entertainment	(485)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,724)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,099)	21		24
25	Fund Raising, Advertising and Promotional	(15,848)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(46,419)	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	2,506	19,21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (131,066)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (131,066)		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

ManorCare at Arlington Heights

ID# 0027433

Report Period Beginning: 06/01/02

Ending: 05/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Personal Purchases Revenue	\$ 2,980	21	1
2	Accounting Fees	(474)	19	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	2,506		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ManorCare at Arlington Heights# 0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,741)	0	0	0	0	0	0	0	0	0	0	(3,741)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,741)	0	0	0	0	0	0	0	0	0	0	(3,741)	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	(2,794)	0	0	0	0	0	0	0	0	0	0	(2,794)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(485)	0	0	0	0	0	0	0	0	0	0	(485)	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	(3,279)	0	0	0	0	0	0	0	0	0	0	(3,279)	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	(18,198)	0	0	0	0	0	0	0	0	0	0	(18,198)	19
20	Fees, Subscriptions & Promotions	(15,848)	0	0	0	0	0	0	0	0	0	0	(15,848)	20
21	Clerical & General Office Expenses	(43,581)	0	0	0	0	0	0	0	0	0	0	(43,581)	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	(77,627)	0	0	0	0	0	0	0	0	0	0	(77,627)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(84,647)	0	0	0	0	0	0	0	0	0	0	(84,647)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ManorCare at Arlington Heights# 0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
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	(46,419)	0	0	0	0	0	0	0	0	0	0	(46,419) 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	(46,419)	0	0	0	0	0	0	0	0	0	0	(46,419) 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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(131,066)	0	0	0	0	0	0	0	0	0	0	(131,066) 45

Facility Name & ID Number ManorCare at Arlington Heights

0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03

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
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O Cost Report)	Toledo,OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See						
2	V	Page						
3	V	8						
4	V							
5	V							
6	V	10a						
		Therapy Management	48,101	Heartland Management Services	100.00%	48,101		
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 666,012			\$ 666,012	\$ *	

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

Facility Name & ID Number ManorCare at Arlington Heights # 0027433 Report Period Beginning: 06/01/02 Ending: 05/31/03

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number ManorCare at Arlington Heights # 0027433 Report Period Beginning: 06/01/02 Ending: 05/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

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	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	\$	9,993,816	\$	0	1
2	1	Dietary - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	920,912	9,993,816	536,824	3,426	2
3	5	Utilities - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	112,862	9,993,816		495	3
4	5	Utilities - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	3,618,915	9,993,816		13,463	4
5	10	Nursing - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	11,131,912	9,993,816	7,408,777	48,866	5
6	10	Nursing - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	2,842,925	9,993,816	1,812,855	10,576	6
7	17	General & Admin - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	19,326,083	9,993,816	15,188,841	84,837	7
8	17	General & Admin - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	66,522,981	9,993,816	38,146,902	247,481	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	2,749,439	9,993,816		12,069	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	25,498,075	9,993,816		94,859	10
11	30	Depreciation - Direct	Accumulated Cost	2,276,617,075	357 Nurs. Fac.	148,355	9,993,816		651	11
12	30	Depreciation - Pooled	Accumulated Cost	2,686,344,447	357 Nurs. Fac.	17,998,306	9,993,816		66,958	12
13										13
14	32	Interest				7,352,132			34,228	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 158,222,897	\$ 63,094,199		\$ 617,911	25

Facility Name & ID Number ManorCare at Arlington Heights # 0027433 Report Period Beginning: 06/01/02 Ending: 05/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Conv. Sub Debentures		X	Facility			\$ 849,637	\$			\$ 34,228	1						
2		Northwest Community						74,307	28,432			4,125	2						
3		Debt Discount						(14,494)	(2,190)			12,304	3						
4		Bank of America						116,222				2,587	4						
5		National City Bank							116,222			908	5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related						\$ 1,025,672	\$ 142,464			\$ 54,152	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$ 1,025,672	\$ 142,464			\$ 54,152	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 at Arlington Heights**# **0027433** Report Period Beginning: **06/01/02** Ending: **05/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2002 report.			\$	361,123	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.)			\$	314,704	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(46,419)	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	314,704	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.)			\$	33,782	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.			\$	302,067	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998	331,619	8		
		1999	312,842	9		
		2000	330,254	10		
		2001	334,976	11		
		2002	348,486	12		
					FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2002	\$		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ManorCare at Arlington Heights COUNTY Cool

FACILITY IDPH LICENSE NUMBER 0027433

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-04-100-008-0000</u>	<u>See Attached</u>	\$ <u>86,862.09</u>	\$ <u>86,862.09</u>
2. <u>08-09-101-011-0000</u>	<u>See Attached</u>	\$ <u>73,352.19</u>	\$ <u>73,352.19</u>
3. <u>08-04-100-008-0000</u>	<u>See Attached</u>	\$ <u>88,672.72</u>	\$ <u>88,672.72</u>
4. <u>08-09-101-011-0000</u>	<u>See Attached</u>	\$ <u>75,256.79</u>	\$ <u>75,256.79</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>324,143.79</u>	\$ <u>324,143.79</u>

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 & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,667 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

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

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

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

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

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

N/A

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

Facility Name & ID Number ManorCare at Arlington Heights# 0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03**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	151		1973	1969	\$ 2,165,884	\$ 27,642		\$ 27,642	\$	\$ 2,626,912	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)										
10			1976		8,839	220,065		220,065		2,239,244	9
11			1978		23,518						10
12			1979		43,635						11
13			1980		3,940						12
14			1981		30,085						13
15			1982		90,702						14
16			1984		63,182						15
17			1985		24,863						16
18			1986		19,944						17
19			1987		105,148						18
20			1988		23,991						19
21			1989		51,409						20
22			1990		58,556						21
23			1991		222,698						22
24			1992		767,104						23
25			1993		52,576						24
26			1994		623,228						25
27			1995		44,468						26
28		UPGRADE LAUNDRY ROOM, STAIRWELL & SHOWER	1996		2,927						27
29		TILE	1996		12,870						28
30		INSTALL BASE COVE / REPLACE CEILING TILE	1996		7,736						29
31		REPLACE ROOF FAN	1996		1,370						30
32		CAPITALIZED LABOR-LAUNDRY RM UPGRADE	1996		7,272						31
33		TOILETS / PLUMBING	1996		2,194						32
34		ELECTRICAL WORK	1996		1,315						33
35		WALLVINYL	1996		1,281						34
36											35
											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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number ManorCare at Arlington Heights

0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	GAZEBO	1996	\$ 2,014	\$		\$	\$	\$		37
38	SPRINKLER SYSTEM	1996	3,035							38
39	WALLCOVERINGS	1996	6,966							39
40	INSTALL ROOFTOP CHILLER	1996	15,766							40
41	FLOOR TILE & INSTALLATION	1996	24,364							41
42	NURSE STATION RENOVATION	1996	20,477							42
43	WALK-IN COOLER & INSTALLATION	1996	19,089							43
44	RENOVATE BATHROOM	1996	11,624							44
45	INSTALL SHELVING	1996	2,931							45
46	A/C REPAIR	1996	1,891							46
47	PIPING - LAUNDRY ROOM	1996	2,013							47
48	CARPETING	1996	7,261							48
49	BATHROOM RENOVATIONS	1996	7,896							49
50	CORPORATE OVERHEAD-NURSES STATION REN	1997	10,516							50
51	INSTALL CARPET	1997	3,794							51
52	INSTALL CABINETS / COUNTERTOPS / DOORS	1997	3,964							52
53	NURSES STATION RENOVATION	1997	6,871							53
54	REPLACE WATER LINE	1997	1,743							54
55	NURSES CALL SYSTEM	1997	23,581							55
56	INSTALL CEILING TILE	1997	7,443							56
57	HVAC	1997	15,227							57
58	POWER GENERATOR	1997	3,088							58
59	RETIREMENTS	1987	(62,983)							59
60	RETIREMENTS	1992	(18,208)							60
61	GENERATOR / SWITCHGEAR	1997	33,312							61
62	WALLCOVERINGS	1997	2,460							62
63	INSTALL CABINETRY	1997	8,800							63
64	REMOVE & INSTALL FENCE	1997	5,250							64
65	REFRIGERATOR / FREEZER REPAIRS	1997	2,830							65
66	FACILITY PLAN ALLOC-NURSES STATION REN	1997	5,965							66
67	REAR EXIT FRAME & DOOR	1997	2,761							67
68	ELECTRICAL	1997	12,876							68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,655,352	\$ 247,707		\$ 247,707	\$	\$ 4,866,156		70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number ManorCare at Arlington Heights

0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,655,352	\$ 247,707		\$ 247,707	\$	\$ 4,866,156	1
2	SIDELIGHT FRAME & DOOR	1997	6,005						2
3	SHOWER ROOM REHAB	1997	16,502						3
4	FRENCH DOORS	1997	4,230						4
5	LIGHTING	1997	4,323						5
6	INSTALL SHOWER / FAUCET	1997	2,600						6
7	KITCHEN WORK	1997	4,960						7
8	HVAC / DUCTWORK	1997	6,590						8
9	SPRINKLER SYSTEM	1997	22,285						9
10	DRYWALL REPAIRS	1997	4,257						10
11	BOND COPIES	1997	316						11
12	EXTERIOR LIGHTING	1997	18,355						12
13	INSTALL CEILING TILE	1997	15,372						13
14	CARPENTRY	1998	9,278						14
15	DOORS / WINDOWS	1998	8,177						15
16	PLUMBING	1998	18,843						16
17	PAINTING / WALLCOVERINGS	1998	61,387						17
18	CASEWORK	1998	7,069						18
19	CEILING / FLOORING	1998	7,397						19
20	DRYWALL / FINISH STUD	1998	13,861						20
21	CORPORATE OVERHEAD	1998	1,651						21
22	DEVELOPER COSTS	1998	2,153						22
23	GENERAL CONTRACTOR FEES	1998	7,789						23
24	ROOFING / SOFFIT REPAIRS	1998	932						24
25	EXTERIOR SIGN WORK	1998	1,040						25
26	PAINTING/WALLCOVERING	1998	1,526						26
27	PLUMBING	1998	9,100						27
28	ELECTRICAL	1998	16,773						28
29	DEVELOPERS	1998	5,555						29
30	FLOORING/CEILING	1998	45,000						30
31	HVAC	1998	5,885						31
32	DOOR/WINDOWS	1998	5,542						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,990,105	\$ 247,707		\$ 247,707	\$	\$ 4,866,156	34

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

Facility Name & ID Number ManorCare at Arlington Heights

0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,990,105	\$ 247,707		\$ 247,707	\$	\$ 4,866,156	1
2	SIGN	1998	11,862						2
3	PLUMBING	1999	2,482						3
4	FLOORING/CEILING	1999	25,000						4
5	LIGHT FIXTURE	1999	2,990						5
6	HVAC	1999	3,230						6
7	ENGINEER FEES, EXPENSES LOUNGE RENOV	1999	998						7
8	NEW DOOR, KICKPLATE, HANDLES	1999	3,071						8
9	WALLCOVERING	1999	360						9
10	WALLCOVERING	1999	121						10
11	ADJ CONST COST FOR RETENTION	1999	(11,545)						11
12	VINYL WALLCOVERING	1999	495						12
13	VINYLIzed FABRIC	1999	68						13
14	WALLCOVERING	1999	459						14
15	COLD WATER PIPES	1999	2,412						15
16	WALLCOVERING	1999	2,296						16
17	WALLCOVERING	1999	112						17
18	CARPET	1999	3,833						18
19	DINING HVAC	1999	2,611						19
20	CABINETS	2000	6,835						20
21	WALCOVERING & FLOORING	1999	10,131						21
22	WALLCOVERING	1999	300						22
23	MJ ROST FREIGHT	2000	81						23
24	MED ROOM REMODEL	2000	11,690						24
25	MJ ROST FREIGHT (CARPET)	2000	128						25
26	LOBBY, RSTROOM, & DINING DECORATIONS	2000	2,215						26
27	FLOORING	2000	1,280						27
28	PAINTING & CERAMIC TILE INSTALLATION	2000	2,114						28
29	VWC REPAIR/VCT	1999	985						29
30	LOUNGE & DINING RENOVATION	2000	2,801						30
31	LOUNGE & DINING HVAC ADDTL COST	2000	116						31
32	WALLCOVERING	2000	125						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,079,761	\$ 247,707		\$ 247,707	\$	\$ 4,866,156	34

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

Facility Name & ID Number ManorCare at Arlington Heights

0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,079,761	\$ 247,707		\$ 247,707	\$	\$ 4,866,156	1
2	WILLIAMSBURG LOUNGE & DINING RENOVATION	2000	3,255						2
3	WALLCOVERING FOR WILLIAMSBURG DINING	2000	374						3
4	ADDTL RENOVATION COST/WILLIAMSBURG DINING	2000	193						4
5	ROOF REPAIRS	2000	1,520						5
6	DOOR	2000	790						6
7	DRYWALL - SITE SURVEY RENO	2000	368						7
8	AIR CONDITION	2000	37,650						8
9	ADJ CONST COST FOR RETENTION	2000	11,545						9
10	COMMUNICATION SYSTEM	2000	2,644						10
11	INSTALLATION - CARPET	2000	4,217						11
12	SIT SURVEY RENO	2000	483						12
13	ELECTRICAL - BREAKER REPLACEMENT	2000	2,370						13
14	CARPET - RESIDENT RM	2000	1,035						14
15	MJ ROST - CARPET	2000	147						15
16	CARPET	2000	878						16
17	AWNING	2000	2,350						17
18	CERAMIC TILE - BATH RENO	2000	19,688						18
19	SLIDING DOORS	2000	9,420						19
20	FRONT ENT DOORS	2000	4,685						20
21	A/C UNITS - ROOFTOP	2000	806						21
22	GATE VALVES & PIPING	2001	21,253						22
23	ASBESTOS ABATEMENT	2001	7,500						23
24	WALLCOVERING & FLOORING	2001	28,409						24
25	WALLCOVERING & FLOORING	2001	11,693						25
26	WALLCOVERING & FLOORING	2001	6,370						26
27	WALLCOVERING & FLOORING	2001	49,540						27
28	WALLCOVERING & FLOORING	2001	3,709						28
29	2 DOORS	2001	2,368						29
30	ROOF	2001	69,425						30
31	CARPET & VCT BASE	2001	9,630						31
32	ROOF	2001	515						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,394,591	\$ 247,707		\$ 247,707	\$	\$ 4,866,156	34

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

STATE OF ILLINOIS

Facility Name & ID Number ManorCare at Arlington Heights

0027433

Report Period Beginning:

06/01/02

Ending:

05/31/03

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,394,591	\$ 247,707		\$ 247,707	\$	\$ 4,866,156	1
2	ROOF	2001	550						2
3	SMOKE WALLS	2002	6,877						3
4	VWC	2001	1,076						4
5	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996	(7,272)	(364)		(364)		(2,636)	5
6	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)	(526)		(526)		(3,242)	6
7	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)	(160)		(160)		(935)	7
8	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)	(138)		(138)		(747)	8
9	C/R 5/31/99 AUDIT ADJ. - MONTHLY CAP BUDGET	1998	(1,651)	(83)		(83)		(413)	9
10	GENERAL OVERHEAD & INTEREST	2002	19,105						10
11	CARPENTRY/BUILDING WIRE	2002	105,537						11
12	CARPETING AND WALLCOVERINGS	2002	14,091						12
13	FLOORING	2002	2,022						13
14	RETROACTIVE ADDITION	2003	1,391						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)		\$ 5,519,836	\$ 246,436		\$ 246,436	\$	\$ 4,858,183	34

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

Facility Name & ID Number ManorCare at Arlington Heights # 0027433 Report Period Beginning: 06/01/02 Ending: 05/31/03

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	\$ 1,291,743	\$ 84,071	\$ 84,071			\$ 1,090,363	71
72	Current Year Purchases	65,354						72
73	Fully Depreciated Assets							73
74	H. O. Allocation			67,609	67,609			74
75	TOTALS	\$ 1,357,097	\$ 84,071	\$ 151,680	\$ 67,609		\$ 1,090,363	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,988,051	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 330,507	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 398,116	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,609	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,948,546	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 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					\$ _____			5
6					\$ _____			6
7	TOTAL				\$ _____			7

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

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

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: \$ 52,190 Description: 02 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	<u>N/A</u>		\$ _____	\$ _____	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.

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)

		Facility			
		1	2	3	4
		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	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.

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	10092 hrs	\$ 252,306	2,323	\$ 58,066	\$ 1,892	12,415	\$ 312,264	1
2	Licensed Speech and Language Development Therapist	10a	2474 hrs	61,851	257	6,417	493	2,731	68,761	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	19442 hrs	486,050	1,017	25,424	1,824	20,459	513,298	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				543,778		543,778	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray,Podiatry,Lab	10a, 39,3				97,171			97,171	13
14	TOTAL			\$ 800,207	3,596	\$ 187,078	\$ 547,987	35,604	\$ 1,535,272	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.

Facility Name & ID Number ManorCare at Arlington Heights

0027433

Report Period Beginning: 06/01/02

Ending:

05/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/03

(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	\$ 22,346	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (118,050))	1,875,291		3
4	Supply Inventory (priced at)	12,196		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,559		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,915,392	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,118		13
14	Buildings, at Historical Cost	5,519,836		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,357,097		16
17	Accumulated Depreciation (book methods)	(5,948,546)		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): CIP	136,183		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,175,688	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,091,080	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 120,279	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	571,910		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	314,704		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	122,394		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,129,287	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	116,222		39
40	Mortgage Payable	26,242		40
41	Bonds Payable			41
42	Deferred Compensation	2,686		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 145,150	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,274,437	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,816,643	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,091,080	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,450,788	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,450,788	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,932,066	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,932,066	17
	B. Transfers (Itemize):		
18	Interdivision	(1,566,211)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,566,211)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,816,643	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ManorCare at Arlington Heights

0027433

Report Period Beginning: 06/01/02

Ending:

05/31/03

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	\$ 8,617,647	1
2	Discounts and Allowances for all Levels	(1,657,042)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,960,605	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,027,131	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,027,131	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	(1,287)	12
13	Barber and Beauty Care	22,215	13
14	Non-Patient Meals	2,048	14
15	Telephone, Television and Radio	5,413	15
16	Rental of Facility Space		16
17	Sale of Drugs	555,950	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	60,734	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,569	21
22	Laundry	1,690	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 652,332	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,027	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,027	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	1,755	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,755	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,642,850	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,206,533	31
32	Health Care	4,387,417	32
33	General Administration	2,486,294	33
B. Capital Expense			
34	Ownership	751,107	34
C. Ancillary Expense			
35	Special Cost Centers	879,433	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)*	\$ 9,710,784	40
41	Income before Income Taxes (line 30 minus line 40)**	1,932,066	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,932,066	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 at Arlington Heights**# **0027433**Report Period Beginning: **06/01/02**Ending: **05/31/03**

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	1,810	1,944	\$ 56,919	\$ 29.28	1
2	2,173	2,334	61,419	26.31	2
3	40,771	43,791	1,143,304	26.11	3
4	19,378	20,814	438,936	21.09	4
5	99,566	106,940	1,254,825	11.73	5
6					6
7	31,014	33,461	742,210	22.18	7
8	4,575	4,936	57,997	11.75	8
9	6,224	6,681	68,204	10.21	9
10					10
11	5,563	5,983	98,159	16.41	11
12					12
13					13
14					14
15	32,548	34,822	410,116	11.78	15
16					16
17	3,566	3,835	56,726	14.79	17
18	19,130	20,555	197,942	9.63	18
19	2,628	2,817	29,889	10.61	19
20	2,231	2,080	92,658	44.55	20
21					21
22					22
23					23
24	19,506	21,241	381,235	17.95	24
25					25
26					26
27					27
28					28
29					29
30					30
31	4,333	4,653	59,174	12.72	31
32					32
33					33
34	295,016	316,887	\$ 5,149,713 *	\$ 16.25	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		\$		35
36	Monthly	54,410	5,9,3	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 (lines 35 - 48)	\$ 54,410		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	329	\$ 8,546	5,10,3	50
51				51
52				52
53	329	\$ 8,546		53

Facility Name & ID Number ManorCare at Arlington Heights# 0027433Report Period Beginning: 06/01/02Ending: 05/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$7,143
- (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 \$2,551
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,476 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. \$ 82,673
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 benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,048
- (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: _____ 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.