

Facility Name & ID Number Manorcare of Arlington Hgts

0050302 Report Period Beginning: 06/01/14 Ending: 06/31/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,982	3,934	22,509	36,425	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,982	3,934	22,509	36,425	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.09%

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 15,286

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:

06/01/14

Ending:

06/31/15

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	217,173	38,037	154,894	410,104		410,104		410,104		1
2	Food Purchase		286,507		286,507		286,507	(7,160)	279,347		2
3	Housekeeping	232,218	31,651	2,597	266,466		266,466		266,466		3
4	Laundry	54,222	15,627		69,849		69,849		69,849		4
5	Heat and Other Utilities			206,735	206,735	2,358	209,093		209,093		5
6	Maintenance	69,396	27,953	131,203	228,552		228,552		228,552		6
7	Other (specify):* Med Waste			2,317	2,317		2,317		2,317		7
8	TOTAL General Services	573,009	399,775	497,746	1,470,530	2,358	1,472,888	(7,160)	1,465,728		8
	B. Health Care and Programs										
9	Medical Director			48,742	48,742		48,742		48,742		9
10	Nursing and Medical Records	4,000,754	311,497	199,711	4,511,962	8,034	4,519,996		4,519,996		10
10a	Therapy	1,884,378	8,889	19,967	1,913,234		1,913,234		1,913,234		10a
11	Activities	104,935	294	6,938	112,167		112,167		112,167		11
12	Social Services	179,492		22,927	202,419		202,419		202,419		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,169,559	320,680	298,285	6,788,524	8,034	6,796,558		6,796,558		16
	C. General Administration										
17	Administrative	114,534		549,385	663,919	(220,602)	443,317		443,317		17
18	Directors Fees										18
19	Professional Services			24,364	24,364	(1,505)	22,859	(22,859)			19
20	Dues, Fees, Subscriptions & Promotions			118,352	118,352		118,352	(74,335)	44,017		20
21	Clerical & General Office Expenses	533,266	66,718	653,421	1,253,405	1,505	1,254,910	(485,937)	768,973		21
22	Employee Benefits & Payroll Taxes			1,041,286	1,041,286	43,666	1,084,952		1,084,952		22
23	Inservice Training & Education			(122)	(122)		(122)		(122)		23
24	Travel and Seminar			6,212	6,212		6,212		6,212		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			344,932	344,932		344,932		344,932		26
27	Other (specify):*										27
28	TOTAL General Administration	647,800	66,718	2,737,830	3,452,348	(176,936)	3,275,412	(583,131)	2,692,281		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,390,368	787,173	3,533,861	11,711,402	(166,544)	11,544,858	(590,291)	10,954,567		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			221,359	221,359	15,593	236,952		236,952			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(12,293)	(12,293)	150,951	138,658		138,658			32
33	Real Estate Taxes			453,832	453,832		453,832		453,832			33
34	Rent-Facility & Grounds			83,333	83,333		83,333		83,333			34
35	Rent-Equipment & Vehicles			58,609	58,609		58,609		58,609			35
36	Other (specify):*											36
37	TOTAL Ownership			804,840	804,840	166,544	971,384		971,384			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		663,255		663,255		663,255		663,255			39
40	Barber and Beauty Shops			9,031	9,031		9,031		9,031			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			191,475	191,475		191,475		191,475			42
43	Other (specify):* IV X-ray & Lab		190,215	106,745	296,960		296,960		296,960			43
44	TOTAL Special Cost Centers		853,470	307,251	1,160,721		1,160,721		1,160,721			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,390,368	1,640,643	4,645,952	13,676,963		13,676,963	(590,291)	13,086,672			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: 06/01/14

Ending: 06/31/15

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	(7,160)	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	(46)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(153)	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	(2,575)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,315)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(482,418)	21		24
25	Fund Raising, Advertising and Promotional	(74,335)	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	(15,289)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (590,291)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (590,291)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Manorcare of Arlington Hgts

ID# 0050302

Report Period Beginning: 06/01/14

Ending: 06/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (745)	21	1
2	Accounting/Collection Fees	(14,544)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(15,289)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/14

Ending:

06/31/15

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	(7,160)	0	0	0	0	0	0	0	0	0	0	(7,160)	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	(7,160)	0	(7,160)	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	(22,859)	0	0	0	0	0	0	0	0	0	0	(22,859)	19
20	Fees, Subscriptions & Promotions	(74,335)	0	0	0	0	0	0	0	0	0	0	(74,335)	20
21	Clerical & General Office Expenses	(485,937)	0	0	0	0	0	0	0	0	0	0	(485,937)	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	(583,131)	0	(583,131)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(590,291)	0	(590,291)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Arlington Hgts

0050302

Report Period Beginning:

06/01/14 Ending:

06/31/15

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)	(590,291)	0	0	0	0	0	0	0	0	0	0	(590,291)	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	\$ 549,385	HCR Manor Care Services, LLC	100.00%	\$ 549,385	\$	1
2	V	Page 8						2
3	V							3
4	V	I-44 Personnel	7,390,368	Heartland Employment Services, LLC	100.00%	7,390,368		4
5	V	10a Therapy Management	15,765	Heartland Rehabilitation Services, LLC	100.00%	15,765		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		\$ 7,955,518			\$ 7,955,518	\$ *	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:

06/01/14

Ending:

06/31/15

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

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Arlington Hgts

0050302

Report Period Beginning:

06/01/14

Ending: 06/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	\$ 700,139	\$ 13,370,720	\$ 2,358	1	
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs		13,370,720	0	2	
3	5	Utilities - Direct to Western Division	Accumulated Cost	346,847,752	45 NFs		13,370,720	0	3	
4	10	Nursing - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	365,628	262,581	13,370,720	1,232	4
5	10	Nursing-Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs	1,781,417	1,228,977	13,370,720	6,803	5
6	10	Nursing-Direct to Western Division	Accumulated Cost	346,847,752	45 NFs			13,370,720	0	6
7	17	General & Administrative - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs & Re	68,653,771	35,393,585	13,370,720	231,259	7
8	17	General & Administrative - Direct	Accumulated Cost	3,501,343,214	356 NFs	12,665,127	2,400,695	13,370,720	48,365	8
9	17	General & Administrative - Direct	Accumulated Cost	346,847,752	40 NFs Jan-Sept	1,411,275		10,028,040	40,803	9
10	17	General & Administrative - Direct	Accumulated Cost	214,769,108	45 NFs Oct-Dec	536,860		3,342,680	8,356	10
11	22	Employee Benefits - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	5,418,631		13,370,720	18,253	11
12	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs	6,655,045		13,370,720	25,414	12
13	22	Employee Benefits - Direct to Western Division	Accumulated Cost	346,847,752	45 NFs			13,370,720	0	13
14	30	Depreciation - Pooled	Accumulated Cost	3,969,355,509	564 NFs, HHs, & R	3,871,414		13,370,720	13,041	14
15	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,501,343,214	356 NFs	668,272		13,370,720	2,551	15
16	30	Depreciation - Direct to Western Division	Accumulated Cost	346,847,752	45 NFs			13,370,720	0	16
17	32	Pooled Interest	Accumulated Cost	3,969,355,509		25,971,677		13,370,720	87,485	17
18	32	Directly Assigned Interest	Not Allocated			17,184,434			63,465	18
19		H/O Costs Allocated to Non-SNFs and Other Divisions				33,870,689				19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 179,754,379	\$ 39,285,838	\$ 549,385		25

Facility Name & ID Number

Manorcare of Arlington Hgts

0050302

Report Period Beginning:

06/01/14

Ending:

06/31/15

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		6.5708	\$ 63,465	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	Home Office Pooled Interest Expense										87,485	6					
7	Interest Income/Interest Expense										(12,293)	7					
8												8					
9	TOTAL Facility Related						\$ 965,859	\$ 965,859			\$ 138,657	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			\$ 138,657	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 2014 report.		\$	<u>456,138</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>523,400</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>67,262</u>		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>455,405</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>23,165</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 \$ <u>92,000</u> For <u>2010</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	<u>(92,000)</u>		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>453,832</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>440,014</u>			8
	2011	<u>448,057</u>			9
	2012	<u>470,046</u>			10
	2013	<u>504,468</u>			11
	2014	<u>517,315</u>			12
Line 2: \$ 523,400 = \$245,943 for the 2nd half of 2013 + \$277,457 for the 1st half of 2014					
Line 4: \$455,405 = \$239,857 for the 1st half of 2014 + \$215,547, estimate for Jan-May 2015.					
Line 5: Worsek & Vihon LLP inv. 539897 \$168 filing fees, inv. 540541 \$23,009 2010 Specific Ojection legal fees,					
Worsek & Vihon LLP (\$11.82) 2002 RE Specific Objection.					
			FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2014	\$		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.

2014 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 Jeff Lewandowski

TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>258,937.76</u>	\$ <u>258,937.76</u>
2. <u>08-04-100-008-0000</u>	<u>See attached</u>	\$ <u>258,376.95</u>	\$ <u>258,376.95</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>517,314.71</u></u>	\$ <u><u>517,314.71</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

06/01/14 Ending:

06/31/15

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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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)	\$	\$ 2,164,345	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					145,590		145,590		4,773,080	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:

06/01/14

Ending:

06/31/15**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	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	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:

06/01/14

Ending:

06/31/15

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	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	1
2	Doors	2004	18,900						2
3	Carpet	2004	5,184						3
4	Handrails & Backer Board	2004	7,990						4
5	Windows	2004	4,946						5
6	Wallcovering, Border & Flooring	2004	5,700						6
7	Electrical Work in Laundry Room	2004	2,742						7
8	Pave Parking Lot, and Stripe & Mark	2004	42,166						8
9	Renov. - General Overhead & Interest Disallowed per audit 4,331	2005							9
10	Renov. - Flooring	2005	18,359						10
11	Renov. - Windows	2005	2,516						11
12	Renov. - Wallcovering & Guards	2005	6,095						12
13	Emergency Electrical Circuit & Light Fixtures	2005	19,672						13
14									14
15	Drainage, Doors, & Brickwork	2005	16,636						15
16	Carpet	2005	1,027						16
17	Electrical work for emergency circuits	2005	4,780						17
18	Door, Frame, & tuckpoint	2005	6,961						18
19	Plumbing - re-configuartion for sink drains	2006	2,460						19
20									20
21	Stair Railings	2006	6,750						21
22	Plumbing - Chiller lines	2006	2,314						22
23	Plumbing - Exterior	2006	17,748						23
24	Carpet	2006	358						24
25	Electrical Work - Install electric heaters	2006	3,985						25
26									26
27	Electrical - 4 emergency outlets in Arlington Corridor	2007	1,955						27
28	Electrical - repair wiring for rooms 152, 154, & 156	2007	2,498						28
29	Foundation Unerdpinning - Pier jacking (7 areas)	2007	16,420						29
30	Foundation Work - Slapjacking 2450 sq feet	2007	3,675						30
31	Renov. - Flooring & Wallcovering	2007	66,271						31
32	Renov. - Carpentry-subcontr	2007	16,701						32
33	Doors	2007	12,641						33
34	TOTAL (lines 1 thru 33)		\$ 6,171,558	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	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:

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Ending:

06/31/15

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	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	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	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	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:

06/01/14

Ending:

06/31/15**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	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	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	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	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:

06/01/14

Ending:

06/31/15

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	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	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	Window Upgrades - 10 windows Heritage Wing	2014	17,486						16
17	Flooring - Heritage Rooms 245-254	2014	6,330						17
18	Freight for flooring	2014	2,001						18
19	Wall Covering - 3 fire walls deck & elevator room	2014	8,181						19
20	Heaters - East Corridor	2015	5,686						20
21	Upper Roof Replacement (second story)	2015	51,119						21
22	Drywall - smoke walls internet café, room 144	2015	22,334						22
23	Heater - ceiling resistance heaters 2nd fl shower rooms	2015	4,891						23
24	Fan Motor - new fan and control board break room & med storage	2015	1,376						24
25	Breakers - new 30a PTAC circuits conf room	2015	2,656						25
26	Heater - 2 ceiling heaters room 102 & front doors	2015	5,087						26
27	Vinyl Awning	2015	1,458						27
28	Ceiling Grid - ceiling grid and tire repair	2015	1,895						28
29	Circuit Panel - life safety panel correction	2015	15,927						29
30	Receptacle Device 9 mounted quad receptacle devices	2015	1,293						30
31	Metal Door - boiler room exterior doors	2015	4,683						31
32	Metal Door - boiler room exterior doors	2015	4,844						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,960,348	\$ 104,165		\$ 104,165	\$	\$ 6,937,425	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	\$ 3,162,072	\$ 117,194	\$ 117,194	\$		\$ 2,887,904	71
72	Current Year Purchases	88,599						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			15,593	15,593			74
75	TOTALS	\$ 3,250,671	\$ 117,194	\$ 132,787	\$ 15,593		\$ 2,887,904	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,322,137	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 221,359	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 236,952	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,593	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,825,329	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	CIP	\$ 832,157	92
93			93
94			94
95		\$ 832,157	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>83,333</u>	<u>41</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>83,333</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.	<u>05/31/2016</u>	\$ <u>83,333</u>
-----	-------------------	------------------

13.	<u>05/31/2017</u>	\$ <u>83,333</u>
-----	-------------------	------------------

14.	<u>05/31/2018</u>	\$ <u>83,333</u>
-----	-------------------	------------------

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 58,609 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: 06/01/14 Ending: 06/31/15
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			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)			
1	Licensed Occupational Therapist	10a	10517	hrs	\$ 443,152		\$	\$ 170	10,517	\$ 443,322	1	
2	Licensed Speech and Language Development Therapist	10a	3516	hrs	148,168			471	3,516	148,639	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	11183	hrs	471,209			8,248	11,183	479,457	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				663,255		663,255	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						190,215		190,215	12	
13	Other (specify): <u>X-Ray & Lab</u>	43,3						106,745		106,745	13	
14	TOTAL				\$ 1,062,529		\$	106,745	\$ 862,359	25,216	\$ 2,031,633	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: 06/01/14

Ending:

06/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/31/15 (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	\$ 42,389	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>678,739</u>)	1,382,841		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,021		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,430,251	\$	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	7,960,348		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,250,670		16
17	Accumulated Depreciation (book methods)	(9,825,329)		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>)	31,772		22
23	Other(specify): <u>CIP</u>	832,157		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,360,736	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,790,987	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 229,826	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	811,689		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	455,405		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>	118,940		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,615,860	\$	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)	\$ 2,581,719	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,209,268	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,790,987	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 905,607	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 905,607	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	402,051	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)	\$ 402,051	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(98,390)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (98,390)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,209,268	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	\$ 14,709,563	1	
2	Discounts and Allowances for all Levels	(8,445,828)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,263,735	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	6,076,523	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,076,523	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	745	12	
13	Barber and Beauty Care	6,756	13	
14	Non-Patient Meals	2,342	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,342,425	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	173,496	19	
20	Radiology and X-Ray	102,750	20	
21	Other Medical Services	72,237	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,700,751	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>Bndld Gain</u>	37,959	28	
28a	<u>Purch Disc</u>	46	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38,005	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,079,014	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,470,530	31	
32	Health Care	6,788,524	32	
33	General Administration	3,452,348	33	
B. Capital Expense				
34	Ownership	804,840	34	
C. Ancillary Expense				
35	Special Cost Centers	969,246	35	
36	Provider Participation Fee	191,475	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,676,963	40	
41	Income before Income Taxes (line 30 minus line 40)**	402,051	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 402,051	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,654,091	44
45	Private Pay - Net Inpatient Revenue	1,041,587	45
46	Medicare - Net Inpatient Revenue	2,551,570	46
47	Other-(specify) <u>Hospice</u>	204,429	47
48	Other-(specify) <u>Insurance</u>	812,058	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,263,735	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:

06/01/14

Ending:

06/31/15

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	1,841	2,002	\$ 94,998	\$ 47.45	1
2	Assistant Director of Nursing	2,883	3,136	113,940	36.33	2
3	Registered Nurses	62,833	68,341	2,302,519	33.69	3
4	Licensed Practical Nurses	5,912	6,430	167,124	25.99	4
5	CNAs & Orderlies	89,420	97,561	1,236,808	12.68	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	28,068	30,556	1,287,548	42.14	7
8	Rehab/Therapy Aides	18,903	20,579	596,830	29.00	8
9	Activity Director	5,902	6,435	104,935	16.31	9
10	Activity Assistants					10
11	Social Service Workers	6,403	6,972	179,492	25.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,943	15,193	217,173	14.29	15
16	Dishwashers					16
17	Maintenance Workers	2,732	2,975	69,396	23.33	17
18	Housekeepers	17,269	18,812	232,218	12.34	18
19	Laundry	4,730	5,154	54,222	10.52	19
20	Administrator	2,080	2,080	99,675	47.92	20
21	Assistant Administrator	343	343	14,859	43.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,132	22,993	533,266	23.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,884	4,230	85,365	20.18	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	288,278	313,792	\$ 7,390,368 *	\$ 23.55	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 48,742	9,3	36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	209	10,531	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)	209	\$ 59,273	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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Clara Leonard (June - Dec)	Administrator	0	\$ 53,506	Workers' Compensation Insurance	\$ 36,408	IDPH License Fee	\$ 3,980	
Anne M. Berg (Jan-May)	Administrator	0	46,169	Unemployment Compensation Insurance	84,979	Advertising: Employee Recruitment	11,554	
Jennifer L. Miller	Asst Administrator	0	14,198	FICA Taxes	532,637	Health Care Worker Background Check (Indicate # of checks performed <u>308</u>)	5,472	
Pamela M. Callas	Asst Administrator	0	661	Employee Health Insurance	367,285	Patient Background Checks <u>1042</u>	10,420	
				Employee Meals		Dues & Subscriptions	6,218	
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues	8,865	
				Disability Payments		Advertising	70,879	
				401 K	24,604	Other Licenses & Permits	964	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 114,534	Appreciation, Other Benefits & Marketing Adjust	(8,505)	Less Non-allowable Association Dues	(3,456)	
				Tuition Program	0	Less: Public Relations Expense	()	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount	SMSP Match & RSU	1	Non-allowable advertising	(70,879)	
Various home office services - See page 8 for breakdown			\$ 549,385	Employee Uniforms	3,877	Yellow page advertising	()	
				Home Office Allocation	43,666			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 549,385					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Law Office of James C. Siebert & As	Legal Fees		\$ 4,000				Out-of-State Travel	\$
SNF Global	Legal Fees		4,315					
(Legal Fees were adjusted off via Page 5, Line 22, therefore no invoices are attached)							In-State Travel	
							Includes travel expense to the Home Office in Toledo, OH for regional meetings	6,212
Meyers & Flowers, LLC	Collect Services		7,448				Seminar Expense	
Transworld Systems, Inc.	Collect Services		4,533					
Weltman, Weinber and Reis Co. LP/	Collect Services		2,563				Entertainment Expense	()
(Collection cost was adjusted off via Page 5A, Line 2)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 6,212
Michigan Peer Review Organization	Review Resident Care		1,505					
(Reclass to Line 21)								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 24,364	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Manorcare of Arlington Hgts# 0050302

Report Period Beginning:

06/01/14

Ending:

06/31/15**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 \$3,257 & AHCA \$ 2,152
- (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. \$ 64,215 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. \$ 191,475
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. \$ 2,342
- (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.