

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0049668

Facility Name: Manorcare of Oak Lawn East

Address: 9401 S Kostner Ave Oak Lawn 60453
Number City Zip Code

County: Cook

Telephone Number: (708) 423-7882 Fax # (708) 423-7947

HFS ID Number:

Date of Initial License for Current Owners: 1977

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Jeff Lewandowski Telephone Number: (419) 252-5736
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/15 to 05/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

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

#	0049668	Report Period Beginning:	06/01/15	Ending:	05/31/16
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D. How many bed-hold days during this year were paid by the Department?

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

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

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 04/07/11 NO ☐

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

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCUAL	☒	MODIFIED	☐	CASH*	☐
CASH*	☐				

Is your fiscal year identical to your tax year? YES ☐ NO ☒

Tax Year: 12/31 **Fiscal Year:** 5/31

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

B. Census-For the entire report period.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.06%

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	335,078	30,921	236	366,235		366,235		366,235			1
2	Food Purchase		246,079		246,079		246,079	(116)	245,963			2
3	Housekeeping	174,057	31,758		205,815		205,815		205,815			3
4	Laundry	46,925	29,520		76,445		76,445		76,445			4
5	Heat and Other Utilities			172,297	172,297	3,203	175,500		175,500			5
6	Maintenance	58,248	12,128	78,539	148,915		148,915		148,915			6
7	Other (specify):* Med Waste			1,288	1,288		1,288		1,288			7
8	TOTAL General Services	614,308	350,406	252,360	1,217,074	3,203	1,220,277	(116)	1,220,161			8
	B. Health Care and Programs											
9	Medical Director			45,129	45,129		45,129		45,129			9
10	Nursing and Medical Records	3,528,951	283,327	127,156	3,939,434	10,751	3,950,185		3,950,185			10
10a	Therapy	1,962,785	16,860	29,924	2,009,569		2,009,569		2,009,569			10a
11	Activities	101,143	1,264	1,350	103,757		103,757		103,757			11
12	Social Services	242,457			242,457		242,457		242,457			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,835,336	301,451	203,559	6,340,346	10,751	6,351,097		6,351,097			16
	C. General Administration											
17	Administrative	166,057		577,179	743,236	(222,948)	520,288		520,288			17
18	Directors Fees											18
19	Professional Services			53,180	53,180		53,180	(53,180)				19
20	Dues, Fees, Subscriptions & Promotions			103,285	103,285		103,285	(31,556)	71,729			20
21	Clerical & General Office Expenses	486,055	63,672	924,226	1,473,953		1,473,953	(816,817)	657,136			21
22	Employee Benefits & Payroll Taxes			1,055,627	1,055,627	48,191	1,103,818		1,103,818			22
23	Inservice Training & Education			1,019	1,019		1,019		1,019			23
24	Travel and Seminar			2,154	2,154		2,154		2,154			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,477,725	1,477,725		1,477,725		1,477,725			26
27	Other (specify):*											27
28	TOTAL General Administration	652,112	63,672	4,194,395	4,910,179	(174,757)	4,735,422	(901,553)	3,833,869			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,101,756	715,529	4,650,314	12,467,599	(160,803)	12,306,796	(901,669)	11,405,127			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			406,636	406,636	16,410	423,046		423,046			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			718,155	718,155	144,393	862,548	(723,340)	139,208			32
33	Real Estate Taxes			499,765	499,765		499,765		499,765			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			68,836	68,836		68,836		68,836			35
36	Other (specify):*											36
37	TOTAL Ownership			1,693,392	1,693,392	160,803	1,854,195	(723,340)	1,130,855			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		628,258		628,258		628,258		628,258			39
40	Barber and Beauty Shops			4,441	4,441		4,441		4,441			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			183,675	183,675		183,675		183,675			42
43	Other (specify):* IV X-Ray & Lab		(15,328)	174,815	159,487		159,487		159,487			43
44	TOTAL Special Cost Centers		612,930	362,931	975,861		975,861		975,861			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,101,756	1,328,459	6,706,637	15,136,852		15,136,852	(1,625,009)	13,511,843			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(116)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(436)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(74)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions	(2,499)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(38,692)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(811,880)	21		24
25	Fund Raising, Advertising and Promotional	(31,556)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(739,756)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,625,009)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,625,009)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$	11	1
2	Misc. Income		21	2
3	Vending Income	(1,928)	21	3
4	Donations Revenue		21	4
5	Accounting/Collection Fees	(14,488)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(723,340)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(739,756)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(116)	0	0	0	0	0	0	0	0	0	0	(116)	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	(116)	0	0	0	0	0	0	0	0	0	0	(116)	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	(53,180)	0	0	0	0	0	0	0	0	0	0	(53,180)	19
20	Fees, Subscriptions & Promotions	(31,556)	0	0	0	0	0	0	0	0	0	0	(31,556)	20
21	Clerical & General Office Expenses	(816,817)	0	0	0	0	0	0	0	0	0	0	(816,817)	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	(901,553)	0	0	0	0	0	0	0	0	0	0	(901,553)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(901,669)	0	0	0	0	0	0	0	0	0	0	(901,669)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(723,340)	0	0	0	0	0	0	0	0	0	0	(723,340)	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	(723,340)	0	0	0	0	0	0	0	0	0	0	(723,340)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,625,009)	0	0	0	0	0	0	0	0	0	0	(1,625,009)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Rehab Svcs, LLC	Toledo	Therapy Mgmt Svcs
				HL Rehab Svcs, LLC	Toledo	Therapy Services
				HL Home Health Care	Toledo	Nursing Staff

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 577,179	HCR Manor Care Services, LLC	100.00%	\$ 577,179		1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	7,101,756	Heartland Employment Services, LLC	100.00%	7,101,756		4
5	V	10a	Therapy Management	14,152	Heartland Rehabilitation Services, LLC	100.00%	14,152		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 7,693,087			\$ 7,693,087	\$ *	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:

06/01/15

Ending:

05/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2			Heartland of Canton IL, LLC	Canton				2
3			Heartland of Champaign IL, LLC	Champaign				3
4			Heartland of Decatur IL, LLC	Decatur				4
5			Heartland of Galesburg IL, LLC	Galesburg				5
6			Heartland of Henry IL, LLC	Henry				6
7			Heartland of Macomb IL, LLC	Macomb				7
8			Heartland of Moline IL, LLC	Moline				8
9			Heartland of Normal IL, LLC	Normal				9
10			Heartland of Paxton IL, LLC	Paxton				10
11			Heartland of Peoria IL, LLC	Peoria				11
12			Heartland-Riverview of East Peoria IL, LLC	East Peoria				12
13			Manor Care at Arlington Heights	Arlington Heights				13
14			Manor Care of Elgin IL, LLC	Elgin				14
15			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				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 (West) IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				1
2			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				2
3			Arden Courts of Northbrook IL, LLC	Northbrook				3
4			Arden Courts of Palos Heights IL, LLC	Palos Heights				4
5			Arden Courts of South Holland IL, LLC	South Holland				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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19								19
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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:

06/01/15Ending: 05/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

HCR Manor Care Services LLC

Street Address

333 North Summit Street

City / State / Zip Code

Toledo, OH 43604-2617

Phone Number

(419) 252-5500

Fax Number

(419) 254-5495

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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities - Pooled	Accumulated Cost	559 NFs, HHs, & Re	\$ 818,127	\$	15,365,737	\$ 3,203	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	357 NFs			15,365,737	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	85 NFs			15,365,737	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	559 NFs, HHs, & Re	314,713	212,796	15,365,737	1,232	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	357 NFs	2,144,378	1,338,476	15,365,737	9,519	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	85 NFs			15,365,737	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	559 NFs, HHs, & Re	60,268,030	28,103,285	15,365,737	235,960	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	357 NFs	14,494,897	5,630,812	15,365,737	64,344	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	85 NFs	3,257,281		15,365,737	53,927	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	559 NFs, HHs, & Re	5,205,729		15,365,737	20,381	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	357 NFs	6,264,775		15,365,737	27,810	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	85 NFs			15,365,737	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	559 NFs, HHs, & Re	3,394,861		15,365,737	13,292	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	357 NFs	702,366		15,365,737	3,118	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	85 NFs			15,365,737	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		28,376,750		15,365,737	111,100	22
23	32	Directly Assigned Interest	Not Allocated		18,868,647			33,293	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions			33,166,797				24
25	TOTALS				\$ 177,277,351	\$ 35,285,370		\$ 577,179	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				\$ 461,443	\$ 440,899		0.0755	\$ 33,293	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Pooled Interest										111,100	7	
8	Interest Expense / Interest Income										(5,185)	8	
9	TOTAL Facility Related						\$ 461,443	\$ 440,899			\$ 139,208	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	\$ 440,899			\$ 139,208	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 2015 report.			\$	490,624	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.)			\$	559,855	2
3. Under or (over) accrual (line 2 minus line 1).			\$	69,231	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	458,453	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.)			\$	9,582	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 \$ <u>37,501</u> For <u>2012</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(37,501)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	499,765	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	<u>406,685</u>	8	
		2012	<u>435,749</u>	9	
		2013	<u>445,374</u>	10	
		2014	<u>519,233</u>	11	
		2015	<u>525,198</u>	12	
Line 2: \$559,855.27 = \$274,277.22 for 2nd half 2014 + \$285,578.05 for 1st half 2015					
Line 4: \$458,452.71 = \$239,620.21 for 2nd half 2015 + \$218,832.50 for Jan - May 2016					
Line 5: \$9,582 = Worsek & Vihon Invoices : \$198 for 2013 Specific Objections Filing Fees & \$9,384 for 2012 Spec Obj #147-COTO-1081					
Line 6: \$37,500.72 = Refund from Maria Pappas, Treasurer, Cook Co for 2012 RE Tax Appeal					
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

FACILITY NAME	<u>Manorcare of Oak Lawn East</u>	COUNTY	<u>Cook</u>
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CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10A

A. Square Feet: 38,616

B. General Construction Type: Exterior Masonry Frame Steel

Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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	\$		\$	\$	2,247,698
5										
6										
7										
8										
	Improvement Type**									
9	Current Year Depreciation					265,606		265,606		3,861,116
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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Carpeting & Wallcovering</u> per audit \$4,001 disallowed	2003	\$ 5,263	\$		\$	\$	\$	37
38	<u>Sheet Vinyl Flooring</u>	2003	1,295						38
39	<u>Carpeting</u>	2003	738						39
40	<u>Metal Doors</u>	2003	5,739						40
41	<u>Kitchen Renov - Stain Steel Wall Plating & Sinks</u>	2004	5,086						41
42	<u>Doors (4) Fire rated</u>	2004	6,608						42
43	<u>Exhauster, Duct Work, & Fire Damper</u>	2004	5,810						43
44	<u>Renov - General Construct. O/H & Int. disallowed per audit</u>	2004							44
45	<u>Renov - Painting</u>	2004	10,565						45
46	<u>Renov - Wall Covering</u>	2004	23,222						46
47	<u>Renov. - Doors & Frames</u>	2004	11,010						47
48	<u>Renov - Drywall & Studs</u>	2004	2,405						48
49	<u>Flooring</u>	2004	30,990						49
50	<u>Ceiling Tile</u>	2004	585						50
51	<u>Awing</u>	2004	2,320						51
52	<u>Flooring</u>	2005	885						52
53	<u>Fire Shutter Door</u>	2005	2,170						53
54	<u>Roofing</u>	2005	17,500						54
55	<u>2005 per audit - Doors for front entrance</u>	2005	8,732						55
56	<u>2005 per audit - Metal Access Doors</u>	2005	3,183						56
57	<u>2005 per audit - Asphalt Driveway, Seal Coat, & Stripe</u>	2005	11,979						57
58	<u>2006 per audit - Electric work for emergency light & feed</u>	2006	894						58
59	<u>2006 per audit - Doors & closers</u>	2006	2,834						59
60									60
61	<u>A/C for Elevator Room</u>	2006	5,960						61
62	<u>Electrical circuits for emergency generator system</u>	2006	8,530						62
63	<u>Electrical circuits - Kitchen & 2nd floor Nurse Station</u>	2006	3,599						63
64									64
65	<u>Renov - Flooring</u>	2007	20,080						65
66	<u>Renov - Wallcovering</u>	2007	1,786						66
67	<u>Renov - Carpentry</u>	2007	2,826						67
68	<u>Renov - Electrical</u>	2007	15,000						68
69	<u>Windows in lounge</u>	2007	3,310						69
70	TOTAL (lines 4 thru 69)		\$ 5,027,323	\$ 265,606		\$ 265,606	\$	\$ 6,108,814	70

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,027,323	\$ 265,606		\$ 265,606		\$ 6,108,814	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	\$ 265,606		\$ 265,606		\$ 6,108,814	34

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,158,203	\$ 265,606		\$ 265,606	\$	\$ 6,108,814	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 (main entrance, courtyard patio, and front office)	2011	10,206						22
23	Countertops & Overhead Cabinets (physian offices #1 & #2)	2011	15,395						23
24	Privacy Fencing, white PVC, 6 Ft (courtyard & generator areas)	2011	13,786						24
25	Repl 14 double hung windows & sills (6 offices & 6 resident rms.)	2011	19,555						25
26	A/C Compressor in 5 ton RTU (PT area)	2011	4,654						26
27	Wander System at Elevator	2011	8,966						27
28	Repl circulation pump on Lochnivar boiler	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	\$ 265,606		\$ 265,606	\$	\$ 6,108,814	34

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,150,031	\$ 265,606		\$ 265,606	\$	\$ 6,108,814	1
2	Stairwell Door	2012	4,230						2
3	Electrical Panel and Wiring consisting of:	2012	29,375						3
4	Replace 200 amp distribution panel with 400 amp panel								4
5	200 amp feed from new panel to 2nd floor Linen Closet								5
6	42 circuit panel board to replace existing 20 fuse panel								6
7	Wiring and conduit to Roof Top Unit #3 & #4 from 2nd floor Linen Closet								7
8	Wiring and conduit to Roof Top Unit #1 (PT) from main electric room								8
9	Asphalt Paving, Sealer, & Striping	2012	14,387						9
10	Electrical Panel, 30 circuits (in main electric room)	2012	1,364						10
11	Renovations to the PT & OT rooms, Training bathroom, and 1st floor offices (5) consisting of:								11
12	Carpentry, Millwork, Drywall, Handrails - Renov. 05-11C	2013	286,556						12
13	Wallcovering, Flooring, Carpet - Renov. 05-11C	2013	6,710						13
14	Engineering & Consulting on Renov. - Renov. 05-11C	2013	38,723						14
15	Light fixtures (58) - Renov. 05-11C	2013	8,835						15
16									16
17	Renovations to the PT & OT rooms, Training bathroom, and 1st floor offices (5) consisting of (additional costs) consisting of:								17
18	Engineering & Consulting on Renov. - Renov. 05-11C	2013	4,229						18
19	Carpentry, Millwork, Drywall, Handrails - Renov. 05-11C	2013	144,053						19
20	Wallcovering, Flooring, Carpet - Renov. 05-11C	2013	1,617						20
21	Light fixture upgrade to whole building	2013	9,989						21
22	Electrical upgrade to Med Rms, Kiosks, & Nurse Station	2014	4,580						22
23	Hot water line & circulating pump	2014	5,897						23
24	Wallcovering & Handrails in Café, PT corridor, lounge, & corridor	2014	9,683						24
25	Renovate front offices and 33 2nd floor resident rooms consisting of:								25
26	Carpentry, Millwork	2014	138,676						26
27	Fire Sprinkler System	2014	3,920						27
28	Plumbing	2014	1,949						28
29	Basic Electrical	2014	44,354						29
30	Resilient Flooring	2014	57,568						30
31	Carpeting	2014	4,583						31
32	Painting	2014	86,160						32
33	Wallcovering	2014	17,334						33
34	TOTAL (lines 1 thru 33)		\$ 8,074,803	\$ 265,606		\$ 265,606	\$	\$ 6,108,814	34

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/15

Ending:

05/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,074,803	\$ 265,606		\$ 265,606	\$	\$ 6,108,814	1
2	EM Electrical Upgrades to Boiler, Sprinkler, Oxgen Rms.	2014	7,354						2
3									3
4	Carpet for Corridor - Materials	2014	14,631						4
5	Carpet for Corridor - Freight	2014	1,058						5
6	Carpet for Corridor - Installation	2014	11,975						6
7	EZ-Path fire stop devices(6) in smoke walls & relate work	2014	9,185						7
8	Drywall & paint firewalls-Med. Rm, Clean Utility, & Corridor	2015	30,308						8
9	Life Safety Elelctrical Panel & related electrical work	2015	14,558						9
10	3 phase electric circuits to two disposals & blender (Kitchen)	2015	7,070						10
11	Blower section on Trane rooftop unit	2015	3,490						11
12									12
13	fire stopping from clean utility/Med room to underside of deck behind								13
14	1st floor nurse station.	2015	19,650						14
15	Fan motor/blade/slinger/hrdwr to repair Kitchen RTU	2015	3,650						15
16	hollow metal door & frame at S stairwell	2015	7,150						16
17	repl compressor, condensor motor, contactor, and crankcase heater for								17
18	walk in cooler	2015	3,780						18
19	1.5 hr fire rated exterior Kitchen door/frame	2015	2,460						19
20	10 sets of double hung windows/ frames: 2nd flr-215, 217, 219 in W wing.								20
21	227, 229, 232-236 in S wing	2015	18,780						21
22	heat exchgr in RTU HVAC for 1st & 2nd flr dining & Ofc areas	2015	11,880						22
23	hollow metal door for kitchen	2016	4,821						23
24	install fire rated panel in kitchen: sink/prep area, wall next to fridge, left of doorway, right of								24
25	doorway in food storage room	2016	9,850						25
26	vinyl plank flooring in the 2 elevators	2016	3,105						26
27	repairs to RTU for 1st & 2nd flr areas: lobby, front ofcs, laundry, dining,								27
28	activites & PT	2016	12,170						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,271,728	\$ 265,606		\$ 265,606	\$	\$ 6,108,814	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	\$ 3,539,046	\$ 141,030	\$ 141,030	\$		\$ 3,041,416	71
72	Current Year Purchases	8,352						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			16,410	16,410			74
75	TOTALS	\$ 3,547,398	\$ 141,030	\$ 157,440	\$ 16,410		\$ 3,041,416	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	12,076,800
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	406,636
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	423,046
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	16,410
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	9,150,230

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: \$ 68,836 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	retired		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	8088	hrs	\$ 332,159		\$	805	8,088	\$ 332,964	1	
2	Licensed Speech and Language Development Therapist	10a	5183	hrs	212,848			702	5,183	213,550	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	10988	hrs	451,248			15,353	10,988	466,601	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				628,258		628,258	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): Inhalation Therapy	10a	1663		68,312	69	3,999		1,732	72,311	12	
13	Other (specify): IV Therapy/X-Ray/Lab	43, 2 & 3					174,815	(15,328)		159,487	13	
14	TOTAL				\$ 1,064,567	69	\$ 178,814	\$ 629,790	25,991	\$ 1,873,171	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	\$ (5,159)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (973,359))	2,080,297		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,462		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,079,600	\$	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	8,271,728		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,547,398		16
17	Accumulated Depreciation (book methods)	(9,150,230)		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) OMIT	57,216		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,483,365	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,562,965	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 152,908	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	518,699		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	458,453		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	160,964		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,291,024	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	440,899		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)	\$ 440,899	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,731,923	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 16,831,042	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 18,562,965	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 17,224,184	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 17,224,184	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,788,098)	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)	\$ (1,788,098)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	1,394,956	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,394,956	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 16,831,042	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning: 06/01/15

Ending: 05/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,658,814	1
2	Discounts and Allowances for all Levels	(8,742,572)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,916,242	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,801,584	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,801,584	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	1,928	12
13	Barber and Beauty Care	4,877	13
14	Non-Patient Meals	116	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,238,316	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	192,872	19
20	Radiology and X-Ray	113,711	20
21	Other Medical Services	78,672	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,630,492	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Discount</u>	436	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 436	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,348,754	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,217,074	31
32	Health Care	6,340,346	32
33	General Administration	4,910,179	33
	B. Capital Expense		
34	Ownership	1,693,392	34
	C. Ancillary Expense		
35	Special Cost Centers	792,186	35
36	Provider Participation Fee	183,675	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,136,852	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,788,098)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,788,098)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,580,137	44
45	Private Pay - Net Inpatient Revenue	607,607	45
46	Medicare - Net Inpatient Revenue	2,132,694	46
47	Other-(specify) <u>Hospice</u>	218,729	47
48	Other-(specify) <u>Insurance</u>	377,075	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,916,242	49

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,588	2,790	\$ 130,925	\$ 46.93	1
2	Assistant Director of Nursing	4,330	4,667	184,045	39.44	2
3	Registered Nurses	39,297	42,360	1,442,528	34.05	3
4	Licensed Practical Nurses	24,882	26,822	659,429	24.59	4
5	CNAs & Orderlies	77,919	84,111	1,085,712	12.91	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	29,234	31,497	1,293,490	41.07	7
8	Rehab/Therapy Aides	22,666	24,420	669,295	27.41	8
9	Activity Director	6,673	7,197	101,143	14.05	9
10	Activity Assistants					10
11	Social Service Workers	8,482	9,148	242,457	26.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,497	25,344	335,078	13.22	15
16	Dishwashers					16
17	Maintenance Workers	1,872	2,019	58,248	28.85	17
18	Housekeepers	15,156	16,344	174,057	10.65	18
19	Laundry	3,819	4,118	46,925	11.40	19
20	Administrator	2,080	2,080	142,819	68.66	20
21	Assistant Administrator	858	858	23,238	27.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,235	26,357	486,055	18.44	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	1,830	1,973	26,312	13.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	289,418	312,105	\$ 7,101,756 *	\$ 22.75	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	53,180	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	139	7,620	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)	139	\$ 60,800		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	237	\$ 17,657	10, 3	50
51	Licensed Practical Nurses	513	22,567	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	750	\$ 40,224		53

STATE OF ILLINOIS

Facility Name & ID Number

Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/15

Ending:

05/31/16

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Marie Hilda Derzey (June-Sept)

Administrator

0

\$ 45,836

Scott Morton (Sept)

Acting Admin.

0

3,173

Katie DeWerdt (Sept-May)

Administrator

0

93,810

Scott Morton

Asst. Admin.

0

23,238

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 166,057

B. Administrative - Other

Description

Amount

Various Home Office Services - See Page 8 for breakdown

\$ 577,179

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 577,179

C. Professional Services

Vendor/Payee

Type

Amount

Anspach Meeks Ellenberger

Legal Fees

\$ 69

Elvidge Kelley Atty @ Law

Legal Fees

1,200

Greenberg Trauig

Legal Fees

6,906

Law Ofc of Brian Scott Dietrich PC

Legal Fees

39

Polsinelli Shughart PC

Legal Fees

104

SNF Global

Legal Fees

30,374

(Legal Fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)

Healthlink Inc

Collection Services

682

Meyers & Flowers LLC

Collection Services

6,269

National Eligibiltiy Solutions LLC

Collection Services

150

Transworld Systems Inc

Collection Services

7,387

(Collection Costs were adjusted off via Page 5a, Line 5)

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 53,180

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 35,547

Unemployment Compensation Insurance

90,021

FICA Taxes

520,452

Employee Health Insurance

388,972

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Disability Payments

401K

18,503

Appreciation, Oth Benefits & Mktg Adj

(5,478)

Tuition Program

SMSP Match

947

Employee Uniforms

6,663

Home Office Allocation

48,191

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,103,818

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

37,751

Health Care Worker Background Check

(Indicate # of checks performed 480)

9,830

Patient Background Checks

684

Dues & Subscriptions

4,810

Association Dues

7,244

Advertising

29,063

Other Licenses and Permits

5,757

Less: Non-Allowable Association Dues

(2,493)

Less: Public Relations Expense

()

Non-allowable advertising

(29,063)

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 71,729

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

2,154

Includes travel expense to the Home Office in Toledo, OH for regional meetings

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 2,154

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number <u>Manorcare of Oak Lawn East</u>	STATE OF ILLINOIS # <u>0049668</u>	Report Period Beginning: <u>06/01/15</u>	Ending: <u>05/31/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
 If YES, give association name and amount. ICHA \$3,015 & ACHA \$1,736

(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. \$ 54,811 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. \$ 183,675
 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. \$ 116

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? NO
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? NO
 Firm Name: _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NO
 Attach invoices and a summary of services for all architect and appraisal fees