

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0049551

Facility Name: Manor Care of Oak Lawn (West) IL, LLC

Address: 6300 West 95th Street Oak Lawn 60453
Number City Zip Code

County: Cook

Telephone Number: (708) 559-8800 Fax # (708) 559-8820

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Gary Geise Telephone Number: (419) 252-5731
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 06/01/10 to 05/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid
Preparer

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

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

Facility Name & ID Number Manor Care of Oak Lawn (West) IL, LLC

0049551 Report Period Beginning: 06/01/10 Ending: 05/31/11

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>192</u>	Skilled (SNF)	<u>192</u>	<u>70,080</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>192</u>	TOTALS	<u>192</u>	<u>70,080</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,476</u>	<u>6,147</u>	<u>30,488</u>	<u>57,111</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>20,476</u>	<u>6,147</u>	<u>30,488</u>	<u>57,111</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.49%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/81

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 192 and days of care provided 23,087

Medicare Intermediary Highmark Medicare Services

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.

STATE OF ILLINOIS

Facility Name & ID Number

Manor Care of Oak Lawn (West) IL, LLC

0049551

Report Period Beginning:

06/01/10

Ending:

05/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	465,848	40,949	11,663	518,460	13,800	532,260		532,260			1
2	Food Purchase		373,902		373,902		373,902	(399)	373,503			2
3	Housekeeping	216,009	36,816	2,300	255,125		255,125		255,125			3
4	Laundry	49,707	33,050	782	83,539		83,539		83,539			4
5	Heat and Other Utilities			226,440	226,440	3,720	230,160		230,160			5
6	Maintenance	78,733	27,239	124,498	230,470		230,470		230,470			6
7	Other (specify):* Med Waste			1,516	1,516		1,516		1,516			7
8	TOTAL General Services	810,297	511,956	367,199	1,689,452	17,520	1,706,972	(399)	1,706,573			8
	B. Health Care and Programs											
9	Medical Director			54,000	54,000		54,000		54,000			9
10	Nursing and Medical Records	4,712,777	491,984	263,269	5,468,030	16,369	5,484,399		5,484,399			10
10a	Therapy	1,872,842	27,190	224,392	2,124,424		2,124,424		2,124,424			10a
11	Activities	158,705	7,219	1,765	167,689		167,689		167,689			11
12	Social Services	198,957	184		199,141		199,141		199,141			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,943,281	526,577	543,426	8,013,284	16,369	8,029,653		8,029,653			16
	C. General Administration											
17	Administrative	152,724		825,848	978,572	(237,222)	741,350		741,350			17
18	Directors Fees											18
19	Professional Services			92,553	92,553	(717)	91,836	(91,836)				19
20	Dues, Fees, Subscriptions & Promotions			98,306	98,306		98,306	(40,129)	58,177			20
21	Clerical & General Office Expenses	626,513	71,163	364,946	1,062,622	717	1,063,339	(247,288)	816,051			21
22	Employee Benefits & Payroll Taxes			1,585,269	1,585,269	62,866	1,648,135		1,648,135			22
23	Inservice Training & Education			1,457	1,457		1,457		1,457			23
24	Travel and Seminar			4,885	4,885		4,885		4,885			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			561,230	561,230		561,230		561,230			26
27	Other (specify):*											27
28	TOTAL General Administration	779,237	71,163	3,534,494	4,384,894	(174,356)	4,210,538	(379,253)	3,831,285			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,532,815	1,109,696	4,445,119	14,087,630	(140,467)	13,947,163	(379,652)	13,567,511			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			433,058	433,058	21,796	454,854		454,854			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			469,415	469,415	118,671	588,086	(478,293)	109,793			32
33	Real Estate Taxes			571,058	571,058		571,058		571,058			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			52,574	52,574		52,574		52,574			35
36	Other (specify):*											36
37	TOTAL Ownership			1,526,105	1,526,105	140,467	1,666,572	(478,293)	1,188,279			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			(500)	(500)		(500)		(500)			38
39	Ancillary Service Centers		781,355		781,355		781,355		781,355			39
40	Barber and Beauty Shops			14,443	14,443		14,443		14,443			40
41	Coffee and Gift Shops	24,896			24,896		24,896		24,896			41
42	Provider Participation Fee			105,120	105,120		105,120		105,120			42
43	Other (specify):* IV Ther/Xray/Lab		138,460	255,524	393,984		393,984		393,984			43
44	TOTAL Special Cost Centers	24,896	919,815	374,587	1,319,298		1,319,298		1,319,298			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,557,711	2,029,511	6,345,811	16,933,033		16,933,033	(857,945)	16,075,088			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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(399)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(199)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(91,836)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(227,621)	21		24
25	Fund Raising, Advertising and Promotional	(40,129)	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	(496,761)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (857,945)		\$	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))	\$ (857,945)		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

Report Period Beginning:

ID#0049551

Ending:

06/01/10

05/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (13,731)	21	1
2	P/R O/H Allod - Marketing	(3,921)	21	2
3	HCP Lease Interest	(478,293)	32	3
4	Vending Income	(790)	21	4
5	Miscellaneous Income	(26)	21	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
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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	(496,761)		49

Summary A

05/31/11

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

[illegible]

Summary B

Facility Name & ID Number	Manor Care of Oak Lawn (West) IL, LLC	#	0049551	Report Period Beginning:	06/01/10	Ending:	05/31/11
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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
		See PG6-Supp for list of related nursing homes in Illinois				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	Home Office Allocation	\$ 825,848	HCR Manor Care Services, LLC	100.00%	\$ 825,848	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	8,557,711	Heartland Employment Services, LLC	100.00%	8,557,711		4
5	V	10a	Therapy Management	13,330	Heartland Rehabilitation Services, LLC	100.00%	13,330		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			\$ 9,396,889			\$ 9,396,889	\$ *	14

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

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 - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights West IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

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 Manor Care of Oak Lawn (West) IL, LLC # 0049551 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	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	1	Dietary - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	\$ 2,652,139	\$ 1,448,591	15,179,081	\$ 13,800	1
2	1	Dietary - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			15,179,081	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs,HHs, Rehab			15,179,081	0	3
4	5	Utilities - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs			15,179,081	0	4
5	5	Utilities - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			15,179,081	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs,HHs, Rehal	817,551		15,179,081	3,720	6
7	10	Nursing - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	15,179,081	14,048	7
8	10	Nursing - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			15,179,081	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs,HHs, Rehal	510,057	376,446	15,179,081	2,321	9
10	17	Gen/Admin - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	15,179,081	128,731	10
11	17	Gen/Admin - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs	1,871,124	5,027,701	15,179,081	41,004	11
12	17	Gen/Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs,HHs, Rehal	92,052,254	34,999,867	15,179,081	418,891	12
13	22	Empl Bnfts - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	7,290,309		15,179,081	37,933	13
14	22	Empl Bnfts - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			15,179,081	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs,HHs, Rehal	5,479,146		15,179,081	24,933	15
16	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954		15,179,081	1,488	16
17	30	Deprec - Direct to Central Div	Accumulated Cost	692,663,974	92 NFs			15,179,081	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs,HHs, Rehal	4,462,801		15,179,081	20,308	18
19										19
20	32	Directly Assigned Interest				12,736,052			118,671	20
21		Non-Central Div Nrsg Hm Allocations				29,513,406				21
22										22
23										23
24										24
25	TOTALS					\$ 185,111,177	\$ 62,809,840		\$ 825,848	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	Conv. Sub. Debentures		X	Various			\$ 2,639,793	\$ 2,639,793		0.0450	\$ 118,671	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income / Expense Other										(8,878)	8	
9	TOTAL Facility Related						\$ 2,639,793	\$ 2,639,793			\$ 109,793	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,639,793	\$ 2,639,793			\$ 109,793	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 2010 report.		\$	530,562	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.)		\$	608,886	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	78,324	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	507,092	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.		\$	14,477	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 \$ See Below For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(28,835)	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	571,058	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	486,443	8	
		2007	495,385	9	
		2008	548,428	10	
		2009	587,433	11	
		2010	586,009	12	
Line 2: \$608,886.50 = \$323,088.38 for 1st half of 2010 + \$285,798.12 for 2nd half of 2009				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
Line 4: \$507,091.68 = \$262,920.85 for 2nd half 2010 + \$244,170.83 for Jan -May 2011				14	PLUS APPEAL COST FROM LINE 5 \$ 14
Line 5: \$14,477.05 = Worsek & Vihon Invoice \$6,963.00 and Rock, Fusco & Assoc invoice \$7,514.05				15	LESS REFUND FROM LINE 6 \$ 15
Line 6: RE Tax Refund totaling (\$28,835) = (1,015.45) for 2000 Tax Year and (\$27,819.32) for 2007 Tax Year				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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manor Care of Oak Lawn (West) IL, LLC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049551

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>24-05-302-005-0000</u>	<u>See Attached</u>	\$ <u>586,009.23</u>	\$ <u>586,009.23</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>586,009.23</u></u>	\$ <u><u>586,009.23</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

50,339

B. General Construction Type:

ExteriorMasonry

FrameSteel

Number of Stories

1

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).

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			1981	\$ 820,000	1
2					2
3	TOTALS			\$ 820,000	3

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	98		1981	1962	\$ 313,600	\$ 29,965		\$ 29,965	\$	1,834,919	4
5	75		1981	1969	658,575						5
6	9			1987	448,818						6
7	10			1999	1,235,114						7
8											8
	Improvement Type**										
9	Current Year Depreciation					171,197		171,197		4,128,940	9
10				1985	2,374						10
11				1986	5,308						11
12				1987	5,756						12
13				1988	251,787						13
14				1989	94,354						14
15				1990	20,764						15
16				1991	63,572						16
17				1992	143,258						17
18				1993	317,964						18
19				1994	192,466						19
20				1995	469,304						20
21				1996	340,114						21
22				1997	203,364						22
23				1998	544,751						23
24				1999	207,547						24
25				2000	106,678						25
26				2001	44,153						26
27	HVAC & ELECTRIC			2002	37,140						27
28	WALLCOVERING, PAINT, & FLOORING			2002	60,964						28
29	WALL REPLACEMENT			2002	5,327						29
30	CARPENTRY & MILLWORK			2002	59,438						30
31	CARPET & WALLCOVERING			2002	13,156						31
32	HVAC & ELECTRICAL			2002	18,957						32
33	ELECTRICAL WORK			2002	2,768						33
34	EMERGENCY POWER UPGRADE CIRCUIT			2002	215,884						34
35	DRAINAGE WORK			2002	23,290						35
36	CARPET			2003	2,365						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 Manor Care of Oak Lawn (West) IL, LLC

0049551

Report Period Beginning:

06/01/10

Ending:

05/31/11

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 WALLCOVERING, BORDERS, & PAINTING	2003	\$ 8,019	\$		\$	\$	\$	37
38 WINDOW TREATMENTS	2003	3,647						38
39 TILE, CABINETS, COUNTER TOP, SINK (Soiled Utility room)	2003	36,272						39
40 HAND RAILS	2003	7,409						40
41 DOORS & FRAMES (9)	2003	17,938						41
42 TILE FLOOR & WALLS, PAINT, (Shower/Tub room)	2003	19,535						42
43 FLOOR TILE (Resident rooms)	2003	31,272						43
44 WALLCOVERING, BORDERS, & PAINTING	2003	38,430						44
45 ELECTRICAL WORK & LIGHT FIXTURES	2003	15,897						45
46 CONSTRUCTION DEPARTMENT COST & INTEREST	2003	25,344						46
47 PARKING LOT UPGRADE	2003	32,065						47
48 FENCING AROUND DUMPSTER	2003	7,898						48
49 DOORS	2004	7,344						49
50 CARPET	2004	10,711						50
51 Carpet	2004	1,899						51
52 Wallcovering & Paint	2004	3,277						52
53 Cabinets	2004	744						53
54 Doors	2004	34,253						54
55 Roofing	2004	5,450						55
56 Renov. - General Overhead & Interest	2004	21,977						56
57 Renov. - Mill Work	2004	4,633						57
58 Renov. - Doors	2004	1,632						58
59 Renov. - Drywall/Studs	2004	9,075						59
60 Renov. - Wallcovering & Corner Guards	2004	34,314						60
61 Renov. - Plumbing	2004	9,436						61
62 Renov. - Electrical	2004	4,345						62
63 Fenceing & Fence Posts	2004	4,500						63
64 Concrete Curbs	2004	8,225						64
65 Exterior Light Fixtures	2004	14,008						65
66 Renov. - General Overhead	2005	1,654						66
67 Renov. - Interest on Construction-Improvements	2005	293						67
68 Renov. - Carpeting & pads	2005	62,268						68
69 Renov. - Wall Covering	2005	1,580						69
70 TOTAL (lines 4 thru 69)		\$ 6,594,254	\$ 201,162		\$ 201,162	\$	\$ 5,963,859	70

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

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	
1 Totals from Page 12A, Carried Forward		\$ 6,594,254	\$ 201,162		\$ 201,162	\$	\$ 5,963,859	1
2 Renov. - General Overhead	2005	5,242						2
3 Renov. - Interest on Construction Imp	2005	320						3
4 Renov. - Freight Costs	2005	476						4
5 Renov. - Resilient Flooring	2005	9,106						5
6 Renov. - Carpeting, Pads & installation	2005	10,655						6
7 Renov. - Wallcovering and corner guards	2005	6,655						7
8 Renov. - Carpentry SubContracting	2005	24,882						8
9 Renov. - HM Doors & Frames	2005	4,310						9
10 30 AMP, 208V circuit	2005	2,399						10
11 Resident Room Doors	2005	31,770						11
12 Doors	2005	1,600						12
13 Sealing coat	2005	2,240						13
14 Renov - General Overhead	2006	2,695						14
15 Renov - Interest on Const - Impr	2006	243						15
16 Renov - Ceramic Tile	2006	6,000						16
17 Renov - Resilient Flooring	2006	29,972						17
18 Renov - Wallcovering	2006	2,840						18
19 Renov - Plumbing	2006	8,655						19
20 lochinvar heater	2006	23,225						20
21 conduit / wiring	2006	2,054						21
22 waterproofing	2006	2,888						22
23 vct	2006	1,672						23
24 windows	2006	6,878						24
25 VWC	2006	11,546						25
26 kitchen wall	2006	7,470						26
27 flooring / painting	2006	40,883						27
28 Conference room paint	2006	2,583						28
29 sidewalk	2006	1,362						29
30 plumbing, electrical, cabinetry for breakroom	2007	6,440						30
31 drains & downspouts	2007	20,196						31
32 Renov - General Overhead	2007	19,230						32
33 Renov - Interest on Const - Impr	2007	1,312						33
34 TOTAL (lines 1 thru 33)		\$ 6,892,053	\$ 201,162		\$ 201,162	\$	\$ 5,963,859	34

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

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	
1 Totals from Page 12B, Carried Forward		\$ 6,892,053	\$ 201,162		\$ 201,162	\$	\$ 5,963,859	1
2 Renov - Phone System Upgrade	2007	81,244						2
3 electrical for pill Dispenser	2007	1,715						3
4 Renov - General Overhead	2007	1,071						4
5 Renov - Interest on constr -imp	2007	87						5
6 renov -carpentry-subcontr Dumb Waiter	2007	19,302						6
7 Renov- New DumbWaiter	2007	21,450						7
8 carpet for nurse station	2007	2,408						8
9 electrical work for lobby	2007	1,773						9
10 west corridor wall covering	2007	5,611						10
11 metal doors	2008	5,880						11
12 paving	2007	12,092						12
13 JANITOR CLOSET	2008	8,883						13
14 SEWER PIPE	2008	6,480						14
15 paint ext window trim	2008	6,736						15
16 KITCHEN DOOR	2008	3,430						16
17 140ft drainage pipes	2008	19,602						17
18 ASPHALT	2008	9,860						18
19 ASPHALT	2008	4,062						19
20 metal /glass front door	2009	2,572						20
21 fire access panels for 35 rooms	2010	8,550						21
22 additional for fire access panels	2010	8,539						22
23 conduit on roof	2010	36,482						23
24 roof replacement	2010	657,742						24
25 smoke door wall magnets	2010	3,975						25
26 vinyl flooring & base	2010	4,095						26
27 HM door and alarm	2010	5,124						27
28 Additional for roof replacement	2011	24,095						28
29 Additional for roof replacement	2011	23,456						29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 7,878,366	\$ 201,162		\$ 201,162	\$	\$ 5,963,859	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	\$ 3,115,262	\$ 231,896	\$ 231,896	\$		\$ 2,721,643	71
72	Current Year Purchases	240,336						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			21,796	21,796			74
75	TOTALS	\$ 3,355,598	\$ 231,896	\$ 253,692	\$ 21,796		\$ 2,721,643	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	Resident	1995 Goshen GCH	1995	\$ 12,107	\$	\$	\$		\$ 12,107
77		Paratransit							
78									
79									
80	TOTALS			\$ 12,107	\$	\$	\$		\$ 12,107

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)			\$ 12,066,071
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 433,058
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 454,854
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 21,796
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 8,697,609

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	\$ 52,209
93		
94		
95		\$ 52,209

* 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: \$ 52,574 Description: 02 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 _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	13260	hrs	\$ 506,244	1,938	\$ 93,010	\$ 3,403	15,198	\$ 602,657	1
2	Licensed Speech and Language Development Therapist	10a	6205	hrs	236,901	241	11,556	381	6,446	248,838	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	8994	hrs	343,426	2,036	97,739	23,406	11,030	464,571	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				781,355		781,355	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Inhalation Therapist</u>	10a	2617		99,909				2,617	99,909	12
13	Other (specify): <u>IV Ther/Xray/Lab</u>	43, 2 & 3					255,524	138,460		393,984	13
14	TOTAL				\$ 1,186,480	4,215	\$ 457,829	\$ 947,005	35,291	\$ 2,591,314	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	\$ 5,558	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (606,563))	2,250,135		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,034		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,260,727	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	820,000		13
14	Buildings, at Historical Cost	7,878,367		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,367,704		16
17	Accumulated Depreciation (book methods)	(8,697,609)		17
18	Deferred Charges	11,086,295		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	52,209		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,506,966	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,767,693	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 279,303	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	821,233		30
31	Accrued Taxes Payable (excluding real estate taxes)	108,108		31
32	Accrued Real Estate Taxes(Sch.IX-B)	507,092		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	181,445		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,897,181	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	43,245,586		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	249,690		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 43,495,276	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 45,392,457	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (28,624,764)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,767,693	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,263,889	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,263,889	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,680,381	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)	\$ 3,680,381	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(33,569,034)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (33,569,034)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (28,624,764)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 20,825,126	1
2	Discounts and Allowances for all Levels	(7,058,899)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,766,227	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,642,062	6
7	Oxygen	24	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,642,086	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	858	12
13	Barber and Beauty Care	14,920	13
14	Non-Patient Meals	399	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	834,805	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	184,126	19
20	Radiology and X-Ray	62,013	20
21	Other Medical Services	107,954	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,205,075	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	Miscellaneous Income	26	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 26	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,613,414	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	1,689,452	31
32	Health Care	8,013,284	32
33	General Administration	4,384,894	33
	B. Capital Expense		
34	Ownership	1,526,105	34
	C. Ancillary Expense		
35	Special Cost Centers	1,214,178	35
36	Provider Participation Fee	105,120	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,933,033	40
41	Income before Income Taxes (line 30 minus line 40)**	3,680,381	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,680,381	43

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

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

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

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

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	1,910	2,056	\$ 85,345	\$ 41.51	1
2	Assistant Director of Nursing	5,126	5,517	191,322	34.68	2
3	Registered Nurses	49,989	53,807	1,816,526	33.76	3
4	Licensed Practical Nurses	35,896	38,638	976,493	25.27	4
5	CNAs & Orderlies	132,350	142,634	1,623,568	11.38	5
6	CNA Trainees					6
7	Licensed Therapist	31,076	33,461	1,277,506	38.18	7
8	Rehab/Therapy Aides	21,353	22,991	595,336	25.89	8
9	Activity Director	10,843	11,677	158,705	13.59	9
10	Activity Assistants					10
11	Social Service Workers	8,211	8,844	198,957	22.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,627	35,139	465,848	13.26	15
16	Dishwashers					16
17	Maintenance Workers	3,764	4,054	78,733	19.42	17
18	Housekeepers	20,369	21,932	216,009	9.85	18
19	Laundry	4,894	5,272	49,707	9.43	19
20	Administrator	2,080	2,080	105,708	50.82	20
21	Assistant Administrator	1,397	1,397	47,016	33.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,169	32,385	606,861	18.74	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	1,354	1,458	19,523	13.39	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	2,027	2,183	24,896	11.40	33
34	TOTAL (lines 1 - 33)	395,435	425,525	\$ 8,538,059 *	\$ 20.06	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	54,000	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)		\$ 54,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	355	\$ 24,143	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	355	\$ 24,143		53

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

** 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.

ICHA \$6,675

(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_\$13610

(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.

\$ 105,669

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.

\$ 105,120

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.

\$ 399

(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 out of Schedule V?

YES

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

NO

Attach invoices and a summary of services for all architect and appraisal fees.