

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0049668</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Manorcare of Oak Lawn East</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/11</u> to <u>05/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>9401 South Kostner Avenue</u> <u>Oak Lawn</u> <u>60453</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(708) 423-7882</u> Fax # <u>(708) 423-7947</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>1977</u>			
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 _____

Facility Name & ID Number Manorcare of Oak Lawn East# 0049668 Report Period Beginning: 06/01/11 Ending: 05/31/12

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>122</u>	Skilled (SNF)	<u>122</u>	<u>44,652</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	122	TOTALS	122	44,652	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>10,132</u>	<u>3,455</u>	<u>27,393</u>	<u>40,980</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,132	3,455	27,393	40,980	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.78%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YesG. 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 1977

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 04/07/11NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 122 and days of care provided 21,055Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐NO ☒Tax Year: 12/31Fiscal Year: 05/31

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

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	371,192	31,683	3,876	406,751		406,751		406,751			1
2	Food Purchase		297,015		297,015		297,015	(1,823)	295,192			2
3	Housekeeping	197,597	28,115	339	226,051		226,051		226,051			3
4	Laundry	55,600	20,464		76,064		76,064		76,064			4
5	Heat and Other Utilities			170,804	170,804	3,212	174,016		174,016			5
6	Maintenance	66,751	29,741	126,783	223,275		223,275		223,275			6
7	Other (specify):* Medical Waste			1,407	1,407		1,407		1,407			7
8	TOTAL General Services	691,140	407,018	303,209	1,401,367	3,212	1,404,579	(1,823)	1,402,756			8
	B. Health Care and Programs											
9	Medical Director			59,497	59,497		59,497		59,497			9
10	Nursing and Medical Records	3,990,133	405,335	233,126	4,628,594	61,303	4,689,897		4,689,897			10
10a	Therapy	2,115,060	28,532	524,583	2,668,175		2,668,175		2,668,175			10a
11	Activities	124,703	3,719	1,505	129,927		129,927		129,927			11
12	Social Services	233,992			233,992		233,992		233,992			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,463,888	437,586	818,711	7,720,185	61,303	7,781,488		7,781,488			16
	C. General Administration											
17	Administrative	83,337		698,932	782,269	(228,939)	553,330		553,330			17
18	Directors Fees											18
19	Professional Services			116,233	116,233	(41,614)	74,619	(74,619)				19
20	Dues, Fees, Subscriptions & Promotions			97,526	97,526		97,526	(39,143)	58,383			20
21	Clerical & General Office Expenses	492,846	91,651	522,442	1,106,939	580	1,107,519	(401,879)	705,640			21
22	Employee Benefits & Payroll Taxes			1,300,343	1,300,343	43,328	1,343,671		1,343,671			22
23	Inservice Training & Education			724	724		724		724			23
24	Travel and Seminar			4,785	4,785		4,785		4,785			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			391,067	391,067		391,067		391,067			26
27	Other (specify):*							(149)	(149)			27
28	TOTAL General Administration	576,183	91,651	3,132,052	3,799,886	(226,645)	3,573,241	(515,790)	3,057,451			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,731,211	936,255	4,253,972	12,921,438	(162,130)	12,759,308	(517,613)	12,241,695			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			437,091	437,091	22,387	459,478		459,478			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,373,842	1,373,842	139,743	1,513,585	(1,381,089)	132,496			32
33	Real Estate Taxes			250,836	250,836		250,836		250,836			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			64,420	64,420		64,420		64,420			35
36	Other (specify):*											36
37	TOTAL Ownership			2,126,189	2,126,189	162,130	2,288,319	(1,381,089)	907,230			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		883,769	800	884,569		884,569		884,569			39
40	Barber and Beauty Shops			11,194	11,194		11,194		11,194			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			208,822	208,822		208,822		208,822			42
43	Other (specify):* IV X-Ray & Lab		207,961	194,688	402,649		402,649		402,649			43
44	TOTAL Special Cost Centers		1,091,730	415,504	1,507,234		1,507,234		1,507,234			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,731,211	2,027,985	6,795,665	16,554,861		16,554,861	(1,898,702)	14,656,159			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,823)	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	(124)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(149)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(74,619)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(341,060)	21		24
25	Fund Raising, Advertising and Promotional	(39,143)	20		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,428,784)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,898,702)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,898,702)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Manorcare of Oak Lawn East

Report Period Beginning:06/01/11

Ending:05/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wage - Marketing	\$ (36,352)	21	1
2	Employee benefits - Marketing	(10,011)	21	2
3	HCP Lease Interest	(1,381,089)	32	3
4	Vending Income	(1,332)	21	4
5	Misc. Income	0	21	5
6	Activity Income	0	11	6
7	Loss on Disposal of Fixed Assets	0	36	7
8			21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,428,784)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/11 Ending: 05/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,823)	0	0	0	0	0	0	0	0	0	0	(1,823)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,823)	0	0	0	0	0	0	0	0	0	0	(1,823)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(74,619)	0	0	0	0	0	0	0	0	0	0	(74,619)	19
20	Fees, Subscriptions & Promotions	(39,143)	0	0	0	0	0	0	0	0	0	0	(39,143)	20
21	Clerical & General Office Expenses	(401,879)	0	0	0	0	0	0	0	0	0	0	(401,879)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(149)	0	0	0	0	0	0	0	0	0	0	(149)	27
28	TOTAL General Administration	(515,790)	0	0	0	0	0	0	0	0	0	0	(515,790)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(517,613)	0	0	0	0	0	0	0	0	0	0	(517,613)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,381,089)	0	0	0	0	0	0	0	0	0	0	(1,381,089)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,381,089)	0	0	0	0	0	0	0	0	0	0	(1,381,089)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,898,702)	0	0	0	0	0	0	0	0	0	0	(1,898,702)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svc	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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 698,932	HCR Manor Care Services, LLC	100.00%	\$ 698,932	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	7,731,211	Heartland Employment Services, LLC	100.00%	7,731,211		4
5	V	10a	Therapy Management	13,860	Heartland Rehabilitation Services, LLC	100.00%	13,860		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			\$ 8,444,003			\$ 8,444,003	\$ *	14

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

Facility Name & ID Number

Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/11

Ending:

05/31/12

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 (SNF), L	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 (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Oak Lawn East# 0049668

Report Period Beginning:

06/01/11Ending: 05/31/12

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,R	\$ 775,999	\$	15,584,484	\$ 3,212	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs			15,584,484	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			15,584,484	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			15,584,484	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehat	485,056	352,684	15,584,484	2,008	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	15,584,484	18,261	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			15,584,484	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			15,584,484	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehat	71,430,003	38,287,220	15,584,484	295,652	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	15,584,484	110,337	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	15,584,484	34,583	11
12	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	15,584,484	29,421	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehat	2,952,374		15,584,484	12,220	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		15,584,484	31,108	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			15,584,484	0	15
16	22	Empl Bnfts - Direct to MW Div S	Accumulated Cost	474,102,184	48 NFs			15,584,484	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs,HHs,Rehat	4,719,938		15,584,484	19,536	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		15,584,484	2,851	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			15,584,484	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			15,584,484	0	20
21										21
22	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		15,584,484	109,037	22
23	32	Directly Assigned Interest	Not Allocated			18,851,990			30,706	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				32,615,916				24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 698,932	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			\$ 461,443	\$ 461,443		6.6543	\$ 30,706	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Home Office Pooled Interest Expense										109,037	6	
7	Interest Income / Interest Expense										(7,247)	7	
8												8	
9	TOTAL Facility Related						\$ 461,443	\$ 461,443			\$ 132,496	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 461,443	\$ 461,443			\$ 132,496	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 2011 report.			\$	514,049	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.)			\$	489,805	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(24,244)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	248,343	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.)			\$	26,737	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.			\$	250,836	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	534,299	8		
	2008	537,091	9		
	2009	600,486	10		
	2010	595,989	11		
	2011	406,685	12		
Line 2: \$489,805 = \$265,720 for the 2nd half of 2010 + \$327,794 for the 1st half of 2011 - \$103,709 adjust expense.					
Line 4: \$248,343 = \$78,891 for the 2nd half 2011 + \$169,452 estimate for Jan-May 2012.					
Line 5: \$26,737 = \$24,237 Worsek & Vihon LLP + \$2,500 Property Valuation Services, appeal 2011 tax assessment.					
Line 6: Reduced assessment amount is reflected on the 2011 tax bill. No refund was necessary.					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Manorcare of Oak Lawn East

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0049668

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 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 24-03-400-032-0000	See attached	\$ 406,685.01	\$ 406,685.01
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 406,685.01	\$ 406,685.01

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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:	38,678	B. General Construction Type:	Exterior	Masonry	Frame	Steel	Number of Stories	2
------------------------	---------------	--------------------------------------	-----------------	----------------	--------------	--------------	--------------------------	----------

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(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	Facility		1977	\$ 257,674	1
2					2
3	TOTALS			\$ 257,674	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	122		1977	1977	\$ 2,247,698	\$ 62,436		\$ 62,436		\$ 2,153,915
5										
6										
7										
8										
	Improvement Type**									
9	Current Year Depreciation					209,440		209,440		2,905,599
10			1981		18,089					
11			1986		2,797					
12			1988		19,012					
13			1989		14,714					
14			1990		202,653					
15			1991		69,401					
16			1992		114,373					
17			1993		63,254					
18			1994		648,943					
19			1995		220,796					
20			1996		238,261					
21			1997		230,127					
22			1998		319,666					
23			1999		57,192					
24			2000		71,071					
25	Reclass \$2,957 artwork to Equip. Disallow \$17,709			2001	106,534					
26	STEEL GATES FOR DUMSTERS			2002	6,355					
27	WINDOW TREATMENTS			2002	4,782					
28	Renovation - General Construction per audit \$4,171 disallowed			2002	24,092					
29	Renovation - Wallcovering per audit \$10,669 disallowed			2002	61,624					
30	Renovation - HVAC & Electrical per audit \$589 disallowed			2002	3,401					
31	ROOFING ON WEST SECTION			2003	19,000					
32	Sink, Tile, Wallcovering & Paint			2003	20,585					
33	Light Fixtures per audit change year from 2003 to 2002			2003	2,572					
34	Construction Department Cost & Interest Disallowed per audit			2003						
35	Ceramic Floor Tile & Related Concrete Work			2003	19,427					
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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Carpeting & Wallcovering per audit \$4,001 disallowed	2003	\$ 5,263	\$		\$	\$		37
38	Sheet Vinyl Flooring	2003	1,295						38
39	Carpeting	2003	738						39
40	Metal Doors	2003	5,739						40
41	Kitchen Renov - Stain Steel Wall Plating & Sinks	2004	5,086						41
42	Doors (4) Fire rated	2004	6,608						42
43	Exhauster, Duct Work, & Fire Damper	2004	5,810						43
44	Renov - General Construct. O/H & Int. disallowed per audit	2004							44
45	Renov - Painting	2004	10,565						45
46	Renov - Wall Covering	2004	23,222						46
47	Renov. - Doors & Frames	2004	11,010						47
48	Renov - Drywall & Studs	2004	2,405						48
49	Flooring	2004	30,990						49
50	Ceiling Tile	2004	585						50
51	Awing	2004	2,320						51
52	Flooring	2005	885						52
53	Fire Shutter Door	2005	2,170						53
54	Roofing	2005	17,500						54
55	2005 per audit - Doors for front entrance	2005	8,732						55
56	2005 per audit - Metal Access Doors	2005	3,183						56
57	2005 per audit - Asphalt Driveway, Seal Coat, & Stripe	2005	11,979						57
58	2006 per audit - Electric work for emergency light & feed	2006	894						58
59	2006 per audit - Doors & closers	2006	2,834						59
60									60
61	A/C for Elevator Room	2006	5,960						61
62	Electrical circuits for emergency generator system	2006	8,530						62
63	Electrical circuits - Kitchen & 2nd floor Nurse Station	2006	3,599						63
64									64
65	Renov - Flooring	2007	20,080						65
66	Renov - Wallcovering	2007	1,786						66
67	Renov - Carpentry	2007	2,826						67
68	Renov - Electrical	2007	15,000						68
69	Windows in lounge	2007	3,310						69
70	TOTAL (lines 4 thru 69)		\$ 5,027,323	\$ 271,876		\$ 271,876	\$	\$ 5,059,514	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,027,323	\$ 271,876		\$ 271,876	\$	\$ 5,059,514	1
2	Roofing	2007	3,500						2
3	Metal Door	2008	8,440						3
4	Door and Frame	2008	3,177						4
5	Water Heater	2008	22,725						5
6									6
7	Renov. - Architech & Engineering	2007	78,362						7
8	Renov. - Plan Reviews	2007	3,660						8
9	Renov. - Capentry-Subcontractor	2008	713,268						9
10	Renov. - Mill Work	2008	38,340						10
11	Renov. - HM Doors & Frames	2009	5,637						11
12	Renov. - Reslient Flooring	2007	55,865						12
13	Renov. - Wallcovering	2007	51,819						13
14	Renov. - Corner Guards	2009	8,604						14
15	Renov. - Fire Sprinkler System	2007	35,900						15
16	Renov. - Plumbing	2008	6,830						16
17	Renov. - Plumbing Specilities	2009	636						17
18	Renov. - HVAC	2008	8,969						18
19	Renov. - Basic Electrical	2009	23,190						19
20	Renov. - Fire Alarm System	2008	17,940						20
21	Renov. - Nurse Call System	2008	4,647						21
22									22
23	Elevator Door Restrictors	2008	8,100						23
24	Annunciator Panel for Generator	2008	2,969						24
25	Door & Ceiling in Vestibule	2009	11,286						25
26	Door Panic Hardware on service door	2009	2,401						26
27	Sprinkler Heads And Piping	2009	5,277						27
28	Eletrical Work - Explosion Proof	2009	4,338						28
29	Door in Vestibule	2009	5,000						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,158,203	\$ 271,876		\$ 271,876	\$	\$ 5,059,514	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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,158,203	\$ 271,876		\$ 271,876	\$	\$ 5,059,514	1
2	Renov. - Carpentry-Subcontractor	2009	230,010						2
3	Renov. - Corner Guards	2009	793						3
4	Renov. - Basic Electrical	2009	12,590						4
5	Renov. - Arch & Engineer	2007	(547)						5
6	Metal Soffit on Front Porch	2009	22,019						6
7	Renov. Elevator Upgrade	2009	56,360						7
8	Renov. - Fire Spinklers	2009	21,042						8
9	Renov. - Basic Electrical	2009	5,486						9
10	Renov. Elevator Upgrade-Smoke Detectors	2009	3,187						10
11	Add Hand railings in 3 Stairwells	2010	11,330						11
12									12
13	Seal coat parking lot	2010	8,527						13
14	Sprinkler Heads (3 stair landings)	2010	3,297						14
15	Renov. - Ductwork & Fire Dampers	2010	240,695						15
16	Fire Dampers (2)	2010	15,295						16
17	HM Doors	2010	6,405						17
18	7.5 ton Rooftop compressor	2011	20,488						18
19	Renov. - Roof Replacement	2011	203,010						19
20	Painting & Wall Covering (1st FL PAT RMS)	2011	6,900						20
21									21
22	Carpet, Installation & Freight	2011	10,206						22
23	Cabintry & Countertops	2011	15,395						23
24	Privacy Fencing 7 Ft	2011	13,786						24
25	Windows (14) Double Hung	2011	19,555						25
26	A/C Compressor 5 Ton	2011	4,654						26
27	Wander System at Elevator	2011	8,966						27
28	Circulation Pump	2011	3,672						28
29	Door HM (2nd Flr Linen Rm)	2011	4,078						29
30	Electrical for out door lights	2011	13,460						30
31	Concrete Pads (Front of Facility)	2012	7,929						31
32	Countertop Upgrade (1st Flr Nurse Station)	2012	2,115						32
33	Rooftop Unit, 7 1/2 ton	2012	21,125						33
34	TOTAL (lines 1 thru 33)		\$ 7,150,031	\$ 271,876		\$ 271,876	\$	\$ 5,059,514	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,952,051	\$165,215	\$165,215	\$		\$2,431,271	71
72	Current Year Purchases	92,805						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			22,387	22,387			74
75	TOTALS	\$3,044,856	\$165,215	\$187,602	\$22,387		\$2,431,271	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	Residents	1996 Dodge Van	1996	\$36,664	\$	\$	\$		\$36,664	76
77										77
78										78
79										79
80	TOTALS			\$36,664	\$	\$	\$		\$36,664	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$10,489,225	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$437,091	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$459,478	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$22,387	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,527,449	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Various	\$51,886	92
93			93
94			94
95		\$51,886	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 56,827
- 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	Patient Tranportation		\$	\$ 7,593	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,593	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 1	13049 hrs	\$ 548,306	2,238	\$ 135,602	\$ 7,647	15,287	\$ 691,555	1
2	Licensed Speech and Language Development Therapist	10a, 1	5471 hrs	229,878			2,014	5,471	231,892	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	12369 hrs	519,776	4,798	290,773	18,871	17,167	829,420	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				883,769		883,769	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV Therapy	43, 2					207,961		207,961	12
13	Other (specify): X-Ray & Lab	43, 3				194,688			194,688	13
14	TOTAL			\$ 1,297,960	7,036	\$ 621,063	\$ 1,120,262	37,925	\$ 3,039,285	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (66,382)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 673,620)	2,833,183		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,269		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,772,070	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	257,674		13
14	Buildings, at Historical Cost	7,150,031		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,081,520		16
17	Accumulated Depreciation (book methods)	(7,527,449)		17
18	Deferred Charges	13,499,579		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	51,886		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,513,241	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,285,311	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 266,662	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	550,571		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	248,343		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	203,692		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,269,268	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	461,443		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)	\$ 461,443	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,730,711	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,554,600	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,285,311	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (18,112,531)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (18,112,531)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,263,524	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,263,524	17
	B. Transfers (Itemize):		
18	Change in Interdivision	34,403,607	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 34,403,607	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 17,554,600	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Oak Lawn East# 0049668Report Period Beginning: 06/01/11Ending: 05/31/12

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	2	
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 18,298,304	1	
2 Discounts and Allowances for all Levels	(7,805,268)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,493,036	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	5,996,941	6	
7 Oxygen	56	7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,996,997	8	
C. Other Operating Revenue			
9 Payments for Education		9	
10 Other Government Grants		10	
11 CNA Training Reimbursements		11	
12 Gift and Coffee Shop	1,481	12	
13 Barber and Beauty Care	12,298	13	
14 Non-Patient Meals	1,823	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs	1,044,504	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory	121,192	19	
20 Radiology and X-Ray	87,206	20	
21 Other Medical Services	59,577	21	
22 Laundry	271	22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,328,352	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***		25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28		28	
28a		28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,818,385	30	

	1	2	
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	1,401,367	31	
32 Health Care	7,720,185	32	
33 General Administration	3,799,886	33	
B. Capital Expense			
34 Ownership	2,126,189	34	
C. Ancillary Expense			
35 Special Cost Centers	1,298,412	35	
36 Provider Participation Fee	208,822	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,554,861	40	
41 Income before Income Taxes (line 30 minus line 40)**	1,263,524	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,263,524	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 1,300,749	44	
45 Private Pay - Net Inpatient Revenue	792,442	45	
46 Medicare - Net Inpatient Revenue	6,491,694	46	
47 Other-(specify) <u>Hospice</u>	35,405	47	
48 Other-(specify) <u>Other</u>	1,872,746	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,493,036	49	

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,516	1,650	\$ 63,891	\$ 38.72	1
2	Assistant Director of Nursing	3,644	3,968	139,408	35.13	2
3	Registered Nurses	45,189	49,209	1,632,517	33.18	3
4	Licensed Practical Nurses	33,038	35,977	937,849	26.07	4
5	CNAs & Orderlies	87,637	95,565	1,191,263	12.47	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	31,457	34,236	1,438,632	42.02	7
8	Rehab/Therapy Aides	25,677	27,946	676,428	24.20	8
9	Activity Director	7,521	8,193	124,703	15.22	9
10	Activity Assistants					10
11	Social Service Workers	8,881	9,673	233,992	24.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,057	28,393	371,192	13.07	15
16	Dishwashers					16
17	Maintenance Workers	2,541	2,768	66,751	24.12	17
18	Housekeepers	16,744	18,252	197,597	10.83	18
19	Laundry	4,860	5,297	55,600	10.50	19
20	Administrator	2,080	2,080	70,914	34.09	20
21	Assistant Administrator	282	282	12,423	44.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,443	24,520	446,483	18.21	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	1,833	1,998	25,205	12.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	321,400	350,007	\$ 7,684,848 *	\$ 21.96	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	59,497	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	209	11,164	10, 1	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)	209	\$ 70,661		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	942	\$ 65,961	10, 3	50
51	Licensed Practical Nurses			10, 3	51
52	Certified Nurse Assistants/Aides			10, 3	52
53	TOTAL (lines 50 - 52)	942	\$ 65,961		53

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

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$4520
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5-10 Years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

67,810

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.

\$

208,822

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.

\$

1,823
- (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.