

		FOR BHF USE					

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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.

I. IDPH License ID Number: 0049676

Facility Name: Manorcare of Northbrook

Address: 3300 Milwaukee Ave Northbrook 60062
Number City Zip Code

County: Cook

Telephone Number: (847) 795-9700 Fax # (847) 795-9600

HFS ID Number:

Date of Initial License for Current Owners: 03/22/1999

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Jeff Lewandowski Telephone Number: (419) 252-5736
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 06/01/15 to 05/31/16 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)
(Type or Print Name) Martin D. Allen
(Title) Director

Paid Preparer

(Signed)
(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 Northbrook

0049676 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	<u>158</u>	Skilled (SNF)	<u>158</u>	<u>57,828</u>	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	<u>158</u>	TOTALS	<u>158</u>	<u>57,828</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,184</u>	<u>4,271</u>	<u>16,108</u>	<u>41,563</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,184</u>	<u>4,271</u>	<u>16,108</u>	<u>41,563</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.87%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 03/22/1999

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 04/07/11 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 158 and days of care provided 8,816

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Northbrook # 0049676 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	411,418	36,577	7,834	455,829		455,829		455,829			1
2	Food Purchase		348,310		348,310		348,310	(3,263)	345,047			2
3	Housekeeping	219,085	31,495	509	251,089		251,089		251,089			3
4	Laundry	94,426	22,865	289	117,580		117,580		117,580			4
5	Heat and Other Utilities			222,824	222,824	2,890	225,714		225,714			5
6	Maintenance	64,124	30,391	118,069	212,584		212,584		212,584			6
7	Other (specify):* Med Waste			3,205	3,205		3,205		3,205			7
8	TOTAL General Services	789,053	469,638	352,730	1,611,421	2,890	1,614,311	(3,263)	1,611,048			8
	B. Health Care and Programs											
9	Medical Director			61,400	61,400		61,400		61,400			9
10	Nursing and Medical Records	3,792,673	357,837	166,926	4,317,436	9,700	4,327,136		4,327,136			10
10a	Therapy	1,291,161	14,795	17,810	1,323,766		1,323,766		1,323,766			10a
11	Activities	142,529	2,527	6,392	151,448		151,448	(50)	151,398			11
12	Social Services	168,486		10,123	178,609		178,609		178,609			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,394,849	375,159	262,651	6,032,659	9,700	6,042,359	(50)	6,042,309			16
	C. General Administration											
17	Administrative	108,870		490,678	599,548	(171,101)	428,447		428,447			17
18	Directors Fees											18
19	Professional Services			46,871	46,871		46,871	(46,871)				19
20	Dues, Fees, Subscriptions & Promotions			111,986	111,986		111,986	(52,475)	59,511			20
21	Clerical & General Office Expenses	525,647	55,764	886,603	1,468,014		1,468,014	(742,923)	725,091			21
22	Employee Benefits & Payroll Taxes			1,103,001	1,103,001	43,476	1,146,477		1,146,477			22
23	Inservice Training & Education			1,148	1,148		1,148		1,148			23
24	Travel and Seminar			27,903	27,903		27,903		27,903			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			442,078	442,078		442,078		442,078			26
27	Other (specify):*											27
28	TOTAL General Administration	634,517	55,764	3,110,268	3,800,549	(127,625)	3,672,924	(842,269)	2,830,655			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,818,419	900,561	3,725,649	11,444,629	(115,035)	11,329,594	(845,582)	10,484,012			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			509,111	509,111	14,804	523,915		523,915			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			689,273	689,273	100,231	789,504	(690,938)	98,566			32
33	Real Estate Taxes			408,327	408,327		408,327		408,327			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,483	31,483		31,483		31,483			35
36	Other (specify):*											36
37	TOTAL Ownership			1,638,194	1,638,194	115,035	1,753,229	(690,938)	1,062,291			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			246	246		246		246			38
39	Ancillary Service Centers		453,676		453,676		453,676		453,676			39
40	Barber and Beauty Shops			10,381	10,381		10,381		10,381			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			254,924	254,924		254,924		254,924			42
43	Other (specify):* IV X-Ray & Lab		(2,340)	84,573	82,233		82,233		82,233			43
44	TOTAL Special Cost Centers		451,336	350,124	801,460		801,460		801,460			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,818,419	1,351,897	5,713,967	13,884,283		13,884,283	(1,536,520)	12,347,763			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,263)	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	(344)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(177)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(2,512)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(30,547)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(739,362)	21		24
25	Fund Raising, Advertising and Promotional	(52,475)	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 5a	(707,840)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,536,520)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,536,520)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$ (50)	11	1
2	Misc. Income		21	2
3	Vending Income	(528)	21	3
4	Donations Revenue		21	4
5	Accounting/Collection Fees	(16,324)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(690,938)	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	(707,840)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Northbrook # 0049676 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	(3,263)	0	0	0	0	0	0	0	0	0	0	(3,263)	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	(3,263)	0	0	0	0	0	0	0	0	0	0	(3,263)	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	(50)	0	0	0	0	0	0	0	0	0	0	(50)	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	(50)	0	0	0	0	0	0	0	0	0	0	(50)	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	(46,871)	0	0	0	0	0	0	0	0	0	0	(46,871)	19
20	Fees, Subscriptions & Promotions	(52,475)	0	0	0	0	0	0	0	0	0	0	(52,475)	20
21	Clerical & General Office Expenses	(742,923)	0	0	0	0	0	0	0	0	0	0	(742,923)	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	(842,269)	0	0	0	0	0	0	0	0	0	0	(842,269)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(845,582)	0	0	0	0	0	0	0	0	0	0	(845,582)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Northbrook # 0049676 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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	(690,938)	0	0	0	0	0	0	0	0	0	0	(690,938)	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	(690,938)	0	0	0	0	0	0	0	0	0	0	(690,938)	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)	(1,536,520)	0	0	0	0	0	0	0	0	0	0	(1,536,520)	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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 490,678	HCR Manor Care Services, LLC	100.00%	\$ 490,678	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,818,419	Heartland Employment Services, LLC	100.00%	6,818,419		4
5	V	10a	Therapy Management	18,328	Heartland Rehabilitation Services, LLC	100.00%	18,328		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			\$ 7,327,425			\$ 7,327,425	\$ *	14

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

Facility Name & ID Number

Manorcare of Northbrook

0049676

Report Period Beginning:

06/01/15

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			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care 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								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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Northbrook# 0049676

Report Period Beginning:

06/01/15Ending: 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 ☐

Name of Related Organization

HCR Manor Care Services LLC

Street Address

333 North Summit Street

City / State / Zip Code

Toledo, OH 43604-2617

Phone Number

(419) 252-5500

Fax Number

(419) 254-5495

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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities - Pooled	Accumulated Cost	559 NFs, HHs, & Re	\$ 818,127	\$	13,862,506	\$ 2,890	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	357 NFs			13,862,506	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	85 NFs			13,862,506	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	559 NFs, HHs, & Re	314,713	212,796	13,862,506	1,112	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	357 NFs	2,144,378	1,338,476	13,862,506	8,588	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	85 NFs			13,862,506	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	559 NFs, HHs, & Re	60,268,030	28,103,285	13,862,506	212,877	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	357 NFs	14,494,897	5,630,812	13,862,506	58,049	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	85 NFs	3,257,281		13,862,506	48,651	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	559 NFs, HHs, & Re	5,205,729		13,862,506	18,387	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	357 NFs	6,264,775		13,862,506	25,089	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	85 NFs			13,862,506	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	559 NFs, HHs, & Re	3,394,861		13,862,506	11,991	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	357 NFs	702,366		13,862,506	2,813	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	85 NFs			13,862,506	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		28,376,750		13,862,506	100,231	22
23	32	Directly Assigned Interest	Not Allocated		18,868,647				23
24		H/O Costs Allocated to Non-SNFs and Other Divisions			33,166,797				24
25	TOTALS				\$ 177,277,351	\$ 35,285,370		\$ 490,678	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7	Pooled Interest											100,231	7
8	Interest Expense / Interest Income											(1,665)	8
9	TOTAL Facility Related						\$					\$ 98,566	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ 98,566	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.)

B. Real Estate Taxes

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 Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049676

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>04-30-200-028-0000</u>	<u>See Attached</u>	\$ <u>560,490.10</u>	\$ <u>403,552.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. <u>The total tax was allocated between</u>	_____	\$ _____	\$ _____
5. <u>SNF (#487) & Arden Court (#433)</u>	_____	\$ _____	\$ _____
6. <u>based on the square footage in each</u>	_____	\$ _____	\$ _____
7. <u>unit.</u>	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>560,490.10</u></u>	\$ <u><u>403,552.88</u></u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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 providecopies of their original **second installment** tax bill.

A. Square Feet: 65,393

B. General Construction Type: Exterior Masonry Frame Steel

Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1999	\$ 1,885,717	1
2			2003	32,884	2
3	TOTALS			\$ 1,918,601	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	148			1999	\$ 8,207,461	\$ 229,500		\$ 229,500	\$	\$ 3,578,771
5	CR 5/31/01 Audit Adj.			1999	494,486					
6	10			2003	478,057					
7										
8										
	Improvement Type**									
9	BUILDING IMPROVEMENTS (Current Year Depreciation)			1999	531	110,766		110,766		1,047,213
10				1999	(531)					
11	CR 5/31/01 AUDIT ADJ			1999	1,470					
12				1999	(1,470)					
13	CR 5/31/01 AUDIT ADJ			1999	73					
14				1999	(73)					
15	CR 5/31/01 AUDIT ADJ			1999	449					
16				1999	(449)					
17	CR 5/31/01 AUDIT ADJ			2000	14,841					
18	SECURE CARE SYSTEM			2000	1,134					
19	MAGNETIC DOOR HOLDER			2000	2,473					
20	ACCESS DOORS - FIRE DAMPERS			2000	14,790					
21	ENGINEER COST V#3413 RESIDENT'S ROOMS			2000	1,398					
22	WALLCOVERING-2ND FL RESIDENTS R			2000	205					
23	ADDT'L CONSTRUCTION COST-RESIDENTS ROOMS			2000	1,374					
24	CIRCUITRY SECURE CARE SYSTEM			2000	1,036,860					
25	SITWORK			2000	(1,036,860)					
26	CR 5/31/01 AUDIT ADJ			2000	965					
27	FENCE			2001	977					
28	BLOCKING AND PULLY SYSTEM			2001	1,298					
29	ELECTRICAL ON GENERATOR			2001	103					
30	FREIGHT ON CARPET			2001	484					
31	CARPET			2001	626					
32	CARPET			2003	395,966					
33	GEN OVERHEAD,ARCHITECT,ENGINEER COSTS			2003	2,646					
34	MILLWORK			2003	3,248					
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Northbrook

0049676

Report Period Beginning:

06/01/15

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CARPET	2003	\$ 840	\$		\$	\$	37
38	CARPET	2003	188					38
39	CARPET, BADE AND TILE	2003	2,275					39
40	FREIGHT ON CARPET	2003	60					40
41	FREIGHT ON CARPET	2003	69					41
42	CARPET	2003	835					42
43	ARCHITECT COSTS	2003	848					43
44	ENGINEERING & ARCHITECT COST	2003	1,680					44
45	ENGINEERING & ARCHITECT COST	2003	738					45
46	CERMAIC TILE	2003	2,450					46
47	FREIGHT ON CARPET	2003	69					47
48	VINYL WALL COVERING	2003	148					48
49	CARPET	2003	620					49
50	VINYL WALL COVERING	2003	201					50
51	ENGINEERING COSTS	2003	3,647					51
52	SITE PREPARATION COSTS	2003	71,550					52
53	ADDTL CIVIL ENGINEERING COST	2004	1,800					53
54	ADDTL ARCHITECTURAL COST	2004	30					54
55	CERAMIC TILE	2004	1,093					55
56	CARPET	2004	707					56
57	ENGINEERING COSTS	2004	125					57
58	FREIGHT ON VINYL	2004	62					58
59	INSTALLATION OF COUNTERTOPS AND CONCRETE	2004	12,653					59
60	COMPLETION OF BORDER AND WALL COVERINGS	2004	7,980					60
61	VINYL WALL COVERING	2004	989					61
62	VINYL WALL COVERING	2004	77					62
63	VINYL WALL COVERING	2004	407					63
64	VINYL WALL COVERING	2004	672					64
65	VINYL WALL COVERING	2004	801					65
66	DRYWALL INSTALLATION FOR LAUNDRY ROOM	2004	1,382					66
67	VINYL WALL COVERING	2004	660					67
68	WINDOW TREATMENTS	2004	2,097					68
69	COMPLETE ADDITIONAL WALL VINYL PATCH	2004	450					69
70	TOTAL (lines 4 thru 69)		\$ 9,740,735	\$ 340,266		\$ 340,266	\$ 4,625,984	70

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

Facility Name & ID Number Manorcare of Northbrook

0049676

Report Period Beginning:

06/01/15

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		\$ 9,740,735	\$ 340,266		\$ 340,266	\$	\$ 4,625,984	1
2	CARPET	2005	4,450						2
3	VINYL SHEET FOR NURSE STATION	2005	14,330						3
4	DOOR HINGES	2005	1,975						4
5	WALLCOVERING	2006	1,650						5
6	PAINTING & CORNER GUARDS	2003	15,000						6
7	WALLCOVERING	2006	345						7
8	STEEL SERVICE DOOR	2006	9,609						8
9	WALLCOVERING	2006	385						9
10	PAINT/CORNER GUARDS	2006	12,466						10
11	PAINT-DINING ROOM AND BAT	2007	1,875						11
12	DOORS ON ELECTRICAL ROOM	2007	736						12
13	LEGAL FEES V21550	2007	1,725						13
14	ELECTRICAL for Steamer	2007	1,286						14
15	CARPENTRY FOR PANTRY	2008	9,979						15
16	00000000305 T&P VALVES	2008	1,600						16
17	00000000307 0408 WATER HEATERS	2008	1,772						17
18	00000000308 0408 WATER HEATERS	2008	39,500						18
19	00000000309 21 CO2 DETECTORS	2008	5,983						19
20	00000000310 CARPET-2nd Floor Corridor	2008	2,324						20
21	00000000311 FRIEGHT FOR CARPET	2008	443						21
22	00000000317 KITCHEN TILES AND DURAROCK	2008	14,683						22
23	00000000318 2ND FLOOR CARPET	2008	2,873						23
24	00000000326 4 HM DOORS AT ARCADIA & 2ND FLR UTLY I	2009	5,450						24
25	00000000312 PAVING	2008	7,582						25
26	0909 TILE & WALLCOVERING	2009	1,023						26
27	0909 STAINLESS STEEL IN KITCHEN	2009	47,220						27
28	3 SETS OF HM DOORS	2009	12,630						28
29	PVC Fence	2010	10,193						29
30	Metal Door	2010	4,280						30
31	Drywall, Paint for Cove Base in rooms 105,107,116,119 & 219.	2011	9,243						31
32	398-prep/paint/carpet 3 physician lounges; tile in 1st fl heritage lou	2011	2,516						32
33	00000000411 5 FIRE DAMPERS	2011	18,540						33
34	TOTAL (lines 1 thru 33)		\$ 10,004,401	\$ 340,266		\$ 340,266	\$	\$ 4,625,984	34

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

Facility Name & ID Number Manorcare of Northbrook

0049676

Report Period Beginning:

06/01/15

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		\$ 10,004,401	\$ 340,266		\$ 340,266	\$	\$ 4,625,984	1
2	00000000415 painting in rooms 105,107,116, 119 & 219	2011	5,220						2
3	00000000421 CONCRETE SIDEWALKDS	2011	7,071						3
4	00000000422 35 X 28 CONCRETE PAD	2011	13,470						4
5	438 0512 All Fire-Smoke Damper Replacements	2012	21,919						5
6	439 0512 All Fire-Smoke Damper Replacements	2012	144,066						6
7	00000000440 CONCRETE sidewalks	2012	15,732						7
8	00000000441 FLOORING in lobby	2012	6,090						8
9	00000000442 0112 1st Flr Flooring	2012	69,091						9
10	444 RENOVATION CONTRACTS-emer generator	2012	3,946						10
11	451 1612 Exterior Drainage plumbing	2012	28,187						11
12	00000000457 PAINT RES ROOMS120, 122, 124 & 126	2013	2,844						12
13	00000000458 PAINT RES ROOMS 155, 104 & 102	2013	3,959						13
14	00000000460 2812 Corridor Doors/Locks	2013	32,381						14
15	00000000461 2812 Corridor Doors/Locks	2013	1,630						15
16	00000000462 CORRIDOR DOOR CLOSER	2013	5,916						16
17	00000000476 Floor Drain	2013	4,554						17
18									18
19	00000000484 KITCHEN FLOORING-install new floors	2013	11,800						19
20	00000000486 Removed old drain line w/new	2013	47,486						20
21	00000000487 Kitchen tile and install	2013	35,801						21
22	00000000503 ELEVATOR FLOORING for 2 elevators	2013	3,292						22
23	00000000506 Install new cabinet in nourishment room	2013	1,259						23
24	00000000515 FIRE WALL UPGRADES	2013	3,771						24
25	00000000522 CENTRAL SHOWER ROOM DOORS	2014	6,696						25
26	00000000525 Install new drywall soffit utility room & receptacle	2014	25,778						26
27									27
28	Paving Upgrades - fill cracks, seal coat, stripe	2014	19,476						28
29	Sidewalk Upgrades - near service door	2014	4,655						29
30	Electric Upgrades - exterior of building	2014	3,461						30
31	Gen Elec Upgrades	2014	4,860						31
32	Electric Upgrades for Dishach-dishwasher	2014	2,588						32
33	Flooring - armstrong tile & cove base	2014	1,107						33
34	TOTAL (lines 1 thru 33)		\$ 10,542,507	\$ 340,266		\$ 340,266	\$	\$ 4,625,984	34

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

Facility Name & ID Number Manorcare of Northbrook

0049676

Report Period Beginning:

06/01/15

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		\$ 10,542,507	\$ 340,266		\$ 340,266	\$	\$ 4,625,984	1
2	Plumbing - waterline repairs	2014	1,737						2
3	Main Doors Upgrade	2014	8,816						3
4	HVAC Compressor - Freezer	2014	2,983						4
5	Fire Alarm	2014	12,857						5
6	Ignitor - replaced control dual spark ignition	2015	1,064						6
7	Lock - pushbutton digital access	2015	3,652						7
8	Cable - cabling for CATV for 5 rooms	2015	2,009						8
9	Wiring - sprinkler room for corridor emergency circuits	2015	2,082						9
10	Flooring - shower stall floors	2015	42,801						10
11	Storage Shed	2015	3,465						11
12	Flooring - resilient room flooring replacement	2015	3,416						12
13	Dry Pendent Fire Spinklers (8)	2015	3,874						13
14	Wiring Conduit - replace underground feed	2015	2,794						14
15	Vinyl Tile - Freight	2015	1,822						15
16									16
17	ASPHALT PAVEMENT-circular & service drive	2015	20,652						17
18	Vinyl Flooring-1st flr medbridge rooms 130-138 & 140	2015	6,405						18
19	FLOOR TILE & Base - 1st flr 10 res rooms: 130-145	2015	17,906						19
20	Vinyl Flooring & Base in res rooms: 138, 140 & 143	2015	6,198						20
21	FIRE LINKS (84) on fire dampers	2015	6,624						21
22	TILE INSTALLATION-res rooms 101-102	2015	3,725						22
23	ROOF MATERIAL for flat roof repair (15 x 25 ft section)	2015	7,850						23
24	Floor tile and wall paint for Arcadia dining room	2016	4,861						24
25	Doors (3) - res bathrooms (2) and res room 218 (1)	2016	4,880						25
26	Mixing VALVES located in mechanical room	2016	5,833						26
27	ZONE sys w/2 thermostats-Conference rn, Admin & HR Offices	2016	3,850						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,724,663	\$ 340,266		\$ 340,266	\$	\$ 4,625,984	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,580,282	\$ 168,845	\$ 168,845	\$		\$ 2,240,217	71
72	Current Year Purchases	89,086						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			14,804	14,804			74
75	TOTALS	\$ 2,669,368	\$ 168,845	\$ 183,649	\$ 14,804		\$ 2,240,217	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 15,312,632	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 509,111	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 523,915	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,804	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,866,201	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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: \$ 31,483 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.

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
☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	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	7566	hrs	\$ 303,862		\$ 614	7,566	\$ 304,476	1
2	Licensed Speech and Language Development Therapist	10a	3654	hrs	146,733		147	3,654	146,880	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10a	7889	hrs	316,841		14,034	7,889	330,875	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			453,676		453,676	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): IV Therapy	43, 2					(2,340)		(2,340)	12
13	Other (specify): X-Ray & Lab	43, 3				84,573			84,573	13
14	TOTAL				\$ 767,436		\$ 84,573	\$ 466,131	19,109 \$ 1,318,140	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.

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	\$ 29,221	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 788,174)	1,593,230		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,779		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,628,230	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,918,601		13
14	Buildings, at Historical Cost	10,724,663		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,669,368		16
17	Accumulated Depreciation (book methods)	(6,866,201)		17
18	Deferred Charges	273,080		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Omit	111,327		22
23	Other(specify): CIP	44,354		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,875,192	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,503,422	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 208,693	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	723,598		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	355,859		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	110,814		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,398,964	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,398,964	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,104,458	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,503,422	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,700,563	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,700,563	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,268,934)	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)	\$ (1,268,934)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	672,829	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 672,829	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,104,458	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Northbrook

0049676

Report Period Beginning: 06/01/15

Ending: 05/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,419,309	1
2	Discounts and Allowances for all Levels	(5,966,499)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,452,810	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,067,809	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,067,809	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	528	12
13	Barber and Beauty Care	12,356	13
14	Non-Patient Meals	3,263	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	925,139	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	90,593	19
20	Radiology and X-Ray	65	20
21	Other Medical Services	62,392	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,094,336	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	Activities Income & Purchase Discounts	394	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 394	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,615,349	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,611,421	31
32	Health Care	6,032,659	32
33	General Administration	3,800,549	33
	B. Capital Expense		
34	Ownership	1,638,194	34
	C. Ancillary Expense		
35	Special Cost Centers	546,536	35
36	Provider Participation Fee	254,924	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,884,283	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,268,934)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,268,934)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,462,845	44
45	Private Pay - Net Inpatient Revenue	1,265,393	45
46	Medicare - Net Inpatient Revenue	1,682,403	46
47	Other-(specify) <u>Hospice</u>	607,313	47
48	Other-(specify) <u>Insurance</u>	434,856	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,452,810	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,947	2,098	\$ 96,974	\$ 46.22	1
2	Assistant Director of Nursing	5,218	5,622	216,220	38.46	2
3	Registered Nurses	42,967	46,289	1,565,793	33.83	3
4	Licensed Practical Nurses	14,816	15,962	415,452	26.03	4
5	CNAs & Orderlies	87,949	94,894	1,460,955	15.40	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	23,509	25,310	1,016,483	40.16	7
8	Rehab/Therapy Aides	8,359	8,999	274,678	30.52	8
9	Activity Director	9,656	10,408	142,529	13.69	9
10	Activity Assistants					10
11	Social Service Workers	6,911	7,446	168,486	22.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,371	26,275	411,418	15.66	15
16	Dishwashers					16
17	Maintenance Workers	2,172	2,342	64,124	27.38	17
18	Housekeepers	15,063	16,238	219,085	13.49	18
19	Laundry	9,114	9,824	94,426	9.61	19
20	Administrator	2,080	2,080	108,870	52.34	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,764	18,132	525,647	28.99	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	2,006	2,163	37,279	17.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	272,902	294,082	\$ 6,818,419 *	\$ 23.19	34

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	61,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 61,400		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

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

** See instructions.

Facility Name & ID Number

Manorcare of Northbrook

STATE OF ILLINOIS

0049676

Report Period Beginning:

06/01/15

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Ending: 05/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tammy A. Wagner (6/2015-10/2015)	Administrator	0	\$ 31,679
Jennifer L. Miller (10/2015-5/2016)	Administrator	0	77,191
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 108,870

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	\$ 490,678
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 490,678

C. Professional Services

Vendor/Payee	Type	Amount
Asnpach Meeks Ellenberger LLP	Legal Fees	\$ 69
Polsinelli Shughart PC	Legal Fees	104
SNF Global	Legal Fees	30,374
(Legal fees were adjusted off via Page 5, Line 22, therefore, no invoices are attached)		
Meyers & Flowers LLC	Collection Services	14,691
National Eligibility Solutions LLC	Collection Services	30
Transworld Systems Inc	Collection Services	1,603
(Collection costs were adjusted off via Page 5a, Line 5, therefore, no invoices are attached)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 46,871

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 82,342
Unemployment Compensation Insurance	74,495
FICA Taxes	496,173
Employee Health Insurance	419,157
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	26,695
Appreciation, Oth Benefits & Mktg Adj	328
Tuition Program	
Smsp Match	106
Employee Uniforms	3,705
Home Office Allocation	43,476
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,146,477

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	\$ 3,980
Advertising: Employee Recruitment	20,908
Health Care Worker Background Check (Indicate # of checks performed 178)	4,862
Patient Background Checks 75	750
Dues & Subscriptions	14,454
Association Dues	9,381
Advertising	49,247
Other Licenses and Permits	8,404
Less: Non-Allowable Association Dues	(3,228)
Less: Public Relations Expense	()
Non-allowable advertising	(49,247)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 59,511

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	27,903
Includes travel expense to the Home Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 27,903

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number <u>Manorcare of Northbrook</u>	STATE OF ILLINOIS # <u>0049676</u>	Report Period Beginning: <u>06/01/15</u>	Ending: <u>05/31/16</u>
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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 \$3,904 & ACHA \$2,250

(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. \$ 81,493 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? YES
 If YES, give effective date of lease. 04/07/11

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 254,924
 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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 3,263

(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