

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0050302

Facility Name: Manorcare Arlington Heights

Address: 715 West Central Rd Arlington Hts 60005
Number City Zip Code

County: Cook

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

HFS ID Number:

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

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501(c)(3)

☐ PROPRIETARY ☐ GOVERNMENTAL
☐ Individual ☐ State
☐ Partnership ☐ County
☐ Corporation ☐ Other
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: a. Dean Shipman Telephone Number: (419) 254-7841
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 06/01/2019 to 05/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Martin D. Allen
(Title) Director

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number Manorcare Arlington Heights

0050302 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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>151</u>	Skilled (SNF)	<u>151</u>	<u>55,266</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>151</u>	TOTALS	<u>151</u>	<u>55,266</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>16,894</u>	<u>1,744</u>	<u>13,724</u>	<u>32,362</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>16,894</u>	<u>1,744</u>	<u>13,724</u>	<u>32,362</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.56%

D. How many bed reserve days during this year were paid by the Department? _____ (Do not include bed reserve 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 07/25/2018 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 8,406

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 Arlington Heights # 0050302 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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	422,668	33,573	3,704	459,945		459,945		459,945			1
2	Food Purchase		226,257		226,257		226,257	(635)	225,622			2
3	Housekeeping	228,868	22,825		251,693		251,693		251,693			3
4	Laundry	28,097	13,207		41,304		41,304		41,304			4
5	Heat and Other Utilities			139,693	139,693	3,079	142,772		142,772			5
6	Maintenance	86,514	15,841	100,517	202,872		202,872		202,872			6
7	Other (specify):* Security & Waste			12,103	12,103		12,103		12,103			7
8	TOTAL General Services	766,147	311,703	256,017	1,333,867	3,079	1,336,946	(635)	1,336,311			8
	B. Health Care and Programs											
9	Medical Director			50,400	50,400		50,400		50,400			9
10	Nursing and Medical Records	3,736,294	244,915	70,854	4,052,063	142	4,052,205		4,052,205			10
10a	Therapy	1,312,331	7,539	11,390	1,331,260		1,331,260		1,331,260			10a
11	Activities	83,541	3,392	2,386	89,319		89,319	(75)	89,244			11
12	Social Services	144,126	153		144,279		144,279		144,279			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,276,292	255,999	135,030	5,667,321	142	5,667,463	(75)	5,667,388			16
	C. General Administration											
17	Administrative	144,469		419,104	563,573	(74,907)	488,666		488,666			17
18	Directors Fees											18
19	Professional Services			51,749	51,749	(908)	50,841	(50,841)				19
20	Dues, Fees, Subscriptions & Promotions			111,313	111,313		111,313	(32,338)	78,975			20
21	Clerical & General Office Expenses	558,523	65,076	729,189	1,352,788	908	1,353,696	(622,910)	730,786			21
22	Employee Benefits & Payroll Taxes			1,046,857	1,046,857	53,249	1,100,106		1,100,106			22
23	Inservice Training & Education			2,503	2,503		2,503		2,503			23
24	Travel and Seminar			13,316	13,316		13,316		13,316			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			514,344	514,344		514,344		514,344			26
27	Other (specify):*											27
28	TOTAL General Administration	702,992	65,076	2,888,375	3,656,443	(21,658)	3,634,785	(706,089)	2,928,696			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,745,431	632,778	3,279,422	10,657,631	(18,437)	10,639,194	(706,799)	9,932,395			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare Arlington Heights #0050302 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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			198,359	198,359	21,882	220,241		220,241			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,477)	(1,477)	(3,445)	(4,922)		(4,922)			32
33	Real Estate Taxes			796,449	796,449		796,449		796,449			33
34	Rent-Facility & Grounds			83,333	83,333		83,333		83,333			34
35	Rent-Equipment & Vehicles			40,213	40,213		40,213		40,213			35
36	Other (specify):*											36
37	TOTAL Ownership			1,116,877	1,116,877	18,437	1,135,314		1,135,314			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		317,831		317,831		317,831		317,831			39
40	Barber and Beauty Shops			6,785	6,785		6,785		6,785			40
41	Coffee and Gift Shops	4,387			4,387		4,387		4,387			41
42	Provider Participation Fee			198,218	198,218		198,218		198,218			42
43	Other (specify):*		69,412	67,802	137,214		137,214		137,214			43
44	TOTAL Special Cost Centers	4,387	387,243	272,805	664,435		664,435		664,435			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,749,818	1,020,021	4,669,104	12,438,943		12,438,943	(706,799)	11,732,144			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	(635)	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	(262)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(60)	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	(8,902)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(36,941)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(613,273)	21		24
25	Fund Raising, Advertising and Promotional	(32,338)	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	(14,388)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (706,799)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (706,799)		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	Exeptional 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	\$ (75)	11	1
2	Misc. Income	0	21	2
3	Vending Income	(413)	21	3
4	Donations Revenue	0	21	4
5	Accounting/Collection Fees	(13,900)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest		32	8
9	WT Rent Expense		34	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
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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	(14,388)		49

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 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	\$ 419,104	HCR Manor Care Services, LLC	0.00%	\$ 419,104	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,749,819	Heartland Employment Services, LLC	0.00%	6,749,819		4
5	V								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			\$ 7,168,923			\$ 7,168,923	\$ *	14

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

Facility Name & ID Number

Manorcare Arlington Heights

0050302

Report Period Beginning:

06/01/2019

Ending:

05/31/2020

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 Galesburg IL, LLC	Galesburg				1
2			Heartland of Henry IL, LLC	Henry				2
3			Heartland of Macomb IL, LLC	Macomb				3
4			Heartland of Moline IL, LLC	Moline				4
5			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				5
6			Manor Care of Hinsdale IL, LLC	Hinsdale				6
7			Manor Care of Homewood IL, LLC	Homewood				7
8			Manor Care of Libertyville IL, LLC	Libertyville				8
9			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				9
10			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				10
11			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				11
12			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				12
13			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				13
14			Arden Courts of Geneva IL, LLC	Geneva				14
15			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				15
16			Arden Courts of Northbrook IL, LLC	Northbrook				16
17			Arden Courts of Palos Heights IL, LLC	Palos Heights				17
18			Arden Courts of South Holland IL, LLC	South Holland				18
19								19
20								20
21								21
22								22
23								23
24	Martin D. Allen	BOD						24
25	Lynne Davis	BOD						25
26	Kathryn S. Hoops	BOD						26
27	Thomas Kile	BOD						27
28	Patricia McCormick	BOD						28
29								29
30								30

Facility Name & ID Number Manorcare Arlington Heights # 0050302 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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 Arlington Heights# 0050302

Report Period Beginning:

06/01/2019Ending: 5/31/2020

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	Utilities - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	\$ 709,073	\$ 0	11,448,314	\$ 3,079	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs		0	11,448,314	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	11,448,314	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	32,137	0	11,448,314	140	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	454	0	11,448,314	2	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	11,448,314	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	57,708,481	23,053	11,448,314	250,561	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	7,841,321	0	11,448,314	42,505	10
11	17	Gen/Admin-Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs	2,818,405	0	11,448,314	51,131	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	5,631,859	35,913,957	11,448,314	24,453	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	5,312,192	1,179,502	11,448,314	28,796	14
15	22	Empl Bnfts-Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	11,448,314	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	4,013,110	0	11,448,314	17,424	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	822,456	0	11,448,314	4,458	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	11,448,314	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	2,636,740,077		(782,905)		11,448,314	(3,399)	22
23	32	Directly Assigned Interest	Not Allocated			(8,038)			(46)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,182,124				24
25	TOTALS					\$ 118,280,668	\$ 37,116,512		\$ 419,104	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			X				\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Home Office Pooled Interest Expense											(3,445)	6
7	Interest Income / Interest Expense											(1,477)	7
8													8
9	TOTAL Facility Related						\$					\$ (4,922)	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ (4,922)	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 2019 report.	\$	524,489							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.)	\$	604,517							2
3. Under or (over) accrual (line 2 minus line 1).	\$	80,029							3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	712,190							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.)	\$	4,230							5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$								6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	796,449							7
Real Estate Tax History:									
Real Estate Tax Bill for Calendar Year:	2015	528,387	8						
	2016	553,544	9						
	2017	592,387	10						
	2018	600,213	11						
	2019	660,234	12						
				FOR BHF USE ONLY					
Line 2: \$604,517 = \$274,400.21 for 2nd half 2018+ \$330,117.11 for 1st half 2019				13	FROM R. E. TAX STATEMENT FOR 2019 \$				13
Line 4: \$712,190.15= \$405,629.32 for 2nd half 2019 + \$306,560.83 for 1st half 2020				14	PLUS APPEAL COST FROM LINE 5 \$				14
Line 5: 2017 Worssek & Vihon \$230 & Urban Real Estate Research \$4000.				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.

FACILITY NAME Manorcare Arlington Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050302

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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.

A. Square Feet: 35,667

B. General Construction Type: ExteriorMasonryFrameSteel, Fire ResistantNumber of Stories2

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).

NONE

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	110,848	1973	\$ 111,118	1
2					2
3	TOTALS	110,848		\$ 111,118	3

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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)	\$	1,957,220	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					156,744		156,744		5,714,021	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

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 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	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	70

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

Facility Name & ID Number Manorcare Arlington Heights

0050302

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	1
2	<u>Doors</u>	2004	18,900						2
3	<u>Carpet</u>	2004	5,184						3
4	<u>Handrails & Backer Board</u>	2004	7,990						4
5	<u>Windows</u>	2004	4,946						5
6	<u>Wallcovering, Border & Flooring</u>	2004	5,700						6
7	<u>Electrical Work in Laundry Room</u>	2004	2,742						7
8	<u>Pave Parking Lot, and Stripe & Mark</u>	2004	42,166						8
9	<u>Renov. - General Overhead & Interest Disallowed per audit 4,33</u>	2005							9
10	<u>Renov. - Flooring</u>	2005	18,359						10
11	<u>Renov. - Windows</u>	2005	2,516						11
12	<u>Renov. - Wallcovering & Guards</u>	2005	6,095						12
13	<u>Emergency Electrical Circuit & Light Fixtures</u>	2005	19,672						13
14									14
15	<u>Drainage, Doors, & Brickwork</u>	2005	16,636						15
16	<u>Carpet</u>	2005	1,027						16
17	<u>Electrical work for emergency circuits</u>	2005	4,780						17
18	<u>Door, Frame, & tuckpoint</u>	2005	6,961						18
19	<u>Plumbing - re-configuartion for sink drains</u>	2006	2,460						19
20									20
21	<u>Stair Railings</u>	2006	6,750						21
22	<u>Plumbing - Chiller lines</u>	2006	2,314						22
23	<u>Plumbing - Exterior</u>	2006	17,748						23
24	<u>Carpet</u>	2006	358						24
25	<u>Electrical Work - Install electric heaters</u>	2006	3,985						25
26									26
27	<u>Electrical - 4 emergency outlets in Arlington Corridor</u>	2007	1,955						27
28	<u>Electrical - repair wiring for rooms 152, 154, & 156</u>	2007	2,498						28
29	<u>Foundation Unerdpinning - Pier jacking (7 areas)</u>	2007	16,420						29
30	<u>Foundation Work - Slapjacking 2450 sq feet</u>	2007	3,675						30
31	<u>Renov. - Flooring & Wallcovering</u>	2007	66,271						31
32	<u>Renov. - Carpentry-subcontr</u>	2007	16,701						32
33	<u>Doors</u>	2007	12,641						33
34	TOTAL (lines 1 thru 33)		\$ 6,171,558	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	34

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

Facility Name & ID Number Manorcare Arlington Heights

0050302

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	1
2	Renov. - Hot Water Boilers (2)	2007	64,296						2
3	7/1/2019 Capital Rate Adjustment pg 12c, ln 2	2007	(32,148)						3
4	Foundation Work - Slapjacking 2450 sq feet	2007	3,675						4
5	H.I. Renov. - Concrete Work	2007	4,584						5
6	H.I. Renov. - HM Doors	2007	4,335						6
7	H.I. Renov. - Flooring	2007	9,514						7
8	H.I. Renov. - Carpeting	2007	5,170						8
9	H.I. Renov. - Wallcovering	2007	28,933						9
10	H.I. Renov. - Cubical Curtains	2007	20,352						10
11	H.I. Renov. - Window Treatment	2007	4,070						11
12	H.I. Renov. - Basic Electrical	2007	11,484						12
13	H.I. Renov. - R.Callahan Construction Company	2007	670,422						13
14	7/1/2019 Capital Rate Adjustment pg 12c, ln 12	2007	(1,435)						14
15	Renov. - HVAC	2007	8,550						15
16	Renov. - Flooring	2007	5,677						16
17	main electrical panel	2007	7,335						17
18	TYCO SPRINLER SYSTEM	2008	5,713						18
19									19
20	Frabricate & Install Window Screens & Caulk Around	2008	20,322						20
21	Renov. - Flooring	2008	3,707						21
22	Renov. - Carpentry	2008	11,117						22
23	Renov. - Painting	2008	5,325						23
24	Renov. - Ceiling	2008	11,842						24
25	Renov. - Flooring	2008	11,685						25
26	Renov. - Wallcovering & Corner Guards	2008	8,812						26
27	Renov. - Hand Rail	2008	7,569						27
28	Renov. - Electrical	2008	7,085						28
29	Renov. - Plumbing	2008	7,101						29
30	KITCHEN DOORS	2008	14,178						30
31	EAST ELEVATOR UPGRADE	2008	6,475						31
32	WEST ELEVATOR UPGRADE	2008	6,475						32
33	Renov. - HVAC chiller 60 Ton Trane Model CGAFC60E	2008	56,602						33
34	TOTAL (lines 1 thru 33)		\$ 7,170,380	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	34

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

Facility Name & ID Number Manorcare Arlington Heights

0050302

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,170,380	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	1
2	6FT FENCE	2008	2,735						2
3	PVC GATE	2008	2,770						3
4	Provide & Install multiple Metal Doors	2009	16,108						4
5									5
6	0309 Elevator Upgrade - Elevators	2009	60,450						6
7	0309 Elevator Upgrade - Doors & Frames	2009	4,485						7
8	Ceiling	2009	2,820						8
9	Hollow Metal Door	2009	5,185						9
10	Thermal Detection for Fire	2009	5,155						10
11	1509 Drainage Piping - Plumbing Piping	2009	33,800						11
12	0409 Boiler Replacement - Engineering Mechanical	2009	65,183						12
13	Second Floor Sprinkler Heads	2009	17,550						13
14	SS Dishwash Exhaust	2010	11,420						14
15									15
16	electrical upgrade - New AC Units in Kitchen	2010	5,494						16
17	Proj 0510 Williamsburg Reno - Ceiling Tile	2010	4,100						17
18	Proj 0510 Williamsburg Reno - Flooring	2010	49,349						18
19	Proj 0510 Williamsburg Reno - Carpeting	2010	19,906						19
20	Proj 0510 Williamsburg Reno - Wall Covering	2010	5,606						20
21	Proj 0510 Williamsburg Reno - Corner Guards	2010	2,104						21
22	Proj 0510 Williamsburg Reno - Millwork	2010	13,952						22
23	Proj 0510 Williamsburg Reno - Basic Electrical	2010	3,370						23
24	5 exterior windows	2010	10,040						24
25	elevator shaft sprinkler head	2010	4,075						25
26	Proj 0510 Williamsburg Reno - Overhead and interest disallowed	2010							26
27									27
28	Fire Rated Hatch	2011	2,984						28
29	Doors HM (3)	2011	9,413						29
30	Chiller, Mltiaqua 10-Ton	2011	22,900						30
31	Flooring (Hallway 18X18)	2011	1,460						31
32	7/1/2019 Capital Rate Adjustment pg 12D, ln 29	2011	(1,460)						32
33	Data & Phone Relocation - Renov. 22-10C	2011	1,105						33
34	TOTAL (lines 1 thru 33)		\$ 7,552,439	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	34

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

Facility Name & ID Number Manorcare Arlington Heights

0050302

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 7,552,439	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	1
2	7/1/2019 Capital Rate Adjustment pg 12D, ln 30	2011	(1,105)						2
3	Concrete floor jacking - Renov. 22-10C	2011	21,875						3
4	Sewer drian replacement - Renov. 22-10C	2011	80,249						4
5	Carpeting - Renov. 22-10C	2011	8,197						5
6	PTAC Unit installation	2011	6,090						6
7	Eletrical wiring & breakers	2011	4,340						7
8	Elevator Cylinder, & PVC Liner	2011	14,985						8
9	Windows (3) Crystal Series	2011	8,024						9
10									10
11	Electrical Upgrade	2012	5,381						11
12	Elevator Hydraulic Pump	2013	7,650						12
13	Phone System Upgrade	2013	11,225						13
14									14
15	Light fixture upgrade - whole building	2013	14,927						15
16	Windows Rooms 144, 125, 127, 116, & PT	2013	7,104						16
17	EM Electric Upgrades to Med rms, Kiosks, nurse station, Offices	2014	8,897						17
18	Electric Upgrade 100 amp, 42 circuit panel-Kitchen, Laundry, Ho	2014	16,676						18
19									19
20	Window Upgrades - 10 windows Heritage Wing	2014	17,486						20
21	Flooring - Heritage Rooms 245-254	2014	6,330						21
22	Freight for flooring	2014	2,001						22
23	Wall Covering - 3 fire walls deck & elevator room	2014	8,181						23
24	Heaters - East Corridor	2015	5,686						24
25	Upper Roof Replacement (second story)	2014	51,119						25
26	Drywall - smoke walls internet café, room 144	2015	22,334						26
27	Heater - ceiling resistance heaters 2nd fl shower rooms	2015	4,891						27
28	Fan Motor - new fan and control board break room & med storag	2015	1,376						28
29	7/1/2019 Capital Rate Adjustment pg 12e, ln 24	2015	(1,376)						29
30	Breakers - new 30a PTAC circuits conf room	2015	2,656						30
31	Heater - 2 ceiling heaters room 102 & front doors	2015	5,087						31
32	Vinyl Awning	2015	1,458						32
33	7/1/2019 Capital Rate Adjustment pg 12e, ln 27	2015	(1,458)						33
34	TOTAL (lines 1 thru 33)		\$ 7,892,725	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	34

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

Facility Name & ID Number Manorcare Arlington Heights

0050302

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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		\$ 7,892,725	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	1
2	Ceiling Grid - celing grid and tire repair	2015	1,895						2
3	7/1/2019 Capital Rate Adjustment pg 12e, ln 28	2015	(1,895)						3
4	Circuit Panel - life safety panel correction	2015	15,927						4
5	Receptacle Device 9 mounted quad receptacle devices	2015	1,293						5
6	7/1/2019 Capital Rate Adjustment pg 12e, ln 30	2015	(1,293)						6
7	Metal Door - boiler room exterior doors	2015	4,683						7
8	Metal Door - boiler room exterior doors	2015	4,844						8
9	HM Door in EE break room	2015	2,888						9
10	HM Door in dishwasher room	2015	3,820						10
11	Rooftop Unit & related electrical work by E. nursing station	2015	17,470						11
12	Roof Replacement (project #012-15)	2015	177,695						12
13	Eletrical work for (19) 2nd Floor TVs	2015	13,397						13
14	HVAC Wall Pack in MDS office	2015	7,198						14
15	Repair Smoke Walls above 2 sets of corridor doors	2015	8,355						15
16	Water Pump for Domestic Water Heater	2015	3,498						16
17	Draft Inducers (3) for Domestic Boilers	2015	3,900						17
18	Extend Generator Exhaust beyound 2nd Floor Roof Line	2015	2,700						18
19	Windows in ms 124, 277 & 2nd Flr South Facing Windows	2015	6,670						19
20	Ceiling Tile inside 2nd flr Environmental Service Office	2015	10,640						20
21	Repair Firewall on Resident Rm 125 & at top of deck	2015	13,680						21
22	Repair Firewall by Room 125, above Maintenance Office	2015	9,360						22
23	Carpet & Wall Base in Environmental Serivces Office	2015	3,048						23
24	HM Door & Frame for East Stairwell	2016	4,660						24
25	Elevator Shaft & Pump	2016	24,300						25
26	Rooftop Chiller Piping for PT	2016	3,200						26
27	Piping and Valve for Chiller, for house system	2016	4,880						27
28	Compressor in Aaon 6 ton RTU for Dining Room	2016	3,275						28
29	Renovate resident rooms and bathrooms:								29
30	Renov - Flooring & Plumbing	2015	340,508						30
31	Renov - Carpentry-subcontractor & HVAC	2015	122,264						31
32	Renov - Painting & Wallcovering	2015	119,969						32
33	Renov. - Basic Composite Electrical	2015	35,161						33
34	TOTAL (lines 1 thru 33)		\$ 8,860,715	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	34

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

Facility Name & ID Number Manorcare Arlington Heights

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Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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 12F, Carried Forward		\$ 8,860,715	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	1
2	Repair Expansion Joints (2) in Hydronic System by room 138	2016	6,200						2
3	Repair Asphalt, Seal & Stripe Parking Lot	2015	13,692						3
4	Concrete Sidewalk (6 sections) & Curbs (80 feet)	2015	9,425						4
5									5
6	Replaced ceramic floor tiles in main kitchen	2016	8,435						6
7	Installed new panic fire-rated door to center stairwell	2016	2,645						7
8	Installed 2 alum frame sliding windows in pt rooms 128 & 278	2016	3,840						8
9	Installed 2 HM entrance doors to Williamsburg unit	2016	8,655						9
10	Installed valve and replace domestic hot water piping and fittings	2017	3,200						10
11	Installed toilet w/diaphragm and spud in room 152	2017	3,266						11
12	Installed valves @ boiler units and storage tank	2017	7,123						12
13	Removed and installed boiler	2017	22,633						13
14	Installed 7 semi-recessed light fixtures in rear corridor & relocate	2017	5,625						14
15	6 light fixtures to lobby								15
16	Paint and replace sheet vinyl floor in pt room on 1st floor	2016	9,872						16
17									17
18	Tile shower in 2nd floor shower room	2017	3,915						18
19	Mechanical room ceiling patch	2017	3,420						19
20	Res room windows in rms 112 & 113	2017	3,071						20
21	CPU alarm in front main lobby	2017	2,820						21
22	Electrical conduit and wiring Rooms 117, 119,121,123.	2017	4,028						22
23	Ceiling pipes in rm 129 and maintenance office	2017	6,920						23
24	2nd floor smoke wall	2017	2,777						24
25	1hr rated drywall ceiling in O2 Room	2017	5,758						25
26	Water lines in south hallway ceiling	2018	5,058						26
27	Exterior LED Light figures, 18 wall mounted & 5 pole mounted in par	2017	2,967						27
28	Awning for entrance canopy 22x8x3' vinyl, blue sea, w/Manor Care gr	2018	2,845						28
29	Asphalt repair - west parking lot & apron, service drive	2017	5,915						29
30									30
31	Install HM door in receptionist office area	2018	2,740						31
32	Installed stainless steel backsplash-kitchen	2018	2,500						32
33	Supplied & installed NEW MIXING VALVE	2018	3,727						33
34	TOTAL (lines 1 thru 33)		\$ 9,023,787	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	34

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

Facility Name & ID Number Manorcare Arlington Heights

0050302

Report Period Beginning:

06/01/2019 Ending: 05/31/2020

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 12G, Carried Forward		\$ 9,023,787	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	1
2	ROOF REPAIR	2018	15,410						2
3	Carpet Mebridge, front lobby area & west entrance hallway	2018	27,754						3
4	Install 3 sheets of white FRP on wall by prep area	2018	3,375						4
5	carpet in lobby area	2018	18,620						5
6	windows in res rms #275,137,135 & 156	2019	9,678						6
7	Paint & drywall repairs throughout the building	2018	3,070						7
8	Dry Fire Sprinkler System repair	2019	3,085						8
9	install 4 sheets of FRP on kitchen wall	2019	3,465						9
10	rep 2 faucets, 3 twist drains & repipe drain	2019	11,651						10
11	vinyl clad windows for rooms #151-155 & 158	2019	8,894						11
12	Lobby fan coil unit replacement	2019	4,079						12
13									13
14	Repair the outlet piping -kichen catch basin	2019	5,862						14
15	Relocate sprinkler heads in 21 room closets	2019	8,925						15
16	Fan coil unit replacement in patient room 125	2019	4,356						16
17	Installed 2 surface mounted quad devices in room 275	2019	2,920						17
18	Replaced 67 sprinkler heads throughout bldg	2019	24,500						18
19	Swing out alum glass door toward parking lot	2019	13,854						19
20	Install up to 2 inches of asphalt surface	2019	3,903						20
21	Meridian Countertop Ice Machine	2019	5,058						21
22	WINDOWS in 4 res rooms, act office & 2nd fl hallway	2019	9,482						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,211,727	\$ 115,319		\$ 115,319	\$	\$ 7,671,241	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	\$ 3,617,755	\$ 83,040	\$ 83,040	\$		\$ 3,357,824	71
72	Current Year Purchases	60,136						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			21,882	21,882			74
75	TOTALS	\$ 3,677,891	\$ 83,040	\$ 104,922	\$ 21,882		\$ 3,357,824	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	13,000,736
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	198,359
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	220,241
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	21,882
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	11,029,065

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 47,888
93		
94		
95		\$ 47,888

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1969		12/19/1972	\$ 83,333	41	10	3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 83,333			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: \$ 40,213
- 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

10. Effective dates of current rental agreement:

Beginning 1/1/2019

Ending 3/31/2023

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

	Fiscal Year Ending	Annual Rent
12.	5/31/2021	\$
13.	5/31/2022	\$
14.	5/31/2023	\$

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)												
		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	5911	hrs	\$ 272,281		\$	862	5,911	\$ 273,143	1	
2	Licensed Speech and Language Development Therapist	10a	3777	hrs	173,971			864	3,777	174,835	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	3922	hrs	180,649			5,142	3,922	185,791	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				317,831		317,831	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): <u>Inhal Therapy</u>	10a, 3				91	6,060		91	6,060	12	
13	Other (specify): <u>X-Ray & Lab IV</u>	43, 2 & 3					67,802	69,412		137,214	13	
14	TOTAL				\$ 626,901	91	\$ 73,862	\$ 394,111	13,701	\$ 1,094,874	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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,480	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 491,812)	1,029,003		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,025		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,036,508	\$	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	9,211,727		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,677,891		16
17	Accumulated Depreciation (book methods)	(11,029,065)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) OMIT	206,285		22
23	Other(specify): CIP	47,888		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,225,844	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,262,352	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 195,738	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	557,231		30
31	Accrued Taxes Payable (excluding real estate taxes)	10		31
32	Accrued Real Estate Taxes(Sch.IX-B)	712,190		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	82,959		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,548,128	\$	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)	\$ 1,548,128	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,714,224	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,262,352	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,107,410	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,107,410	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(658,300)	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)	\$ (658,300)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	265,114	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 265,114	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,714,224	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare Arlington Heights

0050302

Report Period Beginning: 06/01/2019

Ending: 05/31/2020

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	\$ 11,507,231	1
2	Discounts and Allowances for all Levels	(5,254,405)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,252,826	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,895,506	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,895,506	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	413	12
13	Barber and Beauty Care	7,101	13
14	Non-Patient Meals	635	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	741,760	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	69,809	19
20	Radiology and X-Ray	47,472	20
21	Other Medical Services	51,238	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 918,428	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Discount</u>	713,883	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 713,883	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,780,643	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,333,867	31
32	Health Care	5,667,321	32
33	General Administration	3,656,443	33
	B. Capital Expense		
34	Ownership	1,116,877	34
	C. Ancillary Expense		
35	Special Cost Centers	466,217	35
36	Provider Participation Fee	198,218	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,438,943	40
41	Income before Income Taxes (line 30 minus line 40)**	(658,300)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (658,300)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,964,097	44
45	Private Pay - Net Inpatient Revenue	536,498	45
46	Medicare - Net Inpatient Revenue	2,051,876	46
47	Other-(specify) <u>Hospice</u>	173,941	47
48	Other-(specify) <u>Insurance</u>	526,414	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,252,826	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	2,052	2,233	\$ 125,769	\$ 56.32	1
2	Assistant Director of Nursing	3,799	4,134	166,929	40.38	2
3	Registered Nurses	47,545	51,741	1,846,030	35.68	3
4	Licensed Practical Nurses	10,745	11,693	347,722	29.74	4
5	CNAs & Orderlies	66,527	72,633	1,175,585	16.19	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	16,495	17,905	824,688	46.06	7
8	Rehab/Therapy Aides	12,432	13,494	487,643	36.14	8
9	Activity Director	4,392	4,783	83,541	17.47	9
10	Activity Assistants					10
11	Social Service Workers	5,728	6,235	144,126	23.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,636	24,648	422,668	17.15	15
16	Dishwashers					16
17	Maintenance Workers	2,550	2,742	86,514	31.55	17
18	Housekeepers	14,364	15,617	228,868	14.66	18
19	Laundry	2,025	2,205	28,097	12.74	19
20	Administrator	2,080	2,080	144,469	69.46	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,539	21,310	558,523	26.21	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	2,842	3,085	74,259	24.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	331	360	4,387	12.19	33
34	TOTAL (lines 1 - 33)	236,082	256,898	\$ 6,749,818 *	\$ 26.27	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	50,400	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)		\$ 50,400		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

Facility Name & ID Number		Manorcare Arlington Heights		STATE OF ILLINOIS		Report Period Beginning:		06/01/2019		Ending: 05/31/2020	
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		Amount
Anne Berg	Administrator	0	\$ 144,469	Workers' Compensation Insurance		\$ 47,495	IDPH License Fee		\$ 1,990		
				Unemployment Compensation Insurance		5,837	Advertising: Employee Recruitment		34,745		
				FICA Taxes		480,790	Health Care Worker Background Check				
				Employee Health Insurance		424,732	(Indicate # of checks performed 296)		8,038		
				Employee Meals			Patient Background Checks	399	3,990		
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		14,966		
				Disability Payments			Association Dues		9,826		
TOTAL (agree to Schedule V, line 17, col. 1)				401K		75,177	Advertising		29,620		
(List each licensed administrator separately.)			\$ 144,469	Appreciation, Oth Benefits & Mktg Adj		1,795	Other Licenses and Permits		8,138		
B. Administrative - Other				Tuition Program		7,500	Less: Non-Allowable Association Dues		(2,718)		
Description			Amount	SMSP Match			Less: Public Relations Expense	(			
Various Home Office Services - See Page 8 for breakdown			\$ 419,104	Employee Uniforms		3,531	Non-allowable advertising		(29,620)		
				Home Office Allocation		53,249	Yellow page advertising	(			
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,100,106	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 78,975		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 419,104	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)				Description				Description			
C. Professional Services				Line #				Amount			
Vendor/Payee		Type	Amount	Amount				Out-of-State Travel		\$	
Various		Legal Fees	\$ 36,941								
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.											
Various		Collections	13,900					In-State Travel		13,316	
AR Collection Costs were adjusted off via Page 5A, Lines 6 & 7, therefore, no detail schedule is attached.								Includes travel expense to the Home Office in Toledo, OH for regional meetings			
MICHIGAN PEER REVIEW		Consulting Fees	908					Seminar Expense			
(Consultant fees are reclassified to line 21, therefore, no invoices are attached).											
								Entertainment Expense			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				(agree to Sch. V, line 24, col. 8)		(	
(For legal fee disclosure, see page 39 of instructions)			\$ 51,749					TOTAL		\$ 13,316	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA \$4,848 & AHCA \$2,260
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,749 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. 7/28/18
- (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. \$ 198,218
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. \$ 635
- (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?
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 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.