

Facility Name & ID Number Manorcare of Arlington Hgts

0050302 Report Period Beginning: 06/01/13 Ending: 05/31/14

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	10,097	4,657	23,634	38,388	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,097	4,657	23,634	38,388	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.65%

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 16,529

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL 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:

06/01/13

Ending:

05/31/14

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	133,479	35,248	281,007	449,734		449,734		449,734		1
2	Food Purchase		282,528		282,528		282,528	(2,845)	279,683		2
3	Housekeeping	236,536	28,487	1,574	266,597		266,597		266,597		3
4	Laundry	53,987	15,137	7	69,131		69,131		69,131		4
5	Heat and Other Utilities			204,841	204,841	2,349	207,190		207,190		5
6	Maintenance	59,807	15,021	140,827	215,655		215,655		215,655		6
7	Other (specify):* Medical Waste			2,300	2,300		2,300		2,300		7
8	TOTAL General Services	483,809	376,421	630,556	1,490,786	2,349	1,493,135	(2,845)	1,490,290		8
	B. Health Care and Programs										
9	Medical Director			(611)	(611)		(611)		(611)		9
10	Nursing and Medical Records	4,220,071	344,458	116,102	4,680,631	10,238	4,690,869		4,690,869		10
10a	Therapy	1,955,810	12,030	36,465	2,004,305		2,004,305		2,004,305		10a
11	Activities	87,061	1,206	8,299	96,566		96,566	(38)	96,528		11
12	Social Services	195,531	448	3,626	199,605		199,605		199,605		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,458,473	358,142	163,881	6,980,496	10,238	6,990,734	(38)	6,990,696		16
	C. General Administration										
17	Administrative	99,113		575,677	674,790	(231,593)	443,197		443,197		17
18	Directors Fees										18
19	Professional Services			20,861	20,861		20,861	(20,861)			19
20	Dues, Fees, Subscriptions & Promotions			73,589	73,589		73,589	(46,069)	27,520		20
21	Clerical & General Office Expenses	474,334	64,605	518,066	1,057,005		1,057,005	(402,197)	654,808		21
22	Employee Benefits & Payroll Taxes			1,080,790	1,080,790	51,629	1,132,419		1,132,419		22
23	Inservice Training & Education			4,157	4,157		4,157		4,157		23
24	Travel and Seminar			4,677	4,677		4,677		4,677		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			318,911	318,911		318,911		318,911		26
27	Other (specify):*										27
28	TOTAL General Administration	573,447	64,605	2,596,728	3,234,780	(179,964)	3,054,816	(469,127)	2,585,689		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,515,729	799,168	3,391,165	11,706,062	(167,377)	11,538,685	(472,010)	11,066,675		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			255,150	255,150	17,376	272,526		272,526			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(30,567)	(30,567)	150,001	119,434		119,434			32
33	Real Estate Taxes			527,187	527,187		527,187		527,187			33
34	Rent-Facility & Grounds			73,349	73,349		73,349		73,349			34
35	Rent-Equipment & Vehicles			47,192	47,192		47,192		47,192			35
36	Other (specify):*											36
37	TOTAL Ownership			872,311	872,311	167,377	1,039,688		1,039,688			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			(468)	(468)		(468)		(468)			38
39	Ancillary Service Centers		641,434		641,434		641,434		641,434			39
40	Barber and Beauty Shops			9,397	9,397		9,397		9,397			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			215,397	215,397		215,397		215,397			42
43	Other (specify):* IV X-Ray & Lab		172,990	136,345	309,335		309,335		309,335			43
44	TOTAL Special Cost Centers		814,424	360,671	1,175,095		1,175,095		1,175,095			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,515,729	1,613,592	4,624,147	13,753,468		13,753,468	(472,010)	13,281,458			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: 06/01/13

Ending: 05/31/14

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	(2,845)	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)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(5,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,796)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(396,214)	21		24
25	Fund Raising, Advertising and Promotional	(46,069)	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	(5,916)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (472,010)		\$	30

BHF USE ONLY					
48		49		50	51
					52

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

		1	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)	\$ (472,010)		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

Manorcare of Arlington Hgts

ID# 0050302

Report Period Beginning: 06/01/13

Ending: 05/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	HCP Lease Interest	\$ 0	32	1
2	Vending Income	(813)	21	2
3	Misc. Income	0	21	3
4	Activity Income	0	11	4
5	Loss on Disposal of Fixed Assets	0	36	5
6	Acct. Fees for Collections	(5,065)	19	6
7	Collection Agency Fees	0	19	7
8	Hospitality Income	(38)	11	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(5,916)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/13

Ending:

05/31/14

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	(2,845)	0	0	0	0	0	0	0	0	0	0	(2,845)	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	(2,845)	0	0	0	0	0	0	0	0	0	0	(2,845)	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	(38)	0	0	0	0	0	0	0	0	0	0	(38)	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	(38)	0	0	0	0	0	0	0	0	0	0	(38)	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	(20,861)	0	0	0	0	0	0	0	0	0	0	(20,861)	19
20	Fees, Subscriptions & Promotions	(46,069)	0	0	0	0	0	0	0	0	0	0	(46,069)	20
21	Clerical & General Office Expenses	(402,197)	0	0	0	0	0	0	0	0	0	0	(402,197)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(469,127)	0	0	0	0	0	0	0	0	0	0	(469,127)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(472,010)	0	0	0	0	0	0	0	0	0	0	(472,010)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/13 Ending:05/31/14

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)	(472,010)	0	0	0	0	0	0	0	0	0	0	(472,010)	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See Home Office Allocation	\$ 575,677	HCR Manor Care Services, LLC	100.00%	\$ 575,677	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	7,515,729	Heartland Employment Services, LLC	100.00%	7,515,729		4
5	V	10a Therapy Management	16,139	Heartland Rehabilitation Services, LLC	100.00%	16,139		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		\$ 8,107,545			\$ 8,107,545	\$ *	14

* 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:

06/01/13

Ending:

05/31/14

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

Report Period Beginning:

06/01/13

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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

Facility Name & ID Number Manorcare of Arlington Hgts # 0050302 Report Period Beginning: 06/01/13 Ending: 05/31/14

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:

06/01/13

Ending: 05/31/14

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	702 NFs,HHs,R	\$ 702,082		13,112,468	\$ 2,349	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	357 NFs			13,112,468	0	2
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	48 NFs			13,112,468	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	702 NFs,HHs,Rehat	421,070	303,971	13,112,468	1,409	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	357 NFs	2,331,970	10,787,378	13,112,468	8,829	6
7	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	48 NFs			13,112,468	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	702 NFs,HHs,Rehat	66,712,258	34,047,414	13,112,468	223,158	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	357 NFs	18,712,683	6,531,152	13,112,468	70,848	10
11	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	48 NFs	1,887,403	1,136,236	13,112,468	50,078	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	702 NFs,HHs,Rehat	7,831,139		13,112,468	26,196	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	357 NFs	6,717,577		13,112,468	25,433	14
15	22	Empl Bnfts-Direct to MW Div SN	Accumulated Cost	48 NFs			13,112,468	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	702 NFs,HHs,Rehat	4,454,722		13,112,468	14,901	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	357 NFs	653,747		13,112,468	2,475	18
19	30	Depr - Direct to MW Div SNFs	Accumulated Cost	48 NFs			13,112,468	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		25,923,280		13,112,468	86,715	22
23	32	Directly Assigned Interest	Not Allocated		18,563,246			63,286	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions			30,324,259				24
25	TOTALS				\$ 185,235,436	\$ 52,806,151		\$ 575,677	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.)

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		6.5523	\$ 63,286	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	Home Office Pooled Interest Expense										86,715	6					
7	Interest Income / Interest Expense										(30,567)	7					
8												8					
9	TOTAL Facility Related						\$ 965,859	\$ 965,859			\$ 119,434	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 965,859	\$ 965,859			\$ 119,434	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2013 report.		\$ <u>419,467</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <u>482,140</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>62,673</u>	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>456,138</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ <u>9,211</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$835 For 2003 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ <u>(835)</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <u>527,187</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2009 <u>435,357</u>	8	
	2010 <u>440,014</u>	9	
	2011 <u>448,057</u>	10	
	2012 <u>470,046</u>	11	
	2013 <u>504,468</u>	12	
<u>Line 2: \$482,140 = \$223,615 for the 2nd half of 2012 + \$258,525 for the 1st half of 2013.</u>			
<u>Line 4: \$456,138 = \$245,943 for the 2nd half 2013 + \$210,195 estimate for Jan-May 2014.</u>			
<u>Line 5: \$9,211 = \$278 for 2003 refund on line 6 + \$8,765 for 2013 reduction on current tax invoice + \$168 for 2011</u>			
		FOR BHF USE ONLY	
		13 FROM R. E. TAX STATEMENT FOR 2013 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 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 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-09-101-011-0000</u>	<u>See attached</u>	\$ <u>252,681.19</u>	\$ <u>252,681.19</u>
2. <u>08-04-100-008-0000</u>	<u>See attached</u>	\$ <u>251,786.98</u>	\$ <u>251,786.98</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>504,468.17</u></u>	\$ <u><u>504,468.17</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

06/01/13 Ending:

05/31/14

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)	\$	\$ 2,205,770	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					162,761		162,761		4,627,490	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:

06/01/13

Ending:

05/31/14**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	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	70

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

Facility Name & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/13

Ending:

05/31/14**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	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	1
2	<u>Doors</u>	2004	18,900						2
3	<u>Carpet</u>	2004	5,184						3
4	<u>Handrails & Backer Board</u>	2004	7,990						4
5	<u>Windows</u>	2004	4,946						5
6	<u>Wallcovering, Border & Flooring</u>	2004	5,700						6
7	<u>Electrical Work in Laundry Room</u>	2004	2,742						7
8	<u>Pave Parking Lot, and Stripe & Mark</u>	2004	42,166						8
9	<u>Renov. - General Overhead & Interest Disallowed per audit 4,331</u>	2005							9
10	<u>Renov. - Flooring</u>	2005	18,359						10
11	<u>Renov. - Windows</u>	2005	2,516						11
12	<u>Renov. - Wallcovering & Guards</u>	2005	6,095						12
13	<u>Emergency Electrical Circuit & Light Fixtures</u>	2005	19,672						13
14									14
15	<u>Drainage, Doors, & Brickwork</u>	2005	16,636						15
16	<u>Carpet</u>	2005	1,027						16
17	<u>Electrical work for emergency circuits</u>	2005	4,780						17
18	<u>Door, Frame, & tuckpoint</u>	2005	6,961						18
19	<u>Plumbing - re-configuartion for sink drains</u>	2006	2,460						19
20									20
21	<u>Stair Railings</u>	2006	6,750						21
22	<u>Plumbing - Chiller lines</u>	2006	2,314						22
23	<u>Plumbing - Exterior</u>	2006	17,748						23
24	<u>Carpet</u>	2006	358						24
25	<u>Electrical Work - Install electric heaters</u>	2006	3,985						25
26									26
27	<u>Electrical - 4 emergency outlets in Arlington Corridor</u>	2007	1,955						27
28	<u>Electrical - repair wiring for rooms 152, 154, & 156</u>	2007	2,498						28
29	<u>Foundation Unerdpinning - Pier jacking (7 areas)</u>	2007	16,420						29
30	<u>Foundation Work - Slapjacking 2450 sq feet</u>	2007	3,675						30
31	<u>Renov. - Flooring & Wallcovering</u>	2007	66,271						31
32	<u>Renov. - Carpentry-subcontr</u>	2007	16,701						32
33	<u>Doors</u>	2007	12,641						33
34	TOTAL (lines 1 thru 33)		\$ 6,171,558	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	34

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

Facility Name & ID Number Manorcare of Arlington Hgts

0050302

Report Period Beginning:

06/01/13

Ending:

05/31/14

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	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	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	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	34

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

Facility Name & ID Number Manorcare of Arlington Hgts

0050302

Report Period Beginning:

06/01/13

Ending:

05/31/14

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	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	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	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,697,803	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	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	Light fixture upgrade - whole building	2013	14,927						11
12	Windows Rooms 144, 125, 127, 116, & PT	2013	7,104						12
13	EM Electric Upgrades to Med rms, Kiosks, nurse station, Offices	2014	8,897						13
14	Electric Upgrade 100 amp, 42 circuit panel-Kitchen, Laundry, Hou	2014	16,676						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)		\$ 7,803,102	\$ 121,336		\$ 121,336	\$	\$ 6,833,260	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	\$ 3,093,990	\$ 133,814	\$ 133,814	\$		\$ 2,770,710	71
72	Current Year Purchases	68,082						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			17,376	17,376			74
75	TOTALS	\$ 3,162,072	\$ 133,814	\$ 151,190	\$ 17,376		\$ 2,770,710	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)	\$ 11,076,292	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 255,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 272,526	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,376	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,603,970	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>73,349</u>	<u>41</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>73,349</u>			7

10. Effective dates of current rental agreement:

Beginning 01/01/2014

Ending 12/31/2018

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

Fiscal Year Ending Annual Rent

12. 05/31/2015 \$ 83,333

13. 05/31/2016 \$ 83,333

14. 05/31/2017 \$ 83,333

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: \$ 47,192

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: 06/01/13 Ending: 05/31/14
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. 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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)			
										visits	visits	
1	Licensed Occupational Therapist	10a	11981	hrs	\$ 497,691		\$	\$ 376	11,981	\$ 498,067	1	
2	Licensed Speech and Language Development Therapist	10a	3358	hrs	139,495				3,358	139,495	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	12725	hrs	528,570	246	15,322	11,654	12,971	555,546	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				641,434		641,434	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						172,990		172,990	12	
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					136,345			136,345	13	
14	TOTAL				\$ 1,165,756	246	\$ 151,667	\$ 826,454	28,310	\$ 2,143,877	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

0050302

Report Period Beginning: 06/01/13

Ending:

05/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/14 (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	\$ (2,031)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>640,001</u>)	1,923,111		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,279		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,926,359	\$	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	7,803,102		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,162,072		16
17	Accumulated Depreciation (book methods)	(9,603,970)		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 (spec <u>OMIT</u>)	54,498		22
23	Other(specify): <u>CIP</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,526,820	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,453,179	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 156,206	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	776,750		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	456,138		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>	192,619		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,581,713	\$	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)	\$ 2,547,572	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 905,607	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,453,179	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 742,596	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 742,596	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 544,727	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)	\$ 544,727	17
	B. Transfers (Itemize):		
18	Change in Interdivision	\$ (381,716)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (381,716)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 905,607	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	\$ 14,670,342	1	
2	Discounts and Allowances for all Levels	(7,994,774)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,675,568	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	5,997,718	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,997,718	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	813	12	
13	Barber and Beauty Care	10,830	13	
14	Non-Patient Meals	2,845	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,288,569	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	124,401	19	
20	Radiology and X-Ray	122,821	20	
21	Other Medical Services	74,592	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,624,871	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	<u>Hospitality Income</u>	38	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,298,195	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,490,786	31	
32	Health Care	6,980,496	32	
33	General Administration	3,234,780	33	
B. Capital Expense				
34	Ownership	872,311	34	
C. Ancillary Expense				
35	Special Cost Centers	959,698	35	
36	Provider Participation Fee	215,397	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,753,468	40	
41	Income before Income Taxes (line 30 minus line 40)**	544,727	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 544,727	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,193,936	44
45	Private Pay - Net Inpatient Revenue	1,127,607	45
46	Medicare - Net Inpatient Revenue	3,254,616	46
47	Other-(specify) <u>Hospice</u>	199,109	47
48	Other-(specify) <u>Insurance</u>	900,300	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,675,568	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:

06/01/13

Ending:

05/31/14

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	1,804	1,972	\$ 90,785	\$ 46.04	1
2	Assistant Director of Nursing	3,853	4,213	147,297	34.96	2
3	Registered Nurses	61,513	67,253	2,297,051	34.16	3
4	Licensed Practical Nurses	9,269	10,134	262,892	25.94	4
5	CNAs & Orderlies	95,533	104,794	1,328,544	12.68	5
6	CNA Trainees					6
7	Licensed Therapist	30,842	33,726	1,400,944	41.54	7
8	Rehab/Therapy Aides	18,031	19,717	554,866	28.14	8
9	Activity Director	5,427	5,940	87,061	14.66	9
10	Activity Assistants					10
11	Social Service Workers	6,829	7,477	195,531	26.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,786	9,667	133,479	13.81	15
16	Dishwashers					16
17	Maintenance Workers	2,420	2,649	59,807	22.58	17
18	Housekeepers	17,800	19,480	236,536	12.14	18
19	Laundry	4,796	5,248	53,987	10.29	19
20	Administrator	2,080	2,080	99,113	47.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,886	20,582	474,334	23.05	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	4,175	4,570	93,502	20.46	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	292,044	319,502	\$ 7,515,729 *	\$ 23.52	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		9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	220	11,039	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)	220	\$ 11,039		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# 0050302Report Period Beginning: 06/01/13Ending: 05/31/14**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?
If YES, give association name and amount. IHCA \$3,041 & AHCA \$1,577 Yes
- (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. \$ 63,370 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. \$ 215,397
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. \$ 2,845
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees.