

Facility Name & ID Number Manorcare of Arlington Hgts

0050302 Report Period Beginning: 06/01/12 Ending: 05/31/13

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	151	Skilled (SNF)	151	55,115	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	151	TOTALS	151	55,115	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	9,018	4,419	24,165	37,602	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,018	4,419	24,165	37,602	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.22%

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 _____ 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 16,215

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL 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 of Arlington Hgts

0050302

Report Period Beginning:

06/01/12

Ending:

05/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	358,402	33,153	3,449	395,004		395,004		395,004		1
2	Food Purchase		299,916		299,916		299,916	(2,764)	297,152		2
3	Housekeeping	211,574	30,211	208	241,993		241,993		241,993		3
4	Laundry	43,563	14,159	2,802	60,524		60,524		60,524		4
5	Heat and Other Utilities			191,377	191,377	2,606	193,983		193,983		5
6	Maintenance	54,684	14,407	109,277	178,368		178,368		178,368		6
7	Other (specify):* Medical Waste			2,272	2,272		2,272		2,272		7
8	TOTAL General Services	668,223	391,846	309,385	1,369,454	2,606	1,372,060	(2,764)	1,369,296		8
	B. Health Care and Programs										
9	Medical Director			73,611	73,611		73,611		73,611		9
10	Nursing and Medical Records	3,981,968	356,240	154,484	4,492,692	16,241	4,508,933		4,508,933		10
10a	Therapy	1,839,395	7,912	35,414	1,882,721		1,882,721		1,882,721		10a
11	Activities	86,154	2,983	6,950	96,087		96,087		96,087		11
12	Social Services	195,080	532	19,412	215,024		215,024		215,024		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,102,597	367,667	289,871	6,760,135	16,241	6,776,376		6,776,376		16
	C. General Administration										
17	Administrative	123,672		593,483	717,155	(240,808)	476,347		476,347		17
18	Directors Fees										18
19	Professional Services			19,607	19,607	(830)	18,777	(18,777)			19
20	Dues, Fees, Subscriptions & Promotions			115,480	115,480		115,480	(52,358)	63,122		20
21	Clerical & General Office Expenses	492,228	54,425	212,184	758,837	830	759,667	(123,351)	636,316		21
22	Employee Benefits & Payroll Taxes			1,179,742	1,179,742	50,305	1,230,047		1,230,047		22
23	Inservice Training & Education			1,816	1,816		1,816		1,816		23
24	Travel and Seminar			5,411	5,411		5,411		5,411		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			862,560	862,560		862,560		862,560		26
27	Other (specify):*							(540)	(540)		27
28	TOTAL General Administration	615,900	54,425	2,990,283	3,660,608	(190,503)	3,470,105	(195,026)	3,275,079		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,386,720	813,938	3,589,539	11,790,197	(171,656)	11,618,541	(197,790)	11,420,751		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	D. Ownership											
30	Depreciation			335,913	335,913	18,475	354,388		354,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(5,712)	(5,712)	153,181	147,469		147,469			32
33	Real Estate Taxes			482,876	482,876		482,876		482,876			33
34	Rent-Facility & Grounds			63,364	63,364		63,364		63,364			34
35	Rent-Equipment & Vehicles			51,866	51,866		51,866		51,866			35
36	Other (specify):*											36
37	TOTAL Ownership			928,307	928,307	171,656	1,099,963		1,099,963			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			468	468		468		468			38
39	Ancillary Service Centers		617,607	1,310	618,917		618,917		618,917			39
40	Barber and Beauty Shops			9,616	9,616		9,616		9,616			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			212,604	212,604		212,604		212,604			42
43	Other (specify):* IV X-Ray & Lab		180,940	160,200	341,140		341,140		341,140			43
44	TOTAL Special Cost Centers		798,547	384,198	1,182,745		1,182,745		1,182,745			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,386,720	1,612,485	4,902,044	13,901,249		13,901,249	(197,790)	13,703,459			45

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

Facility Name & ID Number Manorcare of Arlington Hgts

0050302

Report Period Beginning: 06/01/12

Ending: 05/31/13

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,764)	2		4
5	Telephone, TV & Radio in Resident Rooms				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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(170)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(540)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(16,683)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(98,127)	21		24
25	Fund Raising, Advertising and Promotional	(52,358)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(27,148)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (197,790)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (197,790)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

Manorcare of Arlington Hgts

ID# 0050302

Report Period Beginning: 06/01/12

Ending: 05/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Wage - Marketing	\$ (19,240)	21	1
2	Employee benefits - Marketing	(5,184)	21	2
3	HCP Lease Interest	0	32	3
4	Vending Income	(630)	21	4
5	Misc. Income	0	21	5
6	Activity Income	0	11	6
7	Loss on Disposal of Fixed Assets	0	36	7
8	Acct. Fees for Collections	(2,094)	19	8
9	Collection Agency Fees	0	19	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		(27,148)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/12

Ending:

05/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,764)	0	0	0	0	0	0	0	0	0	0	(2,764)	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	(2,764)	0	0	0	0	0	0	0	0	0	0	(2,764)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,777)	0	0	0	0	0	0	0	0	0	0	(18,777)	19
20	Fees, Subscriptions & Promotions	(52,358)	0	0	0	0	0	0	0	0	0	0	(52,358)	20
21	Clerical & General Office Expenses	(123,351)	0	0	0	0	0	0	0	0	0	0	(123,351)	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):*	(540)	0	0	0	0	0	0	0	0	0	0	(540)	27
28	TOTAL General Administration	(195,026)	0	0	0	0	0	0	0	0	0	0	(195,026)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(197,790)	0	0	0	0	0	0	0	0	0	0	(197,790)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/12 Ending:05/31/13

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	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(197,790)	0	0	0	0	0	0	0	0	0	0	(197,790)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	Toledo	home office
				HL Empl Svcs, LLC	Toledo	personnel
				HL Rehab Svcs, LLC	Toledo	therapy mgmt svcs
				HL Rehab Svcs, LLC	Toledo	therapy services
				HL Home Health Care	Toledo	nursing staff

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Home Office Allocation	\$ 593,483	HCR Manor Care Services, LLC	100.00%	\$ 593,483	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	7,386,720	Heartland Employment Services, LLC	100.00%	7,386,720		4
5	V	10a Therapy Management	18,012	Heartland Rehabilitation Services, LLC	100.00%	18,012		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 7,998,215			\$ 7,998,215	\$ *	14

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

VII. RELATED PARTIES (continued)

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			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

Facility Name & ID Number

Manorcare of Arlington Hgts

0050302

Report Period Beginning:

06/01/12

Ending:

05/31/13

VII. RELATED PARTIES

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

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

Facility Name & ID Number

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0050302

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				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

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 of Arlington Hgts

0050302

Report Period Beginning:

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Ending: 05/31/13

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 Services, LLC
 Street Address 333 North Summit Street
 City / State / Zip Code Toledo, OH 43604-2617
 Phone Number (419) 252-5500
 Fax Number (419) 254-5495

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	5	Utilities - Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,R	\$ 748,673	\$ 13,923,623	\$ 2,606	1	
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs		13,923,623	0	2	
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	517,936,312	48 NFs		13,923,623	0	3	
4									4	
5	10	Nursing - Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,Rehal	419,407	305,829	13,923,623	1,460	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs	3,769,374	11,422,621	13,923,623	14,781	6
7	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	517,936,312	48 NFs		13,923,623	0	7	
8									8	
9	17	Gen/Admin-Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,Rehal	66,682,648	33,182,703	13,923,623	232,145	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs	18,146,595	4,833,950	13,923,623	71,160	10
11	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	517,936,312	48 NFs	1,836,474	1,251,307	13,923,623	49,370	11
12									12	
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,Rehal	7,480,805		13,923,623	26,043	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs	6,187,019		13,923,623	24,262	14
15	22	Empl Bnfts-Direct to MW Div SN	Accumulated Cost	517,936,312	48 NFs			13,923,623	0	15
16									16	
17	30	Depreciation - Pooled	Accumulated Cost	3,999,514,966	682 NFs,HHs,Rehal	4,579,765		13,923,623	15,944	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,550,656,576	354 NFs	645,474		13,923,623	2,531	18
19	30	Depr - Direct to MW Div SNFs	Accumulated Cost	517,936,312	48 NFs			13,923,623	0	19
20									20	
21									21	
22	32	Pooled Interest	Accumulated Cost	3,999,514,966		25,871,304		13,923,623	90,066	22
23	32	Directly Assigned Interest	Not Allocated			18,513,013			63,115	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				30,612,518				24
25	TOTALS					\$ 185,493,069	\$ 50,996,410	\$ 593,483	25	

Facility Name & ID Number

Manorcare of Arlington Hgts

0050302

Report Period Beginning:

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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	Various			\$ 965,859	\$ 965,859		6.5346	\$ 63,115						
2																	
3																	
4																	
5																	
	Working Capital																
6	Home Office Pooled Interest Expense										90,066						
7	Interest Income / Interest Expense										(5,712)						
8																	
9	TOTAL Facility Related							\$ 965,859	\$ 965,859			\$ 147,469					
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related							\$	\$			\$					
15	TOTALS (line 9+line14)							\$ 965,859	\$ 965,859			\$ 147,469					

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.)

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Arlington Hgts COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0050302
 CONTACT PERSON REGARDING THIS REPORT Gary Geise
 TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(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>08-09-101-011-0000</u>	<u>See attached</u>	\$ <u>231,040.08</u>	\$ <u>231,040.08</u>
2. <u>08-04-100-008-0000</u>	<u>See attached</u>	\$ <u>239,005.84</u>	\$ <u>239,005.84</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>470,045.92</u></u>	\$ <u><u>470,045.92</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Manorcare of Arlington Hgts

0050302 Report Period Beginning:

06/01/12 Ending:

05/31/13

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).

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	TOTALS			\$ 111,118	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	151		1973	1969	\$ 2,165,884	\$ (41,425)		\$ (41,425)	\$	\$ 2,247,195	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					188,170		188,170		4,464,729	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		RETIREMENTS		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		RETIREMENTS		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		Per Audit remove \$28,409, Add \$62,419 from 2002		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 & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/12

Ending:

05/31/13**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>SMOKE WALLS</u>	2002	\$ 6,877	\$		\$	\$	\$	37
38	<u>GENERAL OVERHEAD & INTEREST</u>	2002	19,105						38
39	<u>C/R 5/31/03 AUDIT ADJ. #2b - Overhead & Interest</u>	2002	(19,105)						39
40	<u>CARPENTRY/BUILDING WIRE per audit move 62,419 to 2001</u>	2002	43,118						40
41	<u>CARPETING AND WALLCOVERINGS</u>	2002	14,091						41
42	<u>FLOORING</u>	2002	2,022						42
43	<u>RETROACTIVE ADDITION per audit remove 1,391</u>	2003							43
44	<u>DEVELOPERS COST - OVERHD & INT. disallowed per audit</u>	2003							44
45	<u>CARPENTRY</u>	2003	56,052						45
46	<u>MILLWORK</u>	2003	8,634						46
47	<u>CARPETING AND PADS</u>	2003	3,225						47
48	<u>WALLCOVERINGS</u>	2003	2,117						48
49	<u>BASIC ELECTRICAL</u>	2003	7,658						49
50	<u>EXTERIOR SIGN</u>	2003	562						50
51	<u>CARPET</u>	2003	428						51
52	<u>CARPET</u>	2003	428						52
53	<u>FREIGHT ON CARPET</u>	2003	58						53
54	<u>FREIGHT ON CARPET</u>	2003	139						54
55	<u>CARPET AND VWC</u>	2003	2,650						55
56	<u>COUNTERTOP</u>	2003	1,148						56
57	<u>SIGNAGE - \$1,244 Retired 10/31/07</u>	2003							57
58	<u>CARPET</u>	2004	10,000						58
59	<u>CARPET</u>	2004	4,174						59
60	<u>FABRIC</u>	2004	134						60
61	<u>FLOORING</u>	2004	978						61
62	<u>CARPET</u>	2004	511						62
63	<u>Renov. - General Overhead & Interest Disallowed per audit</u>	2004							63
64	<u>Renov. - Carpeting</u>	2004	2,582						64
65	<u>Renov. - Wallcovering & Corner Guards</u>	2004	11,595						65
66	<u>Renov. - Carpentry \$5,100.00 disallowed per audit</u>	2004	209,960						66
67	<u>Renov. - Millwork Change year to 2003 per audit</u>	2003	19,260						67
68	<u>Renov. - Doors Change to 2003 per audit</u>	2003	39,835						68
69	<u>Wallcovering & Corner Guards</u>	2004	2,125						69
70	TOTAL (lines 4 thru 69)		\$ 5,854,108	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	70

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

Facility Name & ID Number Manorcare of Arlington Hgts

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,854,108	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	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	TOTAL (lines 1 thru 33)		\$ 6,171,558	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	34

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

Facility Name & ID Number Manorcare of Arlington Hgts

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05/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,171,558	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	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	28,933						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 SPRINKLER SYSTEM	2008	5,713						16
17									17
18	Frabricate & Install Window Screens & Caulk Around	2008	20,322						18
19	Renov. - Flooring	2008	3,707						19
20	Renov. - Carpentry	2008	11,117						20
21	Renov. - Painting	2008	5,325						21
22	Renov. - Ceiling	2008	11,842						22
23	Renov. - Flooring	2008	11,685						23
24	Renov. - Wallcovering & Corner Guards	2008	8,812						24
25	Renov. - Hand Rail	2008	7,569						25
26	Renov. - Electrical	2008	7,085						26
27	Renov. - Plumbing	2008	7,101						27
28	KITCHEN DOORS	2008	14,178						28
29	EAST ELEVATOR UPGRADE	2008	6,475						29
30	WEST ELEVATOR UPGRADE	2008	6,475						30
31	Renov. - HVAC chiller 60 Ton Trane Model CGAFC60E	2008	56,602						31
32	6FT FENCE	2008	2,735						32
33	PVC GATE	2008	2,770						33
34	TOTAL (lines 1 thru 33)		\$ 7,209,468	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	34

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

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0050302

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,209,468	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	1
2	<u>Provide & Install multiple Metal Doors</u>	2009	16,108						2
3									3
4	<u>0309 Elevator Upgrade - Elevators</u>	2009	60,450						4
5	<u>0309 Elevator Upgrade - Doors & Frames</u>	2009	4,485						5
6	<u>Ceiling</u>	2009	2,820						6
7	<u>Hollow Metal Door</u>	2009	5,185						7
8	<u>Thermal Detection for Fire</u>	2009	5,155						8
9	<u>1509 Drainage Piping - Plumbing Piping</u>	2009	33,800						9
10	<u>0409 Boiler Replacement - Engineering Mechanical</u>	2009	65,183						10
11	<u>Second Floor Sprinkler Heads</u>	2009	17,550						11
12	<u>SS Dishwash Exhaust</u>	2010	11,420						12
13									13
14	<u>electrical upgrade - New AC Units in Kitchen</u>	2010	5,494						14
15	<u>Proj 0510 Williamsburg Reno - Ceiling Tile</u>	2010	4,100						15
16	<u>Proj 0510 Williamsburg Reno - Flooring</u>	2010	49,349						16
17	<u>Proj 0510 Williamsburg Reno - Carpeting</u>	2010	19,906						17
18	<u>Proj 0510 Williamsburg Reno - Wall Covering</u>	2010	5,606						18
19	<u>Proj 0510 Williamsburg Reno - Corner Guards</u>	2010	2,104						19
20	<u>Proj 0510 Williamsburg Reno - Millwork</u>	2010	13,952						20
21	<u>Proj 0510 Williamsburg Reno - Basic Electrical</u>	2010	3,370						21
22	<u>5 exterior windows</u>	2010	10,040						22
23	<u>elevator shaft sprinkler head</u>	2010	4,075						23
24	<u>Proj 0510 Williamsburg Reno - Overhead and interest disallowed (</u>	2010							24
25									25
26	<u>Fire Rated Hatch</u>	2011	2,984						26
27	<u>Doors HM (3)</u>	2011	9,413						27
28	<u>Chiller, Mltiaqua 10-Ton</u>	2011	22,900						28
29	<u>Flooring (Hallway 18X18)</u>	2011	1,460						29
30	<u>Data & Phone Relocation - Renov. 22-10C</u>	2011	1,105						30
31	<u>Concrete floor jacking - Renov. 22-10C</u>	2011	21,875						31
32	<u>Sewer drian replacement - Renov. 22-10C</u>	2011	80,249						32
33	<u>Carpeting - Renov. 22-10C</u>	2011	8,197						33
34	TOTAL (lines 1 thru 33)		\$ 7,697,803	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,697,803	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	1
2	PTAC Unit installation	2011	6,090						2
3	Electrical wiring & breakers	2011	4,340						3
4	Elevator Cylinder, & PVC Liner	2011	14,985						4
5	Windows (3) Crystal Series	2011	8,024						5
6									6
7	Electrical Upgrade	2012	5,381						7
8	Elevator Hydraulic Pump	2013	7,650						8
9	Phone System Upgrade	2013	11,225						9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,755,498	\$ 146,745		\$ 146,745	\$	\$ 6,711,924	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,038,212	\$ 189,168	\$ 189,168	\$		\$ 2,636,896	71
72	Current Year Purchases	55,778						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			18,475	18,475			74
75	TOTALS	\$ 3,093,990	\$ 189,168	\$ 207,643	\$ 18,475		\$ 2,636,896	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	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)	\$ 10,960,606	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 335,913	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 354,388	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,475	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,348,820	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: Northwest Community Healthcare

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1969</u>		<u>12/19/1972</u>	\$ <u>63,364</u>	<u>41</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>63,364</u>			7

10. Effective dates of current rental agreement:

Beginning 01/01/2009

Ending 12/31/2013

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

Fiscal Year Ending Annual Rent

12. 05/31/2014 \$ 36,962

13. /2015 \$ _____

14. /2016 \$ _____

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: \$ 51,866 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Manorcare of Arlington Hgts # 0050302 Report Period Beginning: 06/01/12 Ending: 05/31/13
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?</p> <p><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 CNA _____</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 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)		
TOTAL TRAINED		

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist	10a, 1	10654	hrs	\$ 440,480	24	\$ 1,494	\$ 692	10,678	\$ 442,666	1	
2	Licensed Speech and Language Development Therapist	10a, 1	3519	hrs	145,515				3,519	145,515	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a, 1	13364	hrs	552,545	252	15,900	7,220	13,616	575,665	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				617,607		617,607	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): <u>IV Therapy</u>	43, 2						180,940		180,940	12	
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					160,200			160,200	13	
14	TOTAL				\$ 1,138,540	276	\$ 177,594	\$ 806,459	27,813	\$ 2,122,593	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 of Arlington Hgts# 0050302Report Period Beginning: 06/01/12

Ending:

05/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/13

(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	\$ (4,375)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>435,439</u>)	1,653,227		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,892		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,651,744	\$	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	7,755,498		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,093,990		16
17	Accumulated Depreciation (book methods)	(9,348,820)		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>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,611,786	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,263,530	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 160,497	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	764,351		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	419,467		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payables</u>	210,760		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,555,075	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	965,859		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 965,859	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,520,934	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 742,596	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,263,530	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,002,872	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,002,872	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	32,466	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)	\$ 32,466	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(292,742)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (292,742)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 742,596	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,169,718	1
2	Discounts and Allowances for all Levels	(6,218,453)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,951,265	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,907,139	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,907,139	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	630	12
13	Barber and Beauty Care	8,702	13
14	Non-Patient Meals	2,764	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	914,411	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	78,250	20
21	Other Medical Services	70,554	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,075,311	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)		26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Income		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,933,715	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,369,454	31
32	Health Care	6,760,135	32
33	General Administration	3,660,608	33
B. Capital Expense			
34	Ownership	928,307	34
C. Ancillary Expense			
35	Special Cost Centers	970,141	35
36	Provider Participation Fee	212,604	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,901,249	40
41	Income before Income Taxes (line 30 minus line 40)**	32,466	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 32,466	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 965,146	44
45	Private Pay - Net Inpatient Revenue	1,138,808	45
46	Medicare - Net Inpatient Revenue	4,475,321	46
47	Other-(specify) <u>HOSP</u>	158,667	47
48	Other-(specify) <u>INSURANCE</u>	1,213,323	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,951,265	49

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

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

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

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

Facility Name & ID Number Manorcare of Arlington Hgts

0050302

Report Period Beginning:

06/01/12

Ending:

05/31/13

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	1,914	2,091	\$ 97,368	\$ 46.57	1
2	Assistant Director of Nursing	3,882	4,242	158,870	37.45	2
3	Registered Nurses	57,004	62,289	2,100,832	33.73	3
4	Licensed Practical Nurses	10,874	11,882	301,878	25.41	4
5	CNAs & Orderlies	90,915	99,673	1,244,409	12.48	5
6	CNA Trainees					6
7	Licensed Therapist	27,537	30,100	1,244,515	41.35	7
8	Rehab/Therapy Aides	20,427	22,328	594,880	26.64	8
9	Activity Director	5,428	5,937	86,154	14.51	9
10	Activity Assistants					10
11	Social Service Workers	7,076	7,737	195,080	25.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,885	26,138	358,402	13.71	15
16	Dishwashers					16
17	Maintenance Workers	2,296	2,513	54,684	21.76	17
18	Housekeepers	15,921	17,424	211,574	12.14	18
19	Laundry	3,792	4,142	43,563	10.52	19
20	Administrator	2,080	2,080	108,736	52.28	20
21	Assistant Administrator	339	339	14,936	44.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,757	20,557	467,804	22.76	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	3,510	3,839	78,611	20.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	295,637	323,311	\$ 7,362,296 *	\$ 22.77	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	73,611	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	233	11,199	10, 1	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)	233	\$ 84,810		49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/12

Ending:

05/31/13**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 \$4163
- (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
- (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. \$ 59,053 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. \$ 212,604
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,764
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.