

		FOR BHF USE					

LL1

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>0049551</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Manorcare of Oak Lawn West</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>6300 West 95th Street</u> <u>Oak Lawn</u> <u>60453</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(708) 559-8800</u> Fax # <u>(708) 559-8820</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>11/1/81</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 West# 0049551 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>192</u>	Skilled (SNF)	<u>192</u>	<u>70,272</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>70,272</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>20,358</u>	<u>4,857</u>	<u>27,547</u>	<u>52,762</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>20,358</u>	<u>4,857</u>	<u>27,547</u>	<u>52,762</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.08%

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 11/1/81

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 191 and days of care provided 21,664Medicare Intermediary Novitas Solutions

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	469,891	38,181	1,026	509,098		509,098		509,098			1
2	Food Purchase		384,242		384,242		384,242	(1,590)	382,652			2
3	Housekeeping	212,127	29,127	203	241,457		241,457		241,457			3
4	Laundry	64,952	57,792	2,114	124,858		124,858		124,858			4
5	Heat and Other Utilities			233,710	233,710	3,810	237,520		237,520			5
6	Maintenance	77,383	34,076	232,853	344,312		344,312		344,312			6
7	Other (specify):* Med Waste			1,627	1,627		1,627		1,627			7
8	TOTAL General Services	824,353	543,418	471,533	1,839,304	3,810	1,843,114	(1,590)	1,841,524			8
	B. Health Care and Programs											
9	Medical Director			63,848	63,848		63,848		63,848			9
10	Nursing and Medical Records	4,619,366	491,226	248,853	5,359,445	24,045	5,383,490		5,383,490			10
10a	Therapy	2,130,242	23,435	39,727	2,193,404		2,193,404		2,193,404			10a
11	Activities	177,790	8,074	1,971	187,835		187,835		187,835			11
12	Social Services	205,191	103	88	205,382		205,382		205,382			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,132,589	522,838	354,487	8,009,914	24,045	8,033,959		8,033,959			16
	C. General Administration											
17	Administrative	142,446		968,373	1,110,819	(410,821)	699,998		699,998			17
18	Directors Fees											18
19	Professional Services			55,602	55,602	42	55,644	(55,644)				19
20	Dues, Fees, Subscriptions & Promotions			69,678	69,678		69,678	(34,571)	35,107			20
21	Clerical & General Office Expenses	562,564	90,307	769,048	1,421,919	(42)	1,421,877	(674,929)	746,948			21
22	Employee Benefits & Payroll Taxes			1,462,447	1,462,447	51,400	1,513,847		1,513,847			22
23	Inservice Training & Education			1,285	1,285		1,285		1,285			23
24	Travel and Seminar			8,498	8,498		8,498		8,498			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			595,510	595,510		595,510		595,510			26
27	Other (specify):*											27
28	TOTAL General Administration	705,010	90,307	3,930,441	4,725,758	(359,421)	4,366,337	(765,144)	3,601,193			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,661,952	1,156,563	4,756,461	14,574,976	(331,566)	14,243,410	(766,734)	13,476,676			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			540,256	540,256	26,558	566,814		566,814			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,182,438	3,182,438	305,008	3,487,446	(3,190,334)	297,112			32
33	Real Estate Taxes			678,783	678,783		678,783		678,783			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,715	39,715		39,715		39,715			35
36	Other (specify):*											36
37	TOTAL Ownership			4,441,192	4,441,192	331,566	4,772,758	(3,190,334)	1,582,424			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,200	1,200		1,200		1,200			38
39	Ancillary Service Centers		789,689	950	790,639		790,639		790,639			39
40	Barber and Beauty Shops			13,529	13,529		13,529		13,529			40
41	Coffee and Gift Shops	25,624			25,624		25,624		25,624			41
42	Provider Participation Fee			326,502	326,502		326,502		326,502			42
43	Other (specify):* IV Ther/Xray/Lab		120,895	220,337	341,232		341,232		341,232			43
44	TOTAL Special Cost Centers	25,624	910,584	562,518	1,498,726		1,498,726		1,498,726			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,687,576	2,067,147	9,760,171	20,514,894		20,514,894	(3,957,068)	16,557,826			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	(1,590)	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	(175)	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	(8,125)	21		18
19	Entertainment				19
20	Contributions	(2,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(55,644)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(617,310)	21		24
25	Fund Raising, Advertising and Promotional	(34,571)	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 See Attached 5a	(3,237,153)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,957,068)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,957,068)		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

Manorcare of Oak Lawn West

Report Period Beginning:

Ending:

ID#0049551

06/01/11

05/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (36,352)	21	1
2	P/R O/H Alloc - Mktg	(9,633)	21	2
3	HCP Lease Interest	(3,190,334)	32	3
4	Vending Income	(830)	21	4
5	Misc. Income	(4)	21	5
6	Activity Income		11	6
7	Loss on disposal of Fixed Asset		36	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
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	(3,237,153)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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	(1,590)	0	0	0	0	0	0	0	0	0	0	(1,590)	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	(1,590)	0	0	0	0	0	0	0	0	0	0	(1,590)	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	(55,644)	0	0	0	0	0	0	0	0	0	0	(55,644)	19
20	Fees, Subscriptions & Promotions	(34,571)	0	0	0	0	0	0	0	0	0	0	(34,571)	20
21	Clerical & General Office Expenses	(674,929)	0	0	0	0	0	0	0	0	0	0	(674,929)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(765,144)	0	0	0	0	0	0	0	0	0	0	(765,144)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(766,734)	0	0	0	0	0	0	0	0	0	0	(766,734)	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	(3,190,334)	0	0	0	0	0	0	0	0	0	0	(3,190,334)	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	(3,190,334)	0	0	0	0	0	0	0	0	0	0	(3,190,334)	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)	(3,957,068)	0	0	0	0	0	0	0	0	0	0	(3,957,068)	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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 968,373	HCR Manor Care Services, LLC	100.00%	\$ 968,373	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	8,687,576	Heartland Employment Services, LLC	100.00%	8,687,576		4
5	V	10a	Therapy Management	21,812	Heartland Rehabilitation Services, LLC	100.00%	21,812		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			\$ 9,677,761			\$ 9,677,761	\$ *	14

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

Facility Name & ID Number

Manorcare of Oak Lawn West

0049551

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, 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 Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/11 Ending: 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	\$ 775,999	\$	18,487,840	\$ 3,810	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs			18,487,840	0	2
3	5	Utilities - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			18,487,840	0	3
4	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			18,487,840	0	4
5	10	Nursing - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	485,056	352,684	18,487,840	2,382	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	3,905,972	1,829,606	18,487,840	21,663	6
7	10	Nursing - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			18,487,840	0	7
8	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			18,487,840	0	8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	71,430,003	38,287,220	18,487,840	350,732	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	23,601,055	18,695,747	18,487,840	130,893	10
11	17	Gen/Admin-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs	1,782,698	1,278,408	18,487,840	41,025	11
12	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	474,102,184	48 NFs	895,017	639,204	18,487,840	34,902	12
13	22	Empl Bnfts - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	2,952,374		18,487,840	14,497	13
14	22	Empl Bnfts -Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	6,653,909		18,487,840	36,903	14
15	22	Empl Bnfts-Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			18,487,840	0	15
16	22	Empl Bnfts - Direct to MW Div S	Accumulated Cost	474,102,184	48 NFs			18,487,840	0	16
17	30	Depreciation - Pooled	Accumulated Cost	3,765,230,368	731 NFs, HHs,Reha	4,719,938		18,487,840	23,176	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,333,512,949	353 NFs	609,966		18,487,840	3,383	18
19	30	Deprec - Direct to Central Div	Accumulated Cost	803,363,605	92 NFs			18,487,840	0	19
20	30	Depr -Direct to MW Div SNFs	Accumulated Cost	474,102,184	48 NFs			18,487,840	0	20
21										21
22	32	Pooled Interest	Accumulated Cost	3,765,230,368		26,343,470		18,487,840	129,350	22
23	32	Directly Assigned Interest				18,851,990			175,658	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions				32,615,916				24
25	TOTALS					\$ 195,623,363	\$ 61,082,869		\$ 968,373	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		0.0665	\$ 175,658	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Pooled Interest										129,350	7	
8	Interest Expense / Interest Income										(7,896)	8	
9	TOTAL Facility Related						\$ 2,639,793	\$ 2,639,793			\$ 297,112	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			\$ 297,112	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.		\$	507,092		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.)		\$	586,875		2
3. Under or (over) accrual (line 2 minus line 1).		\$	79,783		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	596,500		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.)		\$	2,500		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.		\$	678,783		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	495,385	8	
		2008	548,428	9	
		2009	587,433	10	
		2010	586,009	11	
		2011	648,568	12	
Line 2: \$586,874.93 = \$262,920.85 for 2nd half of 2010 + \$322,305.08 for 1st half 2011 + \$1,649 to adjust expense.					
Line 4: \$596,499.85 = \$326,263.18 for 2nd half 2011 + \$270,236.67 for Jan-May 2012					
Line 5: \$2,500 PVS Invoice for 2011 RE Tax Appeal					

	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 West 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 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)
<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>648,568.26</u>	\$ <u>648,568.26</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>648,568.26</u></u>	\$ <u><u>648,568.26</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 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:	50,339	B. General Construction Type:	Exterior	Masonry	Frame	Steel	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	\$ 29,964		\$ 29,964	\$	1,864,883	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					253,388		253,388		4,382,328	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

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	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	PARKLING 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	\$ 283,352		\$ 283,352	\$	\$ 6,247,211	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		\$ 6,594,254	\$ 283,352		\$ 283,352	\$	\$ 6,247,211	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	\$ 283,352		\$ 283,352	\$	\$ 6,247,211	34

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

Facility Name & ID Number Manorcare of Oak Lawn West

0049551

Report Period Beginning:

06/01/11

Ending:

05/31/12

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		\$ 6,892,053	\$ 283,352		\$ 283,352	\$	\$ 6,247,211	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	Additional for roof replacement	2011	411						30
31	Renov - Millwork	2011	39,870						31
32	vinyl base(corridor & Pat Rm)	2011	19,739						32
33	8" backflow in drainline	2011	7,485						33
34	TOTAL (lines 1 thru 33)		\$ 7,945,872	\$ 283,352		\$ 283,352	\$	\$ 6,247,211	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 12C, Carried Forward		\$ 7,945,872	\$ 283,352		\$ 283,352	\$	\$ 6,247,211	1
2	GREASE TRAP	2011	4,500						2
3	PAINTING	2011	4,340						3
4	WATER HEATER	2011	2,583						4
5	2 STORM DRAINS	2011	5,760						5
6	RENOV - GEN OVRHEAD & INTEREST	2011	17,856						6
7	RENOV - RESILIENT FLOORING	2011	119,408						7
8	RENOV - GEN OVRHEAD & INTEREST	2011	53,045						8
9	RENOV - CARPENTRY/SUBCONT	2011	15,762						9
10	RENOV - RESILIENT FLOORING	2011	37,415						10
11	RENOV - CARPETING	2011	6,479						11
12	RENOV - WALLCOVERING & CORNER GUARDS	2011	255,739						12
13	RENOV - BASIC ELECTRICAL	2011	90,834						13
14	RENOV - FIRE ALARM SYSTEM	2011	16,084						14
15	RENOV - PAINTING	2011	800						15
16	RENOV - ADDITIONAL FIRE ALARM SYSTEM	2011	9,644						16
17	RENOV - ADDITIONAL CARPENTRY	2011	4,425						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	TOTAL (lines 1 thru 33)		\$ 8,590,547	\$ 283,352		\$ 283,352	\$	\$ 6,247,211	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	\$3,355,598	\$256,904	\$256,904	\$		\$2,978,547	71
72	Current Year Purchases	308,953						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			26,558	26,558			74
75	TOTALS	\$3,664,551	\$256,904	\$283,462	\$26,558		\$2,978,547	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	76
77		Paratransit								77
78										78
79										79
80	TOTALS			\$12,107	\$	\$	\$		\$12,107	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$13,087,20581
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$540,25682
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$566,81483**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$26,55884
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$9,237,86585

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 39,715
- 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.	/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

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	13239 hrs	\$ 515,189	(962)	\$ (53,680)	\$ 2,284	12,277	\$ 463,793	1
2	Licensed Speech and Language Development Therapist	10a	6176 hrs	240,322	(166)	(9,242)	599	6,010	231,679	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	11730 hrs	456,473	1,659	92,565	20,552	13,389	569,590	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				789,689		789,689	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Inhalation Therapist</u>	10a	2573	100,125	35	1,955		2,608	102,080	12
13	Other (specify): <u>IV Ther/Xray/Lab</u>	43, 2 & 3				220,337	120,895		341,232	13
14	TOTAL			\$ 1,312,109	566	\$ 251,935	\$ 934,019	34,284	\$ 2,498,063	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	\$ (302,055)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (885,689))	3,327,395		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,186		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,032,526	\$	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	8,590,548		14
15	Leasehold Improvements, at Historical Cost	3,676,657		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(9,237,865)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,935,635	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,968,161	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 294,904	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	582,488		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	596,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	259,310		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,733,202	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,639,793		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)	\$ 2,639,793	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,372,995	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,595,166	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,968,161	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (28,624,764)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (28,624,764)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,393,421)	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)	\$ (1,393,421)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	43,613,351	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 43,613,351	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,595,166	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Oak Lawn West# 0049551Report 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	\$ 19,580,517	1
2	Discounts and Allowances for all Levels	(7,167,343)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,413,174	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,521,551	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,521,551	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	830	12
13	Barber and Beauty Care	13,236	13
14	Non-Patient Meals	1,590	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	851,377	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	158,750	19
20	Radiology and X-Ray	62,225	20
21	Other Medical Services	98,736	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,186,744	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	4	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,121,473	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,839,304	31
32	Health Care	8,009,914	32
33	General Administration	4,725,758	33
	B. Capital Expense		
34	Ownership	4,441,192	34
	C. Ancillary Expense		
35	Special Cost Centers	1,172,224	35
36	Provider Participation Fee	326,502	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,514,894	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,393,421)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,393,421)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,505,093	44
45	Private Pay - Net Inpatient Revenue	1,149,706	45
46	Medicare - Net Inpatient Revenue	7,628,894	46
47	Other-(specify)	283,895	47
48	Other-(specify)	845,586	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,413,174	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	1,926	2,077	\$ 86,582	\$ 41.69	1
2	Assistant Director of Nursing	5,863	6,323	223,012	35.27	2
3	Registered Nurses	50,319	54,273	1,834,976	33.81	3
4	Licensed Practical Nurses	34,748	37,478	935,599	24.96	4
5	CNAs & Orderlies	117,906	127,349	1,510,807	11.86	5
6	CNA Trainees	23	24	275	11.46	6
7	Licensed Therapist	33,718	36,339	1,414,127	38.91	7
8	Rehab/Therapy Aides	24,803	26,732	716,115	26.79	8
9	Activity Director	10,936	11,800	177,790	15.07	9
10	Activity Assistants					10
11	Social Service Workers	7,215	7,787	205,191	26.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,505	35,033	469,891	13.41	15
16	Dishwashers					16
17	Maintenance Workers	3,580	3,864	77,383	20.03	17
18	Housekeepers	19,587	21,137	212,127	10.04	18
19	Laundry	6,366	6,869	64,952	9.46	19
20	Administrator	2,080	2,080	103,446	49.73	20
21	Assistant Administrator	1,248	1,248	39,000	31.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,167	26,217	516,579	19.70	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	1,917	2,068	28,115	13.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	2,049	2,211	25,624	11.59	33
34	TOTAL (lines 1 - 33)	380,956	410,909	\$ 8,641,591 *	\$ 21.03	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	Montly	63,848	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)		\$ 63,848		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

0049551

Report Period Beginning:

06/01/11

Page 21

Ending: 05/31/12

Facility Name & ID Number

Manorcare of Oak Lawn West

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Petyko	Administrator	0	\$ 142,446	Workers' Compensation Insurance	\$ 213,660	IDPH License Fee	\$ 1,068	
				Unemployment Compensation Insurance	125,106	Advertising: Employee Recruitment	4,919	
				FICA Taxes	622,115	Health Care Worker Background Check		
				Employee Health Insurance	430,567	(Indicate # of checks performed 513)	11,324	
				Employee Meals		Patient Background Checks	533 5,330	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,037	
				Employee Appreciation	745	Association Dues	22,026	
				401K	52,322	Advertising	18,974	
				Oth Empl Benefits, Mktg Adj, & LT Incent	7,754	Public Relations		
				Tuition Program	2,206	Less: Non-Allowable Association Dues	(15,597)	
				SMSP Match	3,234	Less: Public Relations Expense	(0)	
				Employee Uniforms	4,738	Non-allowable advertising	(18,974)	
				Home Office Allocation	51,400	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 142,446		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
Various Home Office Services			\$ 968,373					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 968,373					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Foote Meyers Mielke Flowers LLC	Legal Fees	\$ 37,756			\$	Out-of-State Travel	\$	
Littler Mendelson PC	Legal Fees	14,908						
Lexis-Nexis	Legal Fees	925						
United Collection Bureau	Fees for Collections	2,054				In-State Travel	8,498	
						Includes travel expense to the Home Office in Toledo, OH for regional meetings		
Legal and collection fees were adjusted off on Schedule VI, Page 5, Line 22. Therefore, no invoices are attached.								
						Seminar Expense		
A2CL Services, LLC	H/R Consultant	(42)						
Consulting Fees reclasses to Line 21.								
						Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 55,602	TOTAL		(agree to Sch. V, line 24, col. 8)	\$ 8,498	

* Attach copy of IMRF notifications

**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. ICHA \$6,429

(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_\$15597

(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.

\$ 98,925

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.

\$ 326,502

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. \$ 1,590

(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.