FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0050302

Facility Name: Manorcare of Arlington Heights

Address: 715 West Central Road (Number) Arlington Heights (City) 60005 (Zip Code)

County: Cook

Telephone Number: (847) 392-2020 **Fax #** (847) 392-0174

HFS ID Number:

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Raymond Lewis **Telephone Number:** (419) 252-5783
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/09 to 05/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry A. Lazarus

(Title) Vice President, Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,642	4,887	27,654	43,183	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,642	4,887	27,654	43,183	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.35%

D. How many bed-hold days during this year were paid by the Department?
3 (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 [X]

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

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 [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 151 and days of care provided 20,984

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

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 Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	358,353	40,042	12,514	410,909	13,424	424,333		424,333			1
2	Food Purchase		304,514		304,514		304,514	(2,695)	301,819			2
3	Housekeeping	197,512	33,138	(3,841)	226,809		226,809		226,809			3
4	Laundry	38,311	10,923	652	49,886		49,886		49,886			4
5	Heat and Other Utilities			203,137	203,137	3,736	206,873		206,873			5
6	Maintenance	81,321	20,539	74,858	176,718		176,718		176,718			6
7	Other (specify):* Medical Waste			1,399	1,399		1,399		1,399			7
8	TOTAL General Services	675,497	409,156	288,719	1,373,372	17,160	1,390,532	(2,695)	1,387,837			8
	B. Health Care and Programs											
9	Medical Director			94,000	94,000		94,000		94,000			9
10	Nursing and Medical Records	4,079,667	366,255	61,600	4,507,522	4,931	4,512,453		4,512,453			10
10a	Therapy	1,641,018	13,121	85,336	1,739,475		1,739,475		1,739,475			10a
11	Activities	75,426	3,715	4,162	83,303		83,303		83,303			11
12	Social Services	249,117			249,117		249,117		249,117			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,045,228	383,091	245,098	6,673,417	4,931	6,678,348		6,678,348			16
	C. General Administration											
17	Administrative	125,890		662,252	788,142	(187,933)	600,209		600,209			17
18	Directors Fees											18
19	Professional Services			37,255	37,255		37,255	(37,255)				19
20	Dues, Fees, Subscriptions & Promotions			78,544	78,544		78,544	(50,137)	28,407			20
21	Clerical & General Office Expenses	438,579	49,253	302,814	790,646		790,646	(208,795)	581,851			21
22	Employee Benefits & Payroll Taxes			1,232,555	1,232,555	111,449	1,344,004		1,344,004			22
23	Inservice Training & Education			1,934	1,934		1,934		1,934			23
24	Travel and Seminar			16,428	16,428		16,428		16,428			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			368,378	368,378		368,378		368,378			26
27	Other (specify):*											27
28	TOTAL General Administration	564,469	49,253	2,700,160	3,313,882	(76,484)	3,237,398	(296,187)	2,941,211			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,285,194	841,500	3,233,977	11,360,671	(54,393)	11,306,278	(298,882)	11,007,396			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.

Facility Name & ID Number Manorcare of Arlington Heights #0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			378,896	378,896	29,799	408,695		408,695			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(11,538)	(11,538)	24,594	13,056		13,056			32
33	Real Estate Taxes			445,909	445,909		445,909		445,909			33
34	Rent-Facility & Grounds			63,364	63,364		63,364		63,364			34
35	Rent-Equipment & Vehicles			111,008	111,008		111,008		111,008			35
36	Other (specify):*											36
37	TOTAL Ownership			987,639	987,639	54,393	1,042,032		1,042,032			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,213	2,213		2,213		2,213			38
39	Ancillary Service Centers		812,676	1,770	814,446		814,446		814,446			39
40	Barber and Beauty Shops			15,265	15,265		15,265		15,265			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,673	82,673		82,673		82,673			42
43	Other (specify):* IV, X-Ray, Lab		177,072	213,287	390,359		390,359		390,359			43
44	TOTAL Special Cost Centers		989,748	315,208	1,304,956		1,304,956		1,304,956			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,285,194	1,831,248	4,536,824	13,653,266		13,653,266	(298,882)	13,354,384			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 Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,695)	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	(171)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(656)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(37,255)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(206,137)	21		24
25	Fund Raising, Advertising and Promotional	(50,137)	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	(1,831)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (298,882)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (298,882)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manorcare of Arlington Heights

ID# 0050302

Report Period Beginning: 06/01/09

Ending: 05/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,498)	21	1
2	Misc. Income	(333)	21	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**	(1,831)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,695)	0	0	0	0	0	0	0	0	0	0	(2,695)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,695)	0	0	0	0	0	0	0	0	0	0	(2,695)	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	(37,255)	0	0	0	0	0	0	0	0	0	0	(37,255)	19
20	Fees, Subscriptions & Promotions	(50,137)	0	0	0	0	0	0	0	0	0	0	(50,137)	20
21	Clerical & General Office Expenses	(208,795)	0	0	0	0	0	0	0	0	0	0	(208,795)	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**	(296,187)	0	0	0	0	0	0	0	0	0	0	(296,187)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(298,882)	0	0	0	0	0	0	0	0	0	0	(298,882)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	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)**	(298,882)	0	0	0	0	0	0	0	0	0	0	(298,882)	45

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, Inc.	100	Health Care & Retirement Corporation of America (see H.O. Cost Report)	Toledo			

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	$ 662,252	HCR Manor Care, Inc.	100.00%	$ 662,252	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	51,944	Heartland Rehab Services, LLC	100.00%	51,944		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 714,196			$ 714,196	$ *	14

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

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	$ 2,826,629	$ 1,585,087	13,571,844	$ 13,424	1
2	1	Dietary - Direct Central Division	Accumulated Cost	691,284,298	359 Nurs. Fac.	0	0	13,571,844	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	0	0	13,571,844	0	3
4	5	Utilities - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	0	0	13,571,844	0	4
5	5	Utilities - Direct Central Division	Accumulated Cost	691,284,298	359 Nurs. Fac.	0	0	13,571,844	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	911,333		13,571,844	3,736	6
7	10	Nursing - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	632,689	715,152	13,571,844	3,005	7
8	10	Nursing - Direct Central Div	Accumulated Cost	691,284,298	359 Nurs. Fac.	0	0	13,571,844	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	469,810	0	13,571,844	1,926	9
10	17	General & Admin - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	35,518,981	0	13,571,844	168,683	10
11	17	General & Admin - Direct Central	Accumulated Cost	691,284,298	359 Nurs. Fac.	1,045,204	0	13,571,844	20,520	11
12	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	69,554,530	79,745,671	13,571,844	285,116	12
13	22	Employee Benefits - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	6,239,311	0	13,571,844	29,631	13
14	22	Employee Benefits - Direct Centra	Accumulated Cost	691,284,298	359 Nurs. Fac.	2,434,366	0	13,571,844	47,793	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	8,300,418	0	13,571,844	34,025	15
16	30	Depreciation - Direct	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	102,714	0	13,571,844	488	16
17	30	Depreciation - Direct Central Div	Accumulated Cost	691,284,298	359 Nurs. Fac.	43,612	0	13,571,844	856	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	359 Nurs. Fac.	6,941,685	0	13,571,844	28,455	18
19										19
20	32	Interest							24,594	20
21		Non-Nursing Home Allocations								21
22										22
23										23
24										24
25	TOTALS					$ 135,021,282	$ 82,045,910		$ 662,252	25

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub Debentures		X	Facility			$ 965,859	$ 965,859		0.0505	$ 24,594	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income Other										(11,538)	8
9	TOTAL Facility Related						$ 965,859	$ 965,859			$ 13,056	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			$ 13,056	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.)**

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	353,303	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.)	$	386,779	2
3. Under or (over) accrual (line 2 minus line 1).	$	33,476	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	412,433	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.**	$		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.	$	445,909	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	356,015	8
2006	360,786	9
2007	377,241	10
2008	382,534	11
2009	435,357	12

Line 2: $386,779 = $193,914 for 2nd half of 2008 paid in Nov 09 + $192,865 for 1st half of 2009 paid in Feb 2010

Line 4: $412,433 = $187,470 estimate for Jan-May 2010 + $224,963 for 2nd half of 2009

Line 12: $435,357 = $210,394 for 1st half of 2009 paid in Feb 2010 + $224,963 for 2nd half of 2009 to be paid in Dec 2010

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Arlington Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050302

CONTACT PERSON REGARDING THIS REPORT Raymond Lewis

TELEPHONE (419) 252-5783 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-04-100-008-0000	See Attached	$ 220,786.96	$ 220,786.96
2.	08-09-101-011-0000	See Attached	$ 214,570.40	$ 214,570.40
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 435,357.36	$ 435,357.36

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	Facility		1973	$ 111,118	1
2					2
3	TOTALS			$ 111,118	3

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	151		1973	1969	$ 2,165,884	$ (41,425)		$ (41,425)	$	$ 2,371,471	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					246,047		246,047		3,770,597	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 Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SMOKE WALLS	2002	$ 6,877	$		$	$	$	37
38	GENERAL OVERHEAD & INTEREST	2002	19,105						38
39	C/R 5/31/03 AUDIT ADJ. #2b - Overhead & Interest	2002	(19,105)						39
40	CARPENTRY/BUILDING WIRE per audit move 62,419 to 2001	2002	43,118						40
41	CARPETING AND WALLCOVERINGS	2002	14,091						41
42	FLOORING	2002	2,022						42
43	RETROACTIVE ADDITION per audit remove 1,391	2003							43
44	DEVELOPERS COST - OVERHD & INT. disallowed per audit	2003							44
45	CARPENTRY	2003	56,052						45
46	MILLWORK	2003	8,634						46
47	CARPETING AND PADS	2003	3,225						47
48	WALLCOVERINGS	2003	2,117						48
49	BASIC ELECTRICAL	2003	7,658						49
50	EXTERIOR SIGN	2003	562						50
51	CARPET	2003	428						51
52	CARPET	2003	428						52
53	FREIGHT ON CARPET	2003	58						53
54	FREIGHT ON CARPET	2003	139						54
55	CARPET AND VWC	2003	2,650						55
56	COUNTERTOP	2003	1,148						56
57	SIGNAGE - $1,244 Retired 10/31/07	2003							57
58	CARPET	2004	10,000						58
59	CARPET	2004	4,174						59
60	FABRIC	2004	134						60
61	FLOORING	2004	978						61
62	CARPET	2004	511						62
63	Renov. - General Overhead & Interest Disallowed per audit	2004							63
64	Renov. - Carpeting	2004	2,582						64
65	Renov. - Wallcovering & Corner Guards	2004	11,595						65
66	Renov. - Carpentry $5,100.00 disallowed per audit	2004	209,960						66
67	Renov. - Millwork Change year to 2003 per audit	2003	19,260						67
68	Renov. - Doors Change to 2003 per audit	2003	39,835						68
69	Wallcovering & Corner Guards	2004	2,125						69
70	TOTAL (lines 4 thru 69)		$ 5,854,108	$ 204,622		$ 204,622	$	$ 6,142,068	70

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

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,854,108	$ 204,622		$ 204,622	$	$ 6,142,068	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	$ 204,622		$ 204,622	$	$ 6,142,068	34

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

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,171,558	$ 204,622		$ 204,622	$	$ 6,142,068	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 SPRINLER 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	$ 204,622		$ 204,622	$	$ 6,142,068	34

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

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,209,468	$ 204,622		$ 204,622	$	$ 6,142,068	1
2	Provide & Install multiple Metal Doors	2009	16,108						2
3									3
4	0309 Elevator Upgrade - Elevators	2009	60,450						4
5	0309 Elevator Upgrade - Doors & Frames	2009	4,485						5
6	Ceiling	2009	2,820						6
7	Hollow Metal Door	2009	5,185						7
8	Thermal Detection for Fire	2009	5,155						8
9	1509 Drainage Piping - Plumbing Piping	2009	33,800						9
10	0409 Boiler Replacement - Engineering Mechanical	2009	65,183						10
11	Second Floor Sprinker Heads	2009	17,550						11
12	SS Dishwash Exhaust	2010	11,420						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,431,623	$ 204,622		$ 204,622	$	$ 6,142,068	34

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

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,517,150	$ 174,274	$ 174,274	$		$ 2,000,264	71
72	Current Year Purchases	158,142						72
73	Fully Depreciated Assets							73
74				29,799	29,799			74
75	TOTALS	$ 2,675,292	$ 174,274	$ 204,073	$ 29,799		$ 2,000,264	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,218,033	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 378,896	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 408,695	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,799	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,142,332	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 [X] 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

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 111,008 Description: 02 Concentrators, Wheelchairs, Gericharis, Elct. Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	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 Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	11010	hrs	$ 433,456	197	$ 11,489	$ 5,257	11,207	$ 450,202	1
2	Licensed Speech and Language Development Therapist	10a	3361	hrs	135,790	56	3,237	155	3,417	139,182	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	12084	hrs	475,491	28	1,653	7,709	12,112	484,853	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				812,676		812,676	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43, 2						177,072		177,072	12
13	Other (specify): X-Ray & Lab	43, 3					213,287			213,287	13
14	TOTAL				$ 1,044,737	281	$ 229,666	$ 1,002,869	26,736	$ 2,277,272	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.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare of Arlington Heights **#** 0050302 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/10 **(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	$ (95,773)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,036,310)	1,376,084		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,619		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,284,930	$	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	7,431,623		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,675,292		16
17	Accumulated Depreciation (book methods)	(8,142,332)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	93,575		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,169,276	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,454,206	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 182,089	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	647,391		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	412,433		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	140,104		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,382,017	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	965,859		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	30,842		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 996,701	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,378,718	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,075,488	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,454,206	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,598,756	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,598,756	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,238,814	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)**	$ 2,238,814	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(2,762,082)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,762,082)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,075,488	24 *

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

Facility Name & ID Number Manorcare of Arlington Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,939,007	1
2	Discounts and Allowances for all Levels	(5,908,109)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,030,898	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,864,450	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,864,450	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	1,498	12
13	Barber and Beauty Care	17,277	13
14	Non-Patient Meals	2,695	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	866,444	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	108,485	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 996,399	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			28
28a	Misc. Income	333	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 333	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,892,080	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,373,372	31
32	Health Care	6,673,417	32
33	General Administration	3,313,882	33
	B. Capital Expense		
34	Ownership	987,639	34
	C. Ancillary Expense		
35	Special Cost Centers	1,222,283	35
36	Provider Participation Fee	82,673	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,653,266	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,238,814	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,238,814	43

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,247	2,449	$ 113,136	$ 46.20	1
2	Assistant Director of Nursing	6,189	6,746	228,556	33.88	2
3	Registered Nurses	49,768	54,239	1,763,616	32.52	3
4	Licensed Practical Nurses	18,893	20,590	522,679	25.39	4
5	CNAs & Orderlies	99,554	109,097	1,360,773	12.47	5
6	CNA Trainees					6
7	Licensed Therapist	26,284	28,889	1,148,294	39.75	7
8	Rehab/Therapy Aides	20,008	21,992	492,724	22.40	8
9	Activity Director	5,127	5,602	75,426	13.46	9
10	Activity Assistants					10
11	Social Service Workers	10,868	11,839	249,117	21.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,232	27,545	358,353	13.01	15
16	Dishwashers					16
17	Maintenance Workers	3,929	4,293	81,321	18.94	17
18	Housekeepers	15,199	16,609	197,512	11.89	18
19	Laundry	3,475	3,796	38,311	10.09	19
20	Administrator	2,080	2,080	125,890	60.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,066	20,777	438,579	21.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,451	4,863	90,907	18.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	312,370	341,406	$ 7,285,194 *	$ 21.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	94,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,890	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 96,890		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa Smelser-Heyde	Administrator	0	$ 125,890
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,890

B. Administrative - Other

Description	Amount
Management Fees	$ 662,252
TOTAL (agree to Schedule V, line 17, col. 3)	$ 662,252
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, Flowers LLC	Legal Fees	$ 26,052
United Collection Bureau Inc.	Collection Services	11,203
(All above adjusted off via Page 5 Line 22, therefore no invoices are attached)		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 37,255

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,462
Unemployment Compensation Insurance	59,034
FICA Taxes	526,599
Employee Health Insurance	459,736
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	84,528
Appreciation & Other Employee Benefits	1,050
Tuition Program	13,175
SMSP Match & RSU	1,802
Employee Uniforms	170
Home Office Allocation	111,448
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,344,004

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,959
Advertising: Employee Recruitment	15,383
Health Care Worker Background Check	1,303
(Indicate # of checks performed 28)	
Patient Background Checks 41	410
Dues & Subscriptions	3,712
Association Dues	13,490
Advertising	42,287
Public Relations	
Less: Public Relations Expense	(7,850)
Non-allowable advertising	(42,287)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,407

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,428
Includes travel expense to the Home	
Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,428

* Attach copy of IMRF notifications

**See instructions.

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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	Amount of Expense Amortized Per Year								
					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 Heights # 0050302 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 $5,640**

(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 $7,850**

(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. $ **76,660** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **82,673**
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. $ **2,695**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.