



Facility Name & ID Number Manorcare at Arlington Heights

# 0027433 Report Period Beginning: 06/01/07 Ending: 05/31/08

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>55,266</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>55,266</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,868</u>	<u>7,087</u>	<u>27,797</u>	<u>44,752</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,868</u>	<u>7,087</u>	<u>27,797</u>	<u>44,752</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.98%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 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 151 and days of care provided 23,386

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Manorcare at Arlington Heights # 0027433 Report Period Beginning: 06/01/07 Ending: 05/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	416,313	35,587	1,246	453,146	4,212	457,358		457,358		1
2	Food Purchase		254,561		254,561		254,561	(6,971)	247,590		2
3	Housekeeping	214,404	28,534	8,889	251,827		251,827		251,827		3
4	Laundry	38,472	13,196	2,304	53,972		53,972		53,972		4
5	Heat and Other Utilities			202,857	202,857	9,661	212,518		212,518		5
6	Maintenance	65,985	21,043	108,258	195,286		195,286		195,286		6
7	Other (specify):* <b>Medical Waste</b>			1,276	1,276		1,276		1,276		7
8	<b>TOTAL General Services</b>	<b>735,174</b>	<b>352,921</b>	<b>324,830</b>	<b>1,412,925</b>	<b>13,873</b>	<b>1,426,798</b>	<b>(6,971)</b>	<b>1,419,827</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			80,000	80,000		80,000		80,000		9
10	Nursing and Medical Records	3,817,753	289,055	168,236	4,275,044	45	4,275,089		4,275,089		10
10a	Therapy	1,337,749	5,785	351,031	1,694,565		1,694,565		1,694,565		10a
11	Activities	78,594	3,630	3,703	85,927		85,927	(250)	85,677		11
12	Social Services	215,494		868	216,362		216,362		216,362		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>5,449,590</b>	<b>298,470</b>	<b>603,838</b>	<b>6,351,898</b>	<b>45</b>	<b>6,351,943</b>	<b>(250)</b>	<b>6,351,693</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	110,039		741,408	851,447	(176,879)	674,568		674,568		17
18	Directors Fees										18
19	Professional Services			6,786	6,786	7,764	14,550	(14,550)			19
20	Dues, Fees, Subscriptions & Promotions			72,920	72,920		72,920	(27,534)	45,386		20
21	Clerical & General Office Expenses	404,983	70,983	174,382	650,348		650,348	(263,611)	386,737		21
22	Employee Benefits & Payroll Taxes			1,164,237	1,164,237	98,764	1,263,001		1,263,001		22
23	Inservice Training & Education			4,524	4,524		4,524		4,524		23
24	Travel and Seminar			10,515	10,515		10,515		10,515		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			213,877	213,877		213,877		213,877		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>515,022</b>	<b>70,983</b>	<b>2,388,649</b>	<b>2,974,654</b>	<b>(70,351)</b>	<b>2,904,303</b>	<b>(305,695)</b>	<b>2,598,608</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>6,699,786</b>	<b>722,374</b>	<b>3,317,317</b>	<b>10,739,477</b>	<b>(56,433)</b>	<b>10,683,044</b>	<b>(312,916)</b>	<b>10,370,128</b>		<b>29</b>

\*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: 06/01/07 Ending: 05/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			305,347	305,347	29,759	335,106		335,106		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			5,128	5,128	26,674	31,802		31,802		32
33	Real Estate Taxes			378,313	378,313		378,313		378,313		33
34	Rent-Facility & Grounds			63,364	63,364		63,364		63,364		34
35	Rent-Equipment & Vehicles			102,500	102,500		102,500		102,500		35
36	Other (specify):* <b>Loss on Fixed Assets</b>			(35)	(35)		(35)	35			36
37	<b>TOTAL Ownership</b>			854,617	854,617	56,433	911,050	35	911,085		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			870	870		870		870		38
39	Ancillary Service Centers		1,037,044		1,037,044		1,037,044		1,037,044		39
40	Barber and Beauty Shops			21,549	21,549		21,549		21,549		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			82,674	82,674		82,674		82,674		42
43	Other (specify):* <b>IV   X-ray &amp; Lab</b>		209,403	177,663	387,066		387,066		387,066		43
44	<b>TOTAL Special Cost Centers</b>		1,246,447	282,756	1,529,203		1,529,203		1,529,203		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,699,786	1,968,821	4,454,690	13,123,297		13,123,297	(312,881)	12,810,416		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:

06/01/07

Ending:

05/31/08

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,971)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(200)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(727)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,550)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(261,579)	21		24
25	Fund Raising, Advertising and Promotional	(27,534)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,320)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (312,881)		\$	30

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)		10a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (312,881)		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.

		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Arlington Heights

ID# 0027433

Report Period Beginning: 06/01/07

Ending: 05/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (1,105)	21	1
2	Misc. Income	0	21	2
3	Activity Income	(250)	11	3
4	Gain/Loss on Desposal of Fixed Assets	35	36	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,320)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Manorcare at Arlington Heights

# 0027433

Report Period Beginning:

06/01/07

Ending:

05/31/08

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,971)	0	0	0	0	0	0	0	0	0	0	(6,971)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,971)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,971)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(250)	0	0	0	0	0	0	0	0	0	0	(250)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(250)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(250)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,550)	0	0	0	0	0	0	0	0	0	0	(14,550)	19
20	Fees, Subscriptions & Promotions	(27,534)	0	0	0	0	0	0	0	0	0	0	(27,534)	20
21	Clerical & General Office Expenses	(263,611)	0	0	0	0	0	0	0	0	0	0	(263,611)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(305,695)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(305,695)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(312,916)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(312,916)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Arlington Heights

# 0027433

Report Period Beginning:

06/01/07 Ending:

Summary B

05/31/08

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	35	0	0	0	0	0	0	0	0	0	0	35	36
37	<b>TOTAL Ownership</b>	<b>35</b>	<b>0</b>	<b>35</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(312,881)</b>	<b>0</b>	<b>(312,881)</b>	<b>45</b>									

Facility Name & ID Number Manorcare at Arlington Heights

# 0027433

Report Period Beginning:

06/01/07

Ending:

05/31/08

**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)				

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 Home Allocation	\$ 740,852	HCR Manor Care, Inc.	100.00%	\$ 740,852	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	78,488	Heartland Management Services	100.00%	78,488	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 819,340			\$ 819,340	\$ *

\* 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: 06/01/07 Ending: 05/31/08

## 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: 06/01/07

Ending: 05/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.	\$ 59,848	\$ 12,532,064	\$ 267	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	1,061,370	577,717	12,532,064	3,945	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.	497,772		12,532,064	2,217	3
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	2,002,556		12,532,064	7,444	4
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.			12,532,064	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	2,100,636	1,287,391	12,532,064	7,809	6
7	17	General & Admin - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.	41,222,846	32,327,667	12,532,064	183,606	7
8	17	General & Admin - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	102,324,370	42,519,840	12,532,064	380,367	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.	7,830,100		12,532,064	34,875	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	17,187,062		12,532,064	63,889	10
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.			12,532,064	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	8,005,430		12,532,064	29,759	12
13										13
14	32	Interest				3,167,921			26,674	14
15		Non-Nursing Home Allocations				23,250,237				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 208,710,148	\$ 76,712,615		\$ 740,852	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

10	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Conv. Sub. Debentures		X	Facility			\$ 849,537	\$ 849,537		3.1398	\$ 26,674	1
2	National City		X				116,222	116,222		6.2467	7,260	2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8	Interest Income Other										(2,132)	8
9	<b>TOTAL Facility Related</b>						\$ 965,759	\$ 965,759			\$ 31,802	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 965,759	\$ 965,759			\$ 31,802	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 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 Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Manorcare at Arlington Heights COUNTY Cook

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 2007 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 2007.

(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 Attahed</u>	\$ <u>198,741.28</u>	\$ <u>198,741.28</u>
2. <u>08-09-101-001-0000</u>	<u>See Attahed</u>	\$ <u>178,500.06</u>	\$ <u>178,500.06</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>377,241.34</u>	\$ <u>377,241.34</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 original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Manorcare at Arlington Heights

# 0027433 Report Period Beginning:

06/01/07 Ending:

05/31/08

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

None

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>	1
2					2
3	<b>TOTALS</b>			\$ <b>111,118</b>	3

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

# **0027433**

Report Period Beginning:

**06/01/07**

Ending:

**05/31/08**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	151		1973	1969	\$ 2,165,884	\$ (41,425)		\$ (41,425)	\$	\$ 2,454,321	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	<b>Current Year Depreciation</b>					205,512		205,512		3,284,486	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	<b>RETIREMENTS</b>			1987	(62,983)						20
21				1988	23,991						21
22				1989	51,409						22
23				1990	58,556						23
24				1991	222,698						24
25				1992	767,104						25
26	<b>RETIREMENTS</b>			1992	(18,208)						26
27				1993	52,576						27
28				1994	623,228						28
29				1995	44,468						29
30				1996	155,020						30
31				1997	239,795						31
32				1998	239,169						32
33				1999	61,954						33
34				2000	120,258						34
35	<b>Per Audit remove \$28,409, Add \$62,419 from 2002</b>			2001	244,972						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number    Manorcare at Arlington Heights

#    0027433

Report Period Beginning:

06/01/07

Ending:

05/31/08

**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	SMOKE WALLS	2002	\$ 6,877	\$		\$	\$	\$	37
38	GENERAL OVERHEAD & INTEREST	2002	19,105						38
39	C/R 5/31/03 AUDIT ADJ. #2b - Overhead & Interest	2002	(19,105)						39
40	CARPENTRY/BUILDING WIRE per audit move 62,419 to 2001	2002	43,118						40
41	CARPETING AND WALLCOVERINGS	2002	14,091						41
42	FLOORING	2002	2,022						42
43	RETROACTIVE ADDITION per audit remove 1,391	2003							43
44	DEVELOPERS COST - OVERHD & INT. disallowed per audit	2003							44
45	CARPENTRY	2003	56,052						45
46	MILLWORK	2003	8,634						46
47	CARPETING AND PADS	2003	3,225						47
48	WALLCOVERINGS	2003	2,117						48
49	BASIC ELECTRICAL	2003	7,658						49
50	EXTERIOR SIGN	2003	562						50
51	CARPET	2003	428						51
52	CARPET	2003	428						52
53	FREIGHT ON CARPET	2003	58						53
54	FREIGHT ON CARPET	2003	139						54
55	CARPET AND VWC	2003	2,650						55
56	COUNTERTOP	2003	1,148						56
57	SIGNAGE - \$1,244 Retired 10/31/07	2003							57
58	CARPET	2004	10,000						58
59	CARPET	2004	4,174						59
60	FABRIC	2004	134						60
61	FLOORING	2004	978						61
62	CARPET	2004	511						62
63	Renov. - General Overhead & Interest Disallowed per audit	2004							63
64	Renov. - Carpeting	2004	2,582						64
65	Renov. - Wallcovering & Corner Guards	2004	11,595						65
66	Renov. - Carpentry \$5,100.00 disallowed per audit	2004	209,960						66
67	Renov. - Millwork Change year to 2003 per audit	2003	19,260						67
68	Renov. - Doors Change to 2003 per audit	2003	39,835						68
69	Wallcovering & Corner Guards	2004	2,125						69
70	TOTAL (lines 4 thru 69)		\$ 5,854,108	\$ 164,087		\$ 164,087	\$	\$ 5,738,807	70

\*\*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:

06/01/07

Ending:

05/31/08**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,854,108	\$ 164,087		\$ 164,087	\$	\$ 5,738,807	1
2	Doors	2004	18,900						2
3	Carpet	2004	5,184						3
4	Handrails & Backer Board	2004	7,990						4
5	Windows	2004	4,946						5
6	Wallcovering, Border & Flooring	2004	5,700						6
7	Electrical Work in Laundry Room	2004	2,742						7
8	Pave Parking Lot, and Stripe & Mark	2004	42,166						8
9	Renov. - General Overhead & Interest Disallowed per audit 4,331	2005							9
10	Renov. - Flooring	2005	18,359						10
11	Renov. - Windows	2005	2,516						11
12	Renov. - Wallcovering & Guards	2005	6,095						12
13	Emergency Electrical Circuit & Light Fixtures	2005	19,672						13
14									14
15	Drainage, Doors, & Brickwork	2005	16,636						15
16	Carpet	2005	1,027						16
17	Electrical work for emergency circuits	2005	4,780						17
18	Door, Frame, & tuckpoint	2005	6,961						18
19	Plumbing - re-configuartion for sink drains	2006	2,460						19
20									20
21	Stair Railings	2006	6,750						21
22	Plumbing - Chiller lines	2006	2,314						22
23	Plumbing - Exterior	2006	17,748						23
24	Carpet	2006	358						24
25	Electrical Work - Install electric heaters	2006	3,985						25
26									26
27	Electrical - 4 emergency outlets in Arlington Corridor	2007	1,955						27
28	Electrical - repair wiring for rooms 152, 154, & 156	2007	2,498						28
29	Foundation Unerdpinning - Pier jacking (7 areas)	2007	16,420						29
30	Foundation Work - Slapjacking 2450 sq feet	2007	3,675						30
31	Renov. - Flooring & Wallcovering	2007	66,271						31
32	Renov. - Carpentry-subcontr	2007	16,701						32
33	Doors	2007	12,641						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,171,558	\$ 164,087		\$ 164,087	\$	\$ 5,738,807	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:

06/01/07

Ending:

05/31/08

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,171,558	\$ 164,087		\$ 164,087	\$	\$ 5,738,807	1
2	Renov. - Hot Water Boilers (2)	2007	64,296						2
3	Foundation Work - Slapjacking 2450 sq feet	2007	3,675						3
4	H.I. Renov. - Concrete Work	2007	4,584						4
5	H.I. Renov. - HM Doors	2007	4,335						5
6	H.I. Renov. - Flooring	2007	9,514						6
7	H.I. Renov. - Carpeting	2007	5,170						7
8	H.I. Renov. - Wallcovering	2007	29,086						8
9	H.I. Renov. - Cubical Curtains	2007	20,352						9
10	H.I. Renov. - Window Treatment	2007	4,070						10
11	H.I. Renov. - Basic Electrical	2007	11,484						11
12	H.I. Renov. - R.Callahan Construction Company	2007	670,422						12
13	Renov. - HVAC	2007	8,550						13
14	Renov. - Flooring	2007	5,677						14
15	main electrical panel	2007	7,335						15
16	TYCO SPRINLER SYSTEM	2008	5,713						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	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,025,820	\$ 164,087		\$ 164,087	\$	\$ 5,738,807	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: 06/01/07 Ending: 05/31/08

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	\$ 2,221,243	\$ 141,260	\$ 141,260	\$		\$ 1,674,228	71
72	Current Year Purchases	248,812						72
73	Fully Depreciated Assets							73
74	Home Office Depr.			29,759	29,759			74
75	TOTALS	\$ 2,470,055	\$ 141,260	\$ 171,019	\$ 29,759		\$ 1,674,228	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,606,993	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 305,347	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 335,106	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,759	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,413,035	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 102,500 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. 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	N/A		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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	5738 hrs	\$ 199,455	2,874	\$ 168,978	\$ 4,167	8,612	\$ 372,600	1
2	Licensed Speech and Language Development Therapist	10a	3419 hrs	118,837	154	9,072	494	3,573	128,403	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	12041 hrs	418,592	1,573	92,479	1,124	13,614	512,195	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				1,037,044		1,037,044	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>X-ray &amp; Lab   IV Ther</u>	43, 3 & 2				177,663	209,403		387,066	13
14	TOTAL			\$ 736,884	4,601	\$ 448,192	\$ 1,252,232	25,799	\$ 2,437,308	14

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

Facility Name & ID Number Manorcare at Arlington Heights# 0027433Report Period Beginning: 06/01/07

Ending:

05/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 05/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 780	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>448,865</u> )	2,454,534		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,616		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,459,930	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,118		13
14	Buildings, at Historical Cost	7,025,820		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,470,055		16
17	Accumulated Depreciation (book methods)	(7,413,035)		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): <u>CIP</u>	95,888		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,289,846	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,749,776	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 82,440	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	592,370		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	357,175		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Payable</u>	300,402		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,332,387	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	116,222		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	18,079		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 134,301	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,466,688	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,283,088	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,749,776	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,717,282	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,717,282	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,714,834	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)	\$ 1,714,834	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	(1,149,028)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,149,028)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,283,088	24 *

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

Facility Name & ID Number Manorcare at Arlington Heights# 0027433Report Period Beginning: 06/01/07Ending: 05/31/08**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,985,579	1
2	Discounts and Allowances for all Levels	(951,876)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,033,703	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,626,950	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,626,950	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,105	12
13	Barber and Beauty Care	22,004	13
14	Non-Patient Meals	6,791	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,146,169	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,407	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,177,476	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	15	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc. Income &amp; Purchase Discounts</b>	(13)	28
28a	<b>Late Charges</b>		28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (13)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,838,131	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,412,925	31
32	Health Care	6,351,898	32
33	General Administration	2,974,654	33
<b>B. Capital Expense</b>			
34	Ownership	854,617	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,446,529	35
36	Provider Participation Fee	82,674	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,123,297	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,714,834	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,714,834	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:

06/01/07

Ending:

05/31/08

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,436	1,567	\$ 64,039	\$ 40.87	1
2	Assistant Director of Nursing	1,985	2,166	73,988	34.16	2
3	Registered Nurses	48,670	53,112	1,674,600	31.53	3
4	Licensed Practical Nurses	21,176	23,109	577,363	24.98	4
5	CNAs & Orderlies	94,793	104,023	1,332,810	12.81	5
6	CNA Trainees					6
7	Licensed Therapist	21,198	23,231	807,546	34.76	7
8	Rehab/Therapy Aides	18,177	19,920	530,203	26.62	8
9	Activity Director	5,480	5,993	78,594	13.11	9
10	Activity Assistants					10
11	Social Service Workers	8,780	9,611	215,494	22.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,064	30,530	416,313	13.64	15
16	Dishwashers					16
17	Maintenance Workers	3,235	3,623	65,985	18.21	17
18	Housekeepers	17,813	19,485	214,404	11.00	18
19	Laundry	3,099	3,389	38,472	11.35	19
20	Administrator	2,080	2,080	110,039	52.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,823	20,835	404,983	19.44	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	4,763	5,212	94,953	18.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	299,572	327,886	\$ 6,699,786 *	\$ 20.43	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	80,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,247	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 88,247		49

**C. CONTRACT NURSES**

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





**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 \$13578
- (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 \$4382
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 69,580 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,674  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,971
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.