

Facility Name & ID Number Manorcare of Northbrook

0049676 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	158	Skilled (SNF)	158	57,670	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	158	TOTALS	158	57,670	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	22,488	5,770	17,786	46,044	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,488	5,770	17,786	46,044	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.84%

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 03/22/1999

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/07/11 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 158 and days of care provided 12,233

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 Northbrook

0049676

Report Period Beginning:

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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	147,791	32,495	496,502	676,788		676,788	676,788			1
2	Food Purchase		126,237		126,237		126,237	(1,596)	124,641		2
3	Housekeeping	233,433	33,306	489	267,228		267,228	267,228			3
4	Laundry	99,553	23,512	291	123,356		123,356	123,356			4
5	Heat and Other Utilities			240,859	240,859	2,295	243,154	243,154			5
6	Maintenance	63,420	17,294	125,100	205,814		205,814	205,814			6
7	Other (specify):* Medical Waste			1,854	1,854		1,854	1,854			7
8	TOTAL General Services	544,197	232,844	865,095	1,642,136	2,295	1,644,431	(1,596)	1,642,835		8
	B. Health Care and Programs										
9	Medical Director			60,672	60,672		60,672	60,672			9
10	Nursing and Medical Records	3,812,058	412,155	90,078	4,314,291	10,007	4,324,298	4,324,298			10
10a	Therapy	1,233,690	8,861	55,793	1,298,344		1,298,344	1,298,344			10a
11	Activities	171,884	10,491	7,473	189,848		189,848	189,848			11
12	Social Services	212,528		2,277	214,805		214,805	214,805			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,430,160	431,507	216,293	6,077,960	10,007	6,087,967	6,087,967			16
	C. General Administration										
17	Administrative	119,309		500,781	620,090	(164,494)	455,596	455,596			17
18	Directors Fees										18
19	Professional Services			29,278	29,278		29,278	(29,278)			19
20	Dues, Fees, Subscriptions & Promotions			103,764	103,764		103,764	(60,722)	43,042		20
21	Clerical & General Office Expenses	472,866	81,795	334,106	888,767		888,767	(175,560)	713,207		21
22	Employee Benefits & Payroll Taxes			986,606	986,606	50,459	1,037,065	1,037,065			22
23	Inservice Training & Education			142	142		142	142			23
24	Travel and Seminar			9,233	9,233		9,233	9,233			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			457,964	457,964		457,964	457,964			26
27	Other (specify):*										27
28	TOTAL General Administration	592,175	81,795	2,421,874	3,095,844	(114,035)	2,981,809	(265,560)	2,716,249		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,566,532	746,146	3,503,262	10,815,940	(101,733)	10,714,207	(267,156)	10,447,051		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			476,477	476,477	16,983	493,460		493,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,060,451	1,060,451	84,750	1,145,201	(1,138,075)	7,126			32
33	Real Estate Taxes			435,087	435,087		435,087		435,087			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,367	25,367		25,367		25,367			35
36	Other (specify):*											36
37	TOTAL Ownership			1,997,382	1,997,382	101,733	2,099,115	(1,138,075)	961,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		425,784		425,784		425,784		425,784			39
40	Barber and Beauty Shops			10,869	10,869		10,869		10,869			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			291,773	291,773		291,773		291,773			42
43	Other (specify):* IV X-Ray & Lab		52,815	113,601	166,416		166,416		166,416			43
44	TOTAL Special Cost Centers		478,599	416,243	894,842		894,842		894,842			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,566,532	1,224,745	5,916,887	13,708,164		13,708,164	(1,405,231)	12,302,933			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 Northbrook

0049676

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	(1,596)	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	(78)	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		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,899)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(174,608)	21		24
25	Fund Raising, Advertising and Promotional	(60,722)	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	(1,144,328)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,405,231)		\$	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)	\$ (1,405,231)		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 Northbrook

ID# 0049676

Report Period Beginning: 06/01/13

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	HCP Lease Interest	\$ (1,138,075)	32	1
2	Vending Income	(874)	21	2
3	Misc. Income		21	3
4	Activity Income		11	4
5	Loss on Disposal of Fixed Assets		36	5
6	Acct. Fees for Collections	(5,379)	19	6
7	Collection Agency Fees		19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,144,328)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Northbrook# 0049676

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	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,596)	0	0	0	0	0	0	0	0	0	0	(1,596)	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	(1,596)	0	(1,596)	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	(29,278)	0	0	0	0	0	0	0	0	0	0	(29,278)	19
20	Fees, Subscriptions & Promotions	(60,722)	0	0	0	0	0	0	0	0	0	0	(60,722)	20
21	Clerical & General Office Expenses	(175,560)	0	0	0	0	0	0	0	0	0	0	(175,560)	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	(265,560)	0	(265,560)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(267,156)	0	(267,156)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Northbrook

0049676

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	(1,138,075)	0	0	0	0	0	0	0	0	0	0	(1,138,075)	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	(1,138,075)	0	0	0	0	0	0	0	0	0	0	(1,138,075)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,405,231)	0	0	0	0	0	0	0	0	0	0	(1,405,231)	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	\$ 500,781	HCR Manor Care Services, LLC	100.00%	\$ 500,781	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	6,566,532	Heartland Employment Services, LLC	100.00%	6,566,532		4
5	V	10a Therapy Management	16,889	Heartland Rehabilitation Services, LLC	100.00%	16,889		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		\$ 7,084,202			\$ 7,084,202	\$ *	14

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

Facility Name & ID Number

Manorcare of Northbrook

0049676

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 at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21								21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights West IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights IL, LLC	Palos Heights				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				26
27			Manor Care of South Holland IL, LLC	South Holland				27
28			Manor Care of Westmont IL, LLC	Westmont				28
29			Manor Care of Wilmette IL, LLC	Wilmette				29
30			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				30

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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 Geneva IL, LLC	Geneva				1
2			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				2
3			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				3
4			Arden Courts of Northbrook IL, LLC	Northbrook				4
5			Arden Courts of Palos Heights IL, LLC	Palos Heights				5
6			Arden Courts of South Holland IL, LLC	South Holland				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 Northbrook

0049676 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		12,815,340	\$ 2,295	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	357 NFs			12,815,340	0	2
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	48 NFs			12,815,340	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	702 NFs,HHs,Rehat	421,070	303,971	12,815,340	1,378	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	357 NFs	2,331,970	10,787,378	12,815,340	8,629	6
7	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	48 NFs			12,815,340	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	702 NFs,HHs,Rehat	66,712,258	34,047,414	12,815,340	218,101	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	357 NFs	18,712,683	6,531,152	12,815,340	69,243	10
11	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	48 NFs	1,887,403	1,136,236	12,815,340	48,943	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	702 NFs,HHs,Rehat	7,831,139		12,815,340	25,602	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	357 NFs	6,717,577		12,815,340	24,857	14
15	22	Empl Bnfts-Direct to MW Div SN	Accumulated Cost	48 NFs			12,815,340	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	702 NFs,HHs,Rehat	4,454,722		12,815,340	14,564	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	357 NFs	653,747		12,815,340	2,419	18
19	30	Depr - Direct to MW Div SNFs	Accumulated Cost	48 NFs			12,815,340	0	19
20									20
21	32	Pooled Interest	Accumulated Cost		25,923,280		12,815,340	84,750	21
22	32	Directly Assigned Interest	Not Allocated		18,563,246				22
23		H/O Costs Allocated to Non-SNFs & Other Divisions			30,324,259				23
24									24
25	TOTALS				\$ 185,235,436	\$ 52,806,151		\$ 500,781	25

Facility Name & ID Number

Manorcare of Northbrook

0049676

Report Period Beginning:

06/01/13

Ending:

05/31/14

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	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	N/A						\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	Home Office Pooled Interest Expense											6					
7	Interest Income / Interest Expense										84,750	7					
8											(77,624)	8					
9	TOTAL Facility Related						\$	\$			\$ 7,126	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$	\$			\$ 7,126	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.		\$	<u>329,638</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>412,236</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>82,598</u>		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>327,120</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>25,369</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 \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>435,087</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>221,321</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		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
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																	
	2010	<u>319,829</u>	9																
	2011	<u>372,988</u>	10																
	2012	<u>361,838</u>	11																
	2013	<u>384,157</u>	12																
<u>Line 2-2nd 1/2 2012(\$195,133.15) & 1st 1/2 2013 (\$217,102.56)</u>																			
<u>Line 4-2nd half 2013 (\$167,054.56) & 1st half 2014 estimated (\$160,065.83)</u>																			
<u>Line 5-\$3240 Property Valuation Services-appraisal fee</u>																			
<u>Line 5-\$22129.20-Worsek & Vihon PC-filing fees</u>																			

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 Northbrook COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0049676
 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>04-30-200-028-0000</u>	<u>See attached</u>	\$ <u>533,551.55</u>	\$ <u>384,157.12</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. <u>The total tax was allocated between</u>	_____	\$ _____	\$ _____
7. <u>SNF (#487) & Arden Court (#433)</u>	_____	\$ _____	\$ _____
8. <u>based on the square footage in each</u>	_____	\$ _____	\$ _____
9. <u>unit.</u>	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>533,551.55</u></u>	\$ <u><u>384,157.12</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? X YES 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 Northbrook

0049676 Report Period Beginning:

06/01/13 Ending:

05/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,393 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1999</u>	<u>\$ 1,885,717</u>	1
2			<u>2003</u>	<u>32,884</u>	2
3	TOTALS			\$ 1,918,601	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	148		1999	\$ 8,207,461	\$ 229,500		\$ 229,500	\$	\$ 3,119,771
5	CR 5/31/01 Audit Adj.		1999	494,486					
6	10		2003	478,057					
7									
8									
Improvement Type**									
9	BUILDING IMPROVEMENTS (Current Year Depreciation)		1999	531	86,432		86,432		843,942
10			1999	(531)					
11	CR 5/31/01 AUDIT ADJ		1999	1,470					
12			1999	(1,470)					
13	CR 5/31/01 AUDIT ADJ		1999	73					
14			1999	(73)					
15	CR 5/31/01 AUDIT ADJ		1999	449					
16			1999	(449)					
17	CR 5/31/01 AUDIT ADJ		2000	14,841					
18	SECURE CARE SYSTEM		2000	1,134					
19	MAGNETIC DOOR HOLDER		2000	2,473					
20	ACCESS DOORS - FIRE DAMPERS		2000	14,790					
21	ENGINEER COST V#3413 RESIDENT'S ROOMS		2000	1,398					
22	WALLCOVERING-2ND FL RESIDENTS R		2000	205					
23	ADDT'L CONSTRUCTION COST-RESIDENTS ROOMS		2000	1,374					
24	CIRCUITRY SECURE CARE SYSTEM		2000	1,036,860					
25	SITWORK		2000	(1,036,860)					
26	CR 5/31/01 AUDIT ADJ		2000	965					
27	FENCE		2001	977					
28	BLOCKING AND PULLY SYSTEM		2001	1,298					
29	ELECTRICAL ON GENERATOR		2001	103					
30	FREIGHT ON CARPET		2001	484					
31	CARPET		2001	626					
32	CARPET		2003	395,966					
33	GEN OVERHEAD,ARCHITECT,ENGINEER COSTS		2003	2,646					
34	MILLWORK		2003	3,248					
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Northbrook

0049676

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	CARPET	2003	\$ 840	\$		\$	\$	\$	37
38	CARPET	2003	188						38
39	CARPET, BADE AND TILE	2003	2,275						39
40	FREIGHT ON CARPET	2003	60						40
41	FREIGHT ON CARPET	2003	69						41
42	CARPET	2003	835						42
43	ARCHITECT COSTS	2003	848						43
44	ENGINEERING & ARCHITECT COST	2003	1,680						44
45	ENGINEERING & ARCHITECT COST	2003	738						45
46	CERMAIC TILE	2003	2,450						46
47	FREIGHT ON CARPET	2003	69						47
48	VINYL WALL COVERING	2003	148						48
49	CARPET	2003	620						49
50	VINYL WALL COVERING	2003	201						50
51	ENGINEERING COSTS	2003	3,647						51
52	SITE PREPARATION COSTS	2003	71,550						52
53	ADDTL CIVIL ENGINEERING COST	2004	1,800						53
54	ADDTL ARCHITECTURAL COST	2004	30						54
55	CERAMIC TILE	2004	1,093						55
56	CARPET	2004	707						56
57	ENGINEERING COSTS	2004	125						57
58	FREIGHT ON VINYL	2004	62						58
59	INSTALLATION OF COUNTERTOPS AND CONCRETE	2004	12,653						59
60	COMPLETION OF BORDER AND WALL COVERINGS	2004	7,980						60
61	VINYL WALL COVERING	2004	989						61
62	VINYL WALL COVERING	2004	77						62
63	VINYL WALL COVERING	2004	407						63
64	VINYL WALL COVERING	2004	672						64
65	VINYL WALL COVERING	2004	801						65
66	DRYWALL INSTALLATION FOR LAUNDRY ROOM	2004	1,382						66
67	VINYL WALL COVERING	2004	660						67
68	WINDOW TREATMENTS	2004	2,097						68
69	COMPLETE ADDITIONAL WALL VINYL PATCH	2004	450						69
70	TOTAL (lines 4 thru 69)		\$ 9,740,735	\$ 315,932		\$ 315,932	\$	\$ 3,963,713	70

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

Facility Name & ID Number Manorcare of Northbrook

0049676

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		\$ 9,740,735	\$ 315,932		\$ 315,932	\$	\$ 3,963,713	1
2	CARPET	2005	4,450						2
3	VINYL SHEET FOR NURSE STATION	2005	14,330						3
4	DOOR HINGES	2005	1,975						4
5	WALLCOVERING	2006	1,650						5
6	PAINTING & CORNER GUARDS	2003	15,000						6
7	WALLCOVERING	2006	345						7
8	STEEL SERVICE DOOR	2006	9,608						8
9	WALLCOVERING	2006	385						9
10	PAINT/CORNER GUARDS	2006	12,466						10
11	PAINT-DINING ROOM AND BAT	2007	1,875						11
12	DOORS ON ELECTRICAL ROOM	2007	736						12
13	LEGAL FEES V21550	2007	1,725						13
14	ELECTRICAL for Steamer	2007	1,286						14
15	CARPENTRY FOR PANTRY	2008	9,979						15
16	00000000305 T&P VALVES	2008	1,600						16
17	00000000307 0408 WATER HEATERS	2008	1,772						17
18	00000000308 0408 WATER HEATERS	2008	39,500						18
19	00000000309 21 CO2 DETECTORS	2008	5,983						19
20	00000000310 CARPET-2nd Floor Corridor	2008	2,323						20
21	00000000311 FRIEGHT FOR CARPET	2008	443						21
22	00000000317 KITCHEN TILES AND DURAROCK	2008	14,683						22
23	00000000318 2ND FLOOR CARPET	2008	2,873						23
24	00000000326 4 HM DOORS AT ARCADIA & 2ND FLR UTLY R	2009	5,450						24
25	00000000312 PAVING	2008	7,582						25
26	0909 TILE & WALLCOVERING	2009	1,023						26
27	0909 STAINLESS STEEL IN KITCHEN	2009	47,220						27
28	3 SETS OF HM DOORS	2009	12,630						28
29	PVC Fence	2010	10,193						29
30	Metal Door	2010	4,280						30
31	Drywall, Paint for Cove Base in rooms 105,107,116,119 & 219.	2011	9,243						31
32	398-prep/paint/carpet 3 physician lounges; tile in 1st fl heritage lou	2011	2,516						32
33	00000000411 5 FIRE DAMPERS	2011	18,540						33
34	TOTAL (lines 1 thru 33)		\$ 10,004,402	\$ 315,932		\$ 315,932	\$	\$ 3,963,713	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 12B, Carried Forward		\$ 10,004,402	\$ 315,932		\$ 315,932	\$	\$ 3,963,713	1
2	00000000415 painting in rooms 105,107,116, 119 & 219	2011	5,220						2
3	00000000421 CONCRETE SIDEWALKS	2011	7,071						3
4	00000000422 35 X 28 CONCRETE PAD	2011	13,470						4
5	438 0512 All Fire-Smoke Damper Replacements	2012	21,919						5
6	439 0512 All Fire-Smoke Damper Replacements	2012	144,066						6
7	00000000440 CONCRETE sidewalks	2012	15,733						7
8	00000000441 FLOORING in lobby	2012	6,090						8
9	00000000442 0112 1st Flr Flooring	2012	69,091						9
10	444 RENOVATION CONTRACTS-emer generator	2012	3,946						10
11	451 1612 Exterior Drainage plumbing	2012	28,187						11
12	00000000457 PAINT RES ROOMS120, 122, 124 & 126	2013	2,844						12
13	00000000458 PAINT RES ROOMS 155, 104 & 102	2013	3,959						13
14	00000000460 2812 Corridor Doors/Locks	2013	32,381						14
15	00000000461 2812 Corridor Doors/Locks	2013	1,630						15
16	00000000462 CORRIDOR DOOR CLOSER	2013	5,916						16
17	00000000476 Floor Drain	2013	4,554						17
18									18
19	00000000484 KITCHEN FLOORING-install new floors	2013	11,800						19
20	00000000486 Removed old drain line w/new	2013	47,486						20
21	00000000487 Kitchen tile and install	2013	35,801						21
22	00000000503 ELEVATOR FLOORING for 2 elevators	2013	3,292						22
23	00000000506 Install new cabinet in nourishment room	2013	1,259						23
24	00000000515 FIRE WALL UPGRADES	2013	3,771						24
25	00000000522 CENTRAL SHOWER ROOM DOORS	2014	6,696						25
26	00000000525 Install new drywall soffit utility room & receptacles	2014	25,778						26
27		2014							27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,506,361	\$ 315,932		\$ 315,932	\$	\$ 3,963,713	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	\$ 2,119,027	\$ 160,545	\$ 160,545	\$		\$ 1,877,889	71
72	Current Year Purchases	305,612						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			16,983	16,983			74
75	TOTALS	\$ 2,424,639	\$ 160,545	\$ 177,528	\$ 16,983		\$ 1,877,889	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)	\$ 14,849,601	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 476,477	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 493,460	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,983	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,841,602	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	Various	\$ 8,326	92
93			93
94			94
95		\$ 8,326	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.

Facility Name & ID Number Manorcare of Northbrook

0049676

Report Period Beginning: 06/01/13

Ending: 05/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 25,367

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 Northbrook # 0049676 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		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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	7467	hrs	\$ 284,723	11	\$ 715	\$ 505	7,478	\$ 285,943	1
2	Licensed Speech and Language Development Therapist	10a	3901	hrs	148,738				3,901	148,738	2
3	Licensed Recreational Therapist	10a	1271	hrs	48,458	84	5,453		1,355	53,911	3
4	Licensed Physical Therapist	10a	7365	hrs	280,854	646	41,892	8,356	8,011	331,102	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				425,784		425,784	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						52,815		52,815	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					113,601			113,601	13
14	TOTAL				\$ 762,773	741	\$ 161,661	\$ 487,460	20,745	\$ 1,411,894	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 Northbrook

0049676

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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (4,326)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>735,366</u>)	1,602,191		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,524		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,603,389	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,918,601		13
14	Buildings, at Historical Cost	10,506,361		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,424,639		16
17	Accumulated Depreciation (book methods)	(5,841,602)		17
18	Deferred Charges	273,080		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>)			22
23	Other(specify): <u>CIP</u>	8,326		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,289,405	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,892,794	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 124,825	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	611,140		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	327,120		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>	192,410		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,255,495	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,255,495	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,637,299	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,892,794	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,534,861	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,534,861	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(770,650)	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)	\$ (770,650)	17
B. Transfers (Itemize):			
18	Change in Interdivision	873,088	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 873,088	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,637,299	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	\$ 13,745,426	1
2	Discounts and Allowances for all Levels	(5,861,422)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,884,004	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,929,854	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,929,854	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	874	12
13	Barber and Beauty Care	10,658	13
14	Non-Patient Meals	1,596	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	849,923	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	124,602	19
20	Radiology and X-Ray		20
21	Other Medical Services	136,003	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,123,656	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 & Misc.		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)	\$ 12,937,514	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,642,136	31
32	Health Care	6,077,960	32
33	General Administration	3,095,844	33
B. Capital Expense			
34	Ownership	1,997,382	34
C. Ancillary Expense			
35	Special Cost Centers	603,069	35
36	Provider Participation Fee	291,773	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,708,164	40
41	Income before Income Taxes (line 30 minus line 40)**	(770,650)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (770,650)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,064,075	44
45	Private Pay - Net Inpatient Revenue	1,555,886	45
46	Medicare - Net Inpatient Revenue	2,796,980	46
47	Other-(specify) <u>Hospice</u>	276,840	47
48	Other-(specify) <u>Insurance</u>	190,223	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,884,004	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 Northbrook

0049676

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	2,113	2,287	\$ 98,779	\$ 43.19	1
2	Assistant Director of Nursing	4,800	5,195	193,942	37.33	2
3	Registered Nurses	48,364	52,339	1,697,520	32.43	3
4	Licensed Practical Nurses	12,615	13,652	327,467	23.99	4
5	CNAs & Orderlies	94,571	102,505	1,458,765	14.23	5
6	CNA Trainees					6
7	Licensed Therapist	22,680	24,529	935,350	38.13	7
8	Rehab/Therapy Aides	9,972	10,785	298,340	27.66	8
9	Activity Director	12,035	13,044	171,884	13.18	9
10	Activity Assistants					10
11	Social Service Workers	8,013	8,674	212,528	24.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,485	10,303	147,791	14.34	15
16	Dishwashers					16
17	Maintenance Workers	2,208	2,391	63,420	26.52	17
18	Housekeepers	17,326	18,776	233,433	12.43	18
19	Laundry	9,841	10,657	99,553	9.34	19
20	Administrator	2,080	2,080	115,895	55.72	20
21	Assistant Administrator	76	76	3,414	44.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,414	19,934	472,866	23.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,986	2,152	35,585	16.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	276,579	299,379	\$ 6,566,532 *	\$ 21.93	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	60,672	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	60,672		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 Northbrook# 0049676

Report Period Beginning:

06/01/13

Ending:

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? Yes
If YES, give association name and amount. IHCA \$3182 & AHCA \$1651
- (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. \$ 90,868 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? Yes
If YES, give effective date of lease. 04/07/11
- (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. \$ 291,773
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. \$ 1,596
- (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.