

		FOR BHF USE				

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

<p>I. IDPH License ID Number: <u>0050302</u></p> <p>Facility Name: <u>Manorcare of Arlington Hts</u></p> <p>Address: <u>715 West Central Rd</u> <u>Arlington Heights</u> <u>60005</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 392-2020</u> Fax # <u>(847) 392-0174</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/01/81</u></p> <p>Type of Ownership:</p> <table border="0"><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input checked="" type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/15</u> to <u>05/31/16</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <p>(Signed) _____ (Date) _____</p> <p>(Type or Print Name) <u>Martin D. Allen</u></p> <p>(Title) <u>Director</u></p> <p>(Signed) _____ (Date) _____</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) () () Fax # () ()</p>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																							
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																							
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																							
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																							
	<input type="checkbox"/> "Sub-S" Corp.																								
	<input checked="" type="checkbox"/> Limited Liability Co.																								
	<input type="checkbox"/> Trust																								
	<input type="checkbox"/> Other _____																								
<p>In the event there are further questions about this report, please contact: Name: <u>Jeff Lewandowski</u> Telephone Number: <u>(419) 252-5736</u> Email Address: _____</p>	<p>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</p>																								

Facility Name & ID Number Manorcare of Arlington Hts

0050302 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	55,266	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	55,266	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	11,800	4,070	19,318	35,188	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,800	4,070	19,318	35,188	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.67%

D. How many bed-hold days during this year were paid by the Department?

(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 12,254

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31 Fiscal Year: 5/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare of Arlington Hts # 0050302 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	355,321	27,892	4,459	387,672		387,672		387,672		1
2	Food Purchase		289,093		289,093		289,093	(3,504)	285,589		2
3	Housekeeping	208,082	25,784	4,712	238,578		238,578		238,578		3
4	Laundry	39,726	14,532		54,258		54,258		54,258		4
5	Heat and Other Utilities			187,363	187,363	2,620	189,983		189,983		5
6	Maintenance	75,761	16,576	55,039	147,376		147,376		147,376		6
7	Other (specify):* Med Waste			1,200	1,200		1,200		1,200		7
8	TOTAL General Services	678,890	373,877	252,773	1,305,540	2,620	1,308,160	(3,504)	1,304,656		8
	B. Health Care and Programs										
9	Medical Director			51,851	51,851		51,851		51,851		9
10	Nursing and Medical Records	3,884,315	304,039	193,721	4,382,075	8,792	4,390,867		4,390,867		10
10a	Therapy	1,694,639	7,126	15,879	1,717,644		1,717,644		1,717,644		10a
11	Activities	101,833	531	6,339	108,703		108,703		108,703		11
12	Social Services	212,049	147	7,573	219,769		219,769		219,769		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,892,836	311,843	275,363	6,480,042	8,792	6,488,834		6,488,834		16
	C. General Administration										
17	Administrative	140,444		514,507	654,951	(224,796)	430,155		430,155		17
18	Directors Fees										18
19	Professional Services			61,665	61,665	(720)	60,945	(60,945)			19
20	Dues, Fees, Subscriptions & Promotions			103,795	103,795		103,795	(53,450)	50,345		20
21	Clerical & General Office Expenses	520,077	49,537	271,968	841,582	720	842,302	(161,296)	681,006		21
22	Employee Benefits & Payroll Taxes			1,046,215	1,046,215	39,413	1,085,628		1,085,628		22
23	Inservice Training & Education			133	133		133		133		23
24	Travel and Seminar			6,425	6,425		6,425		6,425		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			353,553	353,553		353,553		353,553		26
27	Other (specify):*										27
28	TOTAL General Administration	660,521	49,537	2,358,261	3,068,319	(185,383)	2,882,936	(275,691)	2,607,245		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,232,247	735,257	2,886,397	10,853,901	(173,971)	10,679,930	(279,195)	10,400,735		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			238,297	238,297	13,421	251,718		251,718			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(11,730)	(11,730)	160,550	148,820		148,820			32
33	Real Estate Taxes			386,947	386,947		386,947		386,947			33
34	Rent-Facility & Grounds			83,333	83,333		83,333		83,333			34
35	Rent-Equipment & Vehicles			40,004	40,004		40,004		40,004			35
36	Other (specify):*											36
37	TOTAL Ownership			736,851	736,851	173,971	910,822		910,822			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		557,128		557,128		557,128		557,128			39
40	Barber and Beauty Shops			9,013	9,013		9,013		9,013			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			192,031	192,031		192,031		192,031			42
43	Other (specify):* IV X-Ray & Lab		99,018	95,901	194,919		194,919		194,919			43
44	TOTAL Special Cost Centers		656,146	296,945	953,091		953,091		953,091			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,232,247	1,391,403	3,920,193	12,543,843		12,543,843	(279,195)	12,264,648			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 Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,504)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(240)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(166)	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	(1,430)	21		18
19	Entertainment				19
20	Contributions	(6,981)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(52,682)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(151,791)	21		24
25	Fund Raising, Advertising and Promotional	(53,450)	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 Page 5a	(8,951)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (279,195)		\$	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))	\$ (279,195)		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	Exceptional Care Program		X		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	

Manorcare of Arlington Hts

ID# 0050302

Report Period Beginning: 06/01/15

Ending: 05/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$	11	1
2	Misc. Income		21	2
3	Vending Income	(688)	21	3
4	Donations Revenue		21	4
5	Accounting/Collection Fees	(8,263)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest		32	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	(8,951)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Arlington Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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	
	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	(3,504)	0	0	0	0	0	0	0	0	0	0	(3,504)	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	(3,504)	0	0	0	0	0	0	0	0	0	0	(3,504)	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	(60,945)	0	0	0	0	0	0	0	0	0	0	(60,945)	19
20	Fees, Subscriptions & Promotions	(53,450)	0	0	0	0	0	0	0	0	0	0	(53,450)	20
21	Clerical & General Office Expenses	(161,296)	0	0	0	0	0	0	0	0	0	0	(161,296)	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	(275,691)	0	0	0	0	0	0	0	0	0	0	(275,691)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(279,195)	0	0	0	0	0	0	0	0	0	0	(279,195)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Arlington Hts # 0050302 Report Period Beginning: 06/01/15 Ending: 05/31/16

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)	(279,195)	0	0	0	0	0	0	0	0	0	0	(279,195)	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 Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Health Care	Toledo	Nursing Staff

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Home Office Allocation	\$ 514,507	HCR Manor Care Services, LLC	100.00%	\$ 514,507	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	7,232,247	Heartland Employment Services, LLC	100.00%	7,232,247		4
5	V	10a Therapy Management	17,516	Heartland Rehabilitation Services, LLC	100.00%	17,516		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		\$ 7,764,270			\$ 7,764,270	\$ *	14

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

Facility Name & ID Number

Manorcare of Arlington Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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								12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care 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 (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number

Manorcare of Arlington Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number Manorcare of Arlington Hts # 0050302 Report Period Beginning: 06/01/15 Ending: 05/31/16

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 Hts

0050302

Report Period Beginning:

06/01/15

Ending: 05/31/16

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

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

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

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	3,924,650,842	559 NFs, HHs, & Re	\$ 818,127	\$ 12,566,986	\$ 2,620	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs		12,566,986	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs		12,566,986	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	314,713	212,796	12,566,986	1,007
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	2,144,378	1,338,476	12,566,986	7,785
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs		12,566,986	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	60,268,030	28,103,285	12,566,986	192,982
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	14,494,897	5,630,812	12,566,986	52,624
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs	3,257,281		12,566,986	44,105
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	5,205,729		12,566,986	16,669
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	6,264,775		12,566,986	22,744
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs			12,566,986	0
16									16
17	30	Depreciation - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	3,394,861		12,566,986	10,871
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	702,366		12,566,986	2,550
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			12,566,986	0
20									20
21									21
22	32	Pooled Interest	Accumulated Cost	3,924,650,842		28,376,750		12,566,986	90,864
23	32	Directly Assigned Interest	Not Allocated			18,868,647			69,686
24		H/O Costs Allocated to Non-SNFs and Other Divisions				33,166,797			
25	TOTALS					\$ 177,277,351	\$ 35,285,370	\$ 514,507	25

Facility Name & ID Number

Manorcare of Arlington Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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		7	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	\$ 922,858			0.0755	\$ 69,686	1					
2													2					
3													3					
4													4					
5													5					
	Working Capital																	
6													6					
7	Pooled Interest											90,864	7					
8	Interest Expense / Interest Income											(11,730)	8					
9	TOTAL Facility Related						\$ 965,859	\$ 922,858				\$ 148,820	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	\$ 922,858				\$ 148,820	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 2015 report.		\$	455,405	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.)		\$	524,380	2
3. Under or (over) accrual (line 2 minus line 1).		\$	68,976	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	464,026	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.)		\$	48,972	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 \$ 195,027 For 2011 & 2012 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(195,027)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	386,947	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	448,057	8	
	2012	470,046	9	
	2013	504,468	10	
	2014	517,315	11	
	2015	528,387	12	
Line 2: \$524,380.31 = \$239,857.22 for 2nd half 2014 + \$284,523.09 for 1st half 2015				
Line 4: \$464,026.07= \$243,864.40 for 2nd half 2015 + \$220,161.67 for Jan - May 2016				
Line 5: Worsek & Vihon LLP inv#541819 - \$199 filing fees, inv# 542296 - \$24,264 2011 Specific Objection & inv #542475 - \$24,509 2012 Specific Objection legal fees.				
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Arlington Hts 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 2015 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 2015.

(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>08-04-100-008-0000</u>	<u>See Attached</u>	\$ <u>266,063.61</u>	\$ <u>266,063.61</u>
2. <u>08-09-101-011-0000</u>	<u>See Attached</u>	\$ <u>262,323.88</u>	\$ <u>262,323.88</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>528,387.49</u></u>	\$ <u><u>528,387.49</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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).

Blank lines for listing other business entities.

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for index. Row 1: Facility, 1973, \$111,118. Row 2: (blank). Row 3: TOTALS, \$111,118.

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)	\$	\$ 2,122,920	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					169,009		169,009		4,942,089	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 Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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	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	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	70

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

Facility Name & ID Number Manorcare of Arlington Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	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	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	34

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

Facility Name & ID Number Manorcare of Arlington Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	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	Fabricate & 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	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	34

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

Facility Name & ID Number Manorcare of Arlington Hts# 0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16**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	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	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	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	34

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

Facility Name & ID Number Manorcare of Arlington Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	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, Ho	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 storag	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)		\$ 7,960,349	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	34

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

Facility Name & ID Number Manorcare of Arlington Hts# 0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16**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 12E, Carried Forward		\$ 7,960,349	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	1
2	HM Door in EE break room	2015	2,888						2
3	HM Door in dishwasher room	2015	3,820						3
4	Rooftop Unit & related electrical work by E. nursing station	2015	17,470						4
5	Roof Replacement (project #012-15)	2015	177,695						5
6	Electrical work for (19) 2nd Floor TVs	2015	13,397						6
7	HVAC Wall Pack in MDS office	2015	7,198						7
8	Repair Smoke Walls above 2 sets of corridor doors	2015	8,355						8
9	Water Pump for Domestic Water Heater	2015	3,498						9
10	Draft Inducers (3) for Domestic Boilers	2015	3,900						10
11	Extend Generator Exhaust beyond 2nd Floor Roof Line	2015	2,700						11
12	Windows in ms 124, 277 & 2nd Flr South Facing Windows	2015	6,670						12
13	Ceiling Tile inside 2nd flr Environmental Service Office	2015	10,640						13
14	Repair Firewall on Resident Rm 125 & at top of deck	2015	13,680						14
15	Repair Firewall by Room 125, above Maintenance Office	2015	9,360						15
16	Carpet & Wall Base in Environmental Services Office	2015	3,048						16
17	HM Door & Frame for East Stairwell	2016	4,660						17
18	Elevator Shaft & Pump	2016	24,300						18
19	Rooftop Chiller Piping for PT	2016	3,200						19
20	Piping and Valve for Chiller, for house system	2016	4,880						20
21	Compressor in Aeon 6 ton RTU for Dining Room	2016	3,275						21
22	Renovate resident rooms and bathrooms:								22
23	Renov - Flooring & Plumbing	2016	340,508						23
24	Renov - Carpentry-subcontractor & HVAC	2016	122,264						24
25	Renov - Painting & Wallcovering	2016	119,969						25
26	Renov. - Basic Composite Electrical	2016	35,161						26
27	Repair Expansion Joints (2) in Hydronic System by room 138	2016	6,200						27
28	Repair Asphalt, Seal & Stripe Parking Lot	2015	13,692						28
29	Concrete Sidewalk (6 sections) & Curbs (80 feet)	2015	9,425						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,932,202	\$ 127,584		\$ 127,584	\$	\$ 7,065,009	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	\$ 3,250,671	\$ 110,713	\$ 110,713	\$		\$ 2,998,617	71
72	Current Year Purchases	232,250						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			13,421	13,421			74
75	TOTALS	\$ 3,482,921	\$ 110,713	\$ 124,134	\$ 13,421		\$ 2,998,617	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,526,241	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 238,297	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 251,718	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,421	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,063,626	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 Hts

0050302

Report Period Beginning: 06/01/15

Ending: 05/31/16

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:	1969		12/19/1972	\$ 83,333	41	10	3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 83,333			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>5/31/2017</u>	\$ <u>83,333</u>
13.	<u>5/31/2018</u>	\$ <u>83,333</u>
14.		\$

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: \$ 40,004 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	9357 hrs	\$ 402,933		\$	249	9,357	\$ 403,182	1
2	Licensed Speech and Language Development Therapist	10a	3226 hrs	138,922			663	3,226	139,585	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	7581 hrs	326,442			6,214	7,581	332,656	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 prescripts				557,128		557,128	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					99,018		99,018	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3				95,901			95,901	13
14	TOTAL			\$ 868,297		\$ 95,901	\$ 663,272	20,164	\$ 1,627,470	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **05/31/16**

(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	\$ 3,372	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>422,682</u>)	1,376,676		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,523		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,385,571	\$	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	8,932,202		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,482,920		16
17	Accumulated Depreciation (book methods)	(10,063,626)		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 (spe <u>Omit</u>)	78,938		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,541,552	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,927,123	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 203,779	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	718,909		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	464,026		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>	137,039		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,523,753	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	922,858		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)	\$ 922,858	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,446,611	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,480,512	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,927,123	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,209,268	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,209,268	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	726,466	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 726,466	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(455,222)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (455,222)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,480,512	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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,852,354	1
2	Discounts and Allowances for all Levels	(7,869,557)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,982,797	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,768,003	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,768,003	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	688	12
13	Barber and Beauty Care	9,285	13
14	Non-Patient Meals	3,504	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,258,984	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	119,584	19
20	Radiology and X-Ray	68,035	20
21	Other Medical Services	59,189	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,519,269	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	Purchase Discount	240	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 240	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,270,309	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,305,540	31
32	Health Care	6,480,042	32
33	General Administration	3,068,319	33
B. Capital Expense			
34	Ownership	736,851	34
C. Ancillary Expense			
35	Special Cost Centers	761,060	35
36	Provider Participation Fee	192,031	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,543,843	40
41	Income before Income Taxes (line 30 minus line 40)**	726,466	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 726,466	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,902,710	44
45	Private Pay - Net Inpatient Revenue	1,200,779	45
46	Medicare - Net Inpatient Revenue	2,091,621	46
47	Other-(specify) <u>Hospice</u>	134,183	47
48	Other-(specify) <u>Insurance</u>	653,504	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,982,797	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 Hts

0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,540	2,733	\$ 125,910	\$ 46.07	1
2	Assistant Director of Nursing	4,990	5,368	194,432	36.22	2
3	Registered Nurses	55,067	59,240	2,046,432	34.54	3
4	Licensed Practical Nurses	7,103	7,641	196,296	25.69	4
5	CNAs & Orderlies	85,123	91,780	1,244,419	13.56	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	22,991	24,730	1,064,912	43.06	7
8	Rehab/Therapy Aides	19,197	20,649	629,727	30.50	8
9	Activity Director	5,415	5,833	101,833	17.46	9
10	Activity Assistants					10
11	Social Service Workers	7,973	8,582	212,049	24.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,487	24,214	355,321	14.67	15
16	Dishwashers					16
17	Maintenance Workers	3,272	3,521	75,761	21.52	17
18	Housekeepers	15,375	16,560	208,082	12.57	18
19	Laundry	3,680	3,965	39,726	10.02	19
20	Administrator	2,080	2,080	140,444	67.52	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,045	21,540	520,077	24.14	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	3,227	3,473	76,826	22.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	280,565	301,909	\$ 7,232,247 *	\$ 23.96	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 51,851	9, 3	36
37	Medical Records Consultant	Monthly 8,212	10, 3	37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 60,063		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

Facility Name & ID Number Manorcare of Arlington Hts# 0050302

Report Period Beginning:

06/01/15

Ending:

05/31/16**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. ICHA \$3,731 & ACHA \$2,149
- (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. \$ 61,176 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. \$ 192,031
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. \$ 3,504
- (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