

		FOR BHF USE					

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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: <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>06/01/15</u> to <u>05/31/16</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 St</u> <u>Oak Lawn</u> <u>60453</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(708) 559-8800</u> Fax # <u>(708) 559-8820</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Martin D. Allen</u></td></tr><tr><td>(Title) <u>Director</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Martin D. Allen</u>	(Title) <u>Director</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>											
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	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>11/1/81</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Jeff Lewandowski</u> Telephone Number: <u>(419) 252-5736</u>																									
Email Address: _____																									

Facility Name & ID Number Manorcare of Oak Lawn West

0049551 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,992</u>	<u>2,292</u>	<u>24,448</u>	<u>44,732</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>17,992</u>	<u>2,292</u>	<u>24,448</u>	<u>44,732</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 63.66%

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?
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 04/07/11 NO ☐

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 12,887

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 5/31
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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	411,834	31,911	4,786	448,531		448,531		448,531			1
2	Food Purchase		297,803		297,803		297,803	(655)	297,148			2
3	Housekeeping	187,349	27,785	82	215,216		215,216		215,216			3
4	Laundry	44,059	26,360	1,884	72,303		72,303		72,303			4
5	Heat and Other Utilities			209,511	209,511	3,605	213,116		213,116			5
6	Maintenance	50,682	22,561	108,215	181,458		181,458		181,458			6
7	Other (specify):* Med Waste			3,248	3,248		3,248		3,248			7
8	TOTAL General Services	693,924	406,420	327,726	1,428,070	3,605	1,431,675	(655)	1,431,020			8
	B. Health Care and Programs											
9	Medical Director			61,968	61,968		61,968		61,968			9
10	Nursing and Medical Records	4,599,014	452,516	166,911	5,218,441	12,099	5,230,540		5,230,540			10
10a	Therapy	1,939,664	20,836	44,596	2,005,096		2,005,096		2,005,096			10a
11	Activities	93,362	7,310	872	101,544		101,544		101,544			11
12	Social Services	245,188	16		245,204		245,204		245,204			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,877,228	480,678	274,347	7,632,253	12,099	7,644,352		7,644,352			16
	C. General Administration											
17	Administrative	124,613		802,522	927,135	(403,888)	523,247		523,247			17
18	Directors Fees											18
19	Professional Services			137,419	137,419		137,419	(137,419)				19
20	Dues, Fees, Subscriptions & Promotions			100,979	100,979		100,979	(23,065)	77,914			20
21	Clerical & General Office Expenses	537,959	73,307	811,686	1,422,952		1,422,952	(675,822)	747,130			21
22	Employee Benefits & Payroll Taxes			1,233,281	1,233,281	54,232	1,287,513		1,287,513			22
23	Inservice Training & Education			795	795		795		795			23
24	Travel and Seminar			1,589	1,589		1,589		1,589			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			890,289	890,289		890,289		890,289			26
27	Other (specify):*											27
28	TOTAL General Administration	662,572	73,307	3,978,560	4,714,439	(349,656)	4,364,783	(836,306)	3,528,477			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,233,724	960,405	4,580,633	13,774,762	(333,952)	13,440,810	(836,961)	12,603,849			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			648,054	648,054	18,467	666,521		666,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,065,598	1,065,598	315,485	1,381,083	(1,067,173)	313,910			32
33	Real Estate Taxes			645,333	645,333		645,333		645,333			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,605	28,605		28,605		28,605			35
36	Other (specify):*											36
37	TOTAL Ownership			2,387,590	2,387,590	333,952	2,721,542	(1,067,173)	1,654,369			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		763,725	3,455	767,180		767,180		767,180			39
40	Barber and Beauty Shops			4,717	4,717		4,717		4,717			40
41	Coffee and Gift Shops	26,245			26,245		26,245		26,245			41
42	Provider Participation Fee			288,127	288,127		288,127		288,127			42
43	Other (specify):* IV X-Ray & Lab		43,989	156,684	200,673		200,673		200,673			43
44	TOTAL Special Cost Centers	26,245	807,714	452,983	1,286,942		1,286,942		1,286,942			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	8,259,969	1,768,119	7,421,206	17,449,294		17,449,294	(1,904,134)	15,545,160			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	(655)	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	(106)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(76)	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	(29)	21		18
19	Entertainment				19
20	Contributions	(2,986)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(47,329)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(706,955)	21		24
25	Fund Raising, Advertising and Promotional	(23,065)	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	(1,122,933)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,904,134)		\$	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))	\$ (1,904,134)		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	(5)	21	2
3	Vending Income	(1,119)	21	3
4	Donations Revenue		21	4
5	Accounting/Collection Fees	(54,636)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest	(1,067,173)	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
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24				24
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28				28
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,122,933)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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	(655)	0	0	0	0	0	0	0	0	0	0	(655)	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	(655)	0	0	0	0	0	0	0	0	0	0	(655)	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	(101,965)	0	0	0	0	0	0	0	0	0	0	(101,965)	19
20	Fees, Subscriptions & Promotions	(23,065)	0	0	0	0	0	0	0	0	0	0	(23,065)	20
21	Clerical & General Office Expenses	(711,276)	0	0	0	0	0	0	0	0	0	0	(711,276)	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	(836,306)	0	0	0	0	0	0	0	0	0	0	(836,306)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(836,961)	0	0	0	0	0	0	0	0	0	0	(836,961)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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	(1,067,173)	0	0	0	0	0	0	0	0	0	0	(1,067,173)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,067,173)	0	0	0	0	0	0	0	0	0	0	(1,067,173)	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)	(1,904,134)	0	0	0	0	0	0	0	0	0	0	(1,904,134)	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	\$ 802,522	HCR Manor Care Services, LLC	100.00%	\$ 802,522	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	8,259,969	Heartland Employment Services, LLC	100.00%	8,259,969		4
5	V	10a	Therapy Management	22,272	Heartland Rehabilitation Services, LLC	100.00%	22,272		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			\$ 9,084,763			\$ 9,084,763	\$ *	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:

06/01/15

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 (East) 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
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:

06/01/15Ending: 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, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	5	Utilities - Pooled	Accumulated Cost	559 NFs, HHs, & Re	\$ 818,127	\$	17,291,897	\$ 3,605	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	357 NFs			17,291,897	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	85 NFs			17,291,897	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	559 NFs, HHs, & Re	314,713	212,796	17,291,897	1,387	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	357 NFs	2,144,378	1,338,476	17,291,897	10,712	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	85 NFs			17,291,897	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	559 NFs, HHs, & Re	60,268,030	28,103,285	17,291,897	265,538	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	357 NFs	14,494,897	5,630,812	17,291,897	72,409	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	85 NFs	3,257,281		17,291,897	60,687	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	559 NFs, HHs, & Re	5,205,729		17,291,897	22,936	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	357 NFs	6,264,775		17,291,897	31,296	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	85 NFs			17,291,897	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	559 NFs, HHs, & Re	3,394,861		17,291,897	14,958	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	357 NFs	702,366		17,291,897	3,509	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	85 NFs			17,291,897	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		28,376,750		17,291,897	125,027	22
23	32	Directly Assigned Interest	Not Allocated		18,868,647			190,458	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions			33,166,797				24
25	TOTALS				\$ 177,277,351	\$ 35,285,370		\$ 802,522	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				\$ 2,639,793	\$ 2,522,268		0.0755	\$ 190,458	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Pooled Interest										125,027	7	
8	Interest Expense / Interest Income										(1,575)	8	
9	TOTAL Facility Related						\$ 2,639,793	\$ 2,522,268			\$ 313,910	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	\$ 2,522,268			\$ 313,910	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.)

FACILITY NAME Manorcare of Oak Lawn West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049551

CONTACT PERSON REGARDING THIS REPORT Jeff Lewandowski

TELEPHONE (419) 252-5736 FAX #: (419) 254-5495

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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	Facility		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	\$	\$ 1,981,007	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					416,216		416,216		5,606,418	9
10				1985	2,374						10
11				1986	5,308						11
12				1987	5,756						12
13				1988	251,787						13
14				1989	94,354						14
15				1990	20,764						15
16				1991	63,572						16
17				1992	143,258						17
18				1993	317,964						18
19				1994	192,466						19
20				1995	469,304						20
21				1996	340,114						21
22				1997	203,364						22
23				1998	544,751						23
24				1999	207,547						24
25				2000	106,678						25
26				2001	44,153						26
27	HVAC & ELECTRIC			2002	37,140						27
28	WALLCOVERING, PAINT, & FLOORING			2002	60,964						28
29	WALL REPLACEMENT			2002	5,327						29
30	CARPENTRY & MILLWORK			2002	59,438						30
31	CARPET & WALLCOVERING			2002	13,156						31
32	HVAC & ELECTRICAL			2002	18,957						32
33	ELECTRICAL WORK			2002	2,768						33
34	EMERGENCY POWER UPGRADE CIRCUIT			2002	215,884						34
35	DRAINAGE WORK			2002	23,290						35
36	CARPET			2003	2,365						36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Oak Lawn West

0049551

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 WALLCOVERING, BORDERS, & PAINTING	2003	\$ 8,019	\$		\$	\$	\$	37
38 WINDOW TREATMENTS	2003	3,647						38
39 TILE, CABINETS, COUNTER TOP, SINK (Soiled Utility room)	2003	36,272						39
40 HAND RAILS	2003	7,409						40
41 DOORS & FRAMES (9)	2003	17,938						41
42 TILE FLOOR & WALLS, PAINT, (Shower/Tub room)	2003	19,535						42
43 FLOOR TILE (Resident rooms)	2003	31,272						43
44 WALLCOVERING, BORDERS, & PAINTING	2003	38,430						44
45 ELECTRICAL WORK & LIGHT FIXTURES	2003	15,897						45
46 CONSTRUCTION DEPARTMENT COST & INTEREST	2003	25,344						46
47 PARKING LOT UPGRADE	2003	32,065						47
48 FENCING AROUND DUMPSTER	2003	7,898						48
49 DOORS	2004	7,344						49
50 CARPET	2004	10,711						50
51 Carpet	2004	1,899						51
52 Wallcovering & Paint	2004	3,277						52
53 Cabinets	2004	744						53
54 Doors	2004	34,253						54
55 Roofing	2004	5,450						55
56 Renov. - General Overhead & Interest	2004	21,977						56
57 Renov. - Mill Work	2004	4,633						57
58 Renov. - Doors	2004	1,632						58
59 Renov. - Drywall/Studs	2004	9,075						59
60 Renov. - Wallcovering & Corner Guards	2004	34,314						60
61 Renov. - Plumbing	2004	9,436						61
62 Renov. - Electrical	2004	4,345						62
63 Fenceing & Fence Posts	2004	4,500						63
64 Concrete Curbs	2004	8,225						64
65 Exterior Light Fixtures	2004	14,008						65
66 Renov. - General Overhead	2005	1,654						66
67 Renov. - Interest on Construction-Improvements	2005	293						67
68 Renov. - Carpeting & pads	2005	62,268						68
69 Renov. - Wall Covering	2005	1,580						69
70 TOTAL (lines 4 thru 69)		\$ 6,594,254	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	70

**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:

06/01/15

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 6,594,254	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	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 lochivar 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	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	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:

06/01/15

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		\$ 6,892,053	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	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	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	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:

06/01/15

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		\$ 7,945,872	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	1
2	<u>GREASE TRAP</u>	2011	4,500						2
3	<u>PAINTING</u>	2011	4,340						3
4	<u>WATER HEATER</u>	2011	2,583						4
5	<u>2 STORM DRAINS</u>	2011	5,760						5
6	<u>RENOV - GEN OVRHEAD & INTEREST</u>	2011	17,856						6
7	<u>RENOV - RESILIENT FLOORING</u>	2011	119,408						7
8	<u>RENOV - GEN OVRHEAD & INTEREST</u>	2011	53,045						8
9	<u>RENOV - CARPENTRY/SUBCONT</u>	2011	15,762						9
10	<u>RENOV - RESILIENT FLOORING</u>	2011	37,415						10
11	<u>RENOV - CARPETING</u>	2011	6,479						11
12	<u>RENOV - WALLCOVERING & CORNER GUARDS</u>	2011	255,739						12
13	<u>RENOV - BASIC ELECTRICAL</u>	2011	90,834						13
14	<u>RENOV - FIRE ALARM SYSTEM</u>	2011	16,084						14
15	<u>RENOV - PAINTING</u>	2011	800						15
16	<u>RENOV - ADDITIONAL FIRE ALARM SYSTEM</u>	2011	9,644						16
17	<u>RENOV - ADDITIONAL CARPENTRY</u>	2011	4,425						17
18	<u>concrete patio off main lobby</u>	2012	13,457						18
19	<u>masonry work - 21 new brick window sills</u>	2012	16,325						19
20	<u>2 hm doors arcadia dining</u>	2012	9,265						20
21	<u>sewer line - 2 resident rooms in west wing</u>	2012	21,925						21
22	<u>2 elec panels in west wing</u>	2012	5,182						22
23	<u>Kitchen door</u>	2013	3,385						23
24	<u>Smoke Wall Upgrds - 3 EZ path dev w/faceplates in 3 smoke walls.</u>								24
25	<u>ReAlign 3 sets of double acting smoke doors</u>	2013	4,875						25
26	<u>hot water tank</u>	2013	4,590						26
27	<u>DOOR ALARM SYSTEM COMPUTER</u>	2014	1,801						27
28	<u>MITSUBISHI DUCTLESS HEAT PUMP for basement</u>	2014	5,895						28
29	<u>Carpeting for ADON office</u>	2014	3,568						29
30	<u>Carpeting for MD office</u>	2014	1,784						30
31	<u>HVAC heat pump replacement</u>	2014	4,138						31
32	<u>wire to repair cut slab conduits</u>	2014	1,705						32
33	<u>replace smoke alarms with addressables</u>	2014	3,596						33
34	TOTAL (lines 1 thru 33)		\$ 8,692,037	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	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:

06/01/15

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		\$ 8,692,037	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	1
2	fire wall @PT addition, smoke walls @ E & W walls of lobby	2015	9,717						2
3	heat pump rplacement for room 130	2015	1,222						3
4	overhead paging system	2015	2,865						4
5	dry head sprinklers (32)	2015	8,344						5
6	flood valve for front bldg/parking lot	2014	10,499						6
7	ALARM WIRING for 5 alarms	2015	1,815						7
8	MIX VALVE in basement	2015	1,438						8
9	DRAIN 3" repair	2014	1,517						9
10	GEN ELEC UPGRADES	2014	6,936						10
11	Freight for flooring	2014	1,354						11
12	Freigh for flooring	2014	378						12
13	Freight for flooring	2014	815						13
14	elec upgrades for flood control pump NE corner of bldg	2014	2,858						14
15	VWC for basement, dining, W corridor, crash rail N Hall	2014	3,135						15
16	consulting on water damage	2014	6,291						16
17	repl flooring in BOM Ofc. Break rm and hallways in basement, and								17
18	lobby due to flood/sewage damage	2014	11,973						18
19	water heater for kitchen	2014	2,286						19
20	Mechanical Rm Door	2014	2,106						20
21	add'l-repl flrg in BOM Ofc. Brkrm/halls in bsmt/lobby due to floor	2014	4,295						21
22	4-6ft sections of pipe for kitchen/dish area	2015	3,150						22
23	flooring for kitchen/ dish area	2015	15,180						23
24	flooring for kitchen/ dish area	2015	19,488						24
25	ROOF GUTTER	2015	4,275						25
26	change out water pipe in E Wing ceiling	2015	1,701						26
27	tile floor in kitchen	2015	21,624						27
28	renov - concrete sidewalks	2015	52,790						28
29	renov - permanent fencing	2015	9,262						29
30									30
31	remove/repair bad areas in parking lots: 4400 sq ft in main								31
32	lot and 1500 sq ft in back lot.	2015	5,885						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,905,234	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	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:

06/01/15

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 12E, Carried Forward		\$ 8,905,234	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	1
2	remove/ repair damaged asphalt areas on East Drive & area around								2
3	2 water drains on Svc Drive	2015	7,550						3
4	INTERIOR REMOVATION CONSISTING OF THE FOLLOWING:								4
5	Masonry & bldg demolition	2015	61,673						5
6	Carpentry, millwork, windows, & HVAC	2015	279,109						6
7	Roofing & accousitcal ceiling tiles	2015	14,511						7
8	HM Doors/frames, Drywall, flooring & plumbing	2015	350,036						8
9	Carpeting,painting,wall covering, & corner guards	2015	361,558						9
10	Fire sprinkler sysem	2015	3,741						10
11	Electrical	2015	258,099						11
12	Signs	2015	484						12
13									13
14	replace compressor & heat pump in nurse office	2015	5,450						14
15	install 8" SDR drainage pipe in W Courtyard	2015	14,780						15
16	replacement heat pump for room 144	2015	4,250						16
17	remove existing chimney in middle of bldg over kitchen near N unit to roof line, rebuild w new								17
18	brick & mortar. Install new limestone cap.	2015	9,670						18
19	seal, stipe 4400 sq ft of main lot and 1500 sq ft of back lot	2015	5,212						19
20	rebuild fire wall above ceiling of bathroom in rm 166	2015	14,900						20
21	furnish/ install 2 hr fire wall in rm 168. Repair/paint ceiling.	2015	4,220						21
22	hollow metal door to N exit door to Svc Drive	2015	6,688						22
23	repl 120 gal storage tank in basement Mech Rm: Leaking	2015	4,230						23
24	new 120/208V 100 amp 42 circuit panelbd: basement elec rm	2016	7,815						24
25	hollow metal door to S exit door	2016	5,960						25
26	7 slider windows/sills in Arcadia dining & future dialysis rm	2016	12,890						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,338,061	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	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	\$4,065,383	\$201,874	\$201,874	\$		\$3,829,963	71
72	Current Year Purchases	616,189						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			18,467	18,467			74
75	TOTALS	\$4,681,572	\$201,874	\$220,341	\$18,467		\$3,829,963	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 GHC	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 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$15,851,740	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$648,054	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$666,521	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$18,467	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$11,429,495	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	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: \$ 28,605 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2017 | \$ |
| 13. | /2018 | \$ |
| 14. | /2019 | \$ |

* 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.)

	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	10345	hrs	\$ 415,294		\$	2,161	10,345	\$ 417,455	1	
2	Licensed Speech and Language Development Therapist	10a	5279	hrs	211,901	8	478	1,387	5,287	213,766	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	11434	hrs	458,991			17,288	11,434	476,279	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				763,725		763,725	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): InhalationTherapist	10a, 1 & 43, 2	468		18,768	241	13,613		709	32,381	12	
13	Other (specify): IV Therapy/X-Ray/Lab	43, 2 & 3					156,684	43,989		200,673	13	
14	TOTAL				\$ 1,104,954	249	\$ 170,775	\$ 828,550	27,775	\$ 2,104,279	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	\$ (6,398)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (751,968))	2,225,997		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,022		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,226,621	\$	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	10,338,062		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,693,678		16
17	Accumulated Depreciation (book methods)	(11,429,495)		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) OMIT	57,042		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,565,582	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,792,203	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 284,198	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	596,214		30
31	Accrued Taxes Payable (excluding real estate taxes)	623,062		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	148,574		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,652,048	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,522,268		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)	\$ 2,522,268	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,174,316	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,617,887	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,792,203	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,607,270	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,607,270	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,884,014)	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)	\$ (1,884,014)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	1,894,631	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,894,631	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,617,887	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Oak Lawn West

0049551

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	\$ 17,373,048	1
2	Discounts and Allowances for all Levels	(10,778,865)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,594,183	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,069,194	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,069,194	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	1,119	12
13	Barber and Beauty Care	5,305	13
14	Non-Patient Meals	655	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,532,226	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	208,075	19
20	Radiology and X-Ray	95,177	20
21	Other Medical Services	59,235	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,901,792	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>	111	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 111	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,565,280	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,428,070	31
32	Health Care	7,632,253	32
33	General Administration	4,714,439	33
	B. Capital Expense		
34	Ownership	2,387,590	34
	C. Ancillary Expense		
35	Special Cost Centers	998,815	35
36	Provider Participation Fee	288,127	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,449,294	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,884,014)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,884,014)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,075,487	44
45	Private Pay - Net Inpatient Revenue	588,986	45
46	Medicare - Net Inpatient Revenue	2,154,081	46
47	Other-(specify) <u>Hospice</u>	499,666	47
48	Other-(specify) <u>Insurance</u>	275,963	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,594,183	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	1,753	1,880	\$ 86,171	\$ 45.84	1
2	Assistant Director of Nursing	5,291	5,676	216,796	38.20	2
3	Registered Nurses	51,144	54,868	1,964,025	35.80	3
4	Licensed Practical Nurses	31,204	33,476	856,672	25.59	4
5	CNAs & Orderlies	107,893	115,904	1,437,960	12.41	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	31,093	33,335	1,338,159	40.14	7
8	Rehab/Therapy Aides	21,410	22,954	601,505	26.20	8
9	Activity Director	5,418	5,818	93,362	16.05	9
10	Activity Assistants					10
11	Social Service Workers	9,499	10,192	245,188	24.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,166	30,236	411,834	13.62	15
16	Dishwashers					16
17	Maintenance Workers	1,972	2,119	50,682	23.92	17
18	Housekeepers	16,223	17,406	187,349	10.76	18
19	Laundry	4,381	4,703	44,059	9.37	19
20	Administrator	2,080	2,080	64,263	30.90	20
21	Assistant Administrator	2,072	2,072	60,350	29.13	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,387	26,033	537,959	20.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,027	2,175	37,390	17.19	31
32	Other Health Care(specify)					32
33	Other(specify)Hospitality	1,989	2,134	26,245	12.30	33
34	TOTAL (lines 1 - 33)	348,002	373,061	\$ 8,259,969 *	\$ 22.14	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	61,698	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)		\$ 61,698		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	820	\$ 49,795	10, 3	50
51	Licensed Practical Nurses	54	2,463	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	874	\$ 52,258		53

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

** See instructions.

STATE OF ILLINOIS

0049551

Report Period Beginning:

06/01/15

Ending:

05/31/16

Facility Name & ID Number

Manorcare of Oak Lawn West

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Justine Humber

Administrator

0

\$ 29,946

Stephanie Johnson

Acting Admin

0

3,500

Renee Mills

Administrator

0

30,817

Stephanie Johnson

Asst Admin

0

60,350

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

(List each licensed administrator separately.)

\$ 124,613

B. Administrative - Other

Description

Amount

Various Home Office Services - See Page 8 for breakdown

\$ 802,522

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

(Attach a copy of any management service agreement)

\$ 802,522

C. Professional Services

Vendor/Payee

Type

Amount

Anspach Meeks Ellenberger LLP

Legal Fees

\$ 69

Elvidge Kelley Atty @ Law

Legal Fees

2,450

Greenberg Traurig

Legal Fees

14,331

Polsinelli Shughart/SNF Global

Legal Fees

30,478

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

Healthlink /Meyers & Flowers LLC

Collection Services

44,082

National Eligibility Solutions

Collection Services

30

Transworld Systems Inc

Collection Services

10,524

(Collection Costs were ajusted off via Page 5a, Line 6)

Jay M Brooker

Clinical Consulting

32,100

Southwest Nephrology Assoc. SC

Clinical Consulting

3,354

(Consulting Fees reclassified to Line 21)

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

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

\$ 137,419

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 98,881

Unemployment Compensation Insurance

98,664

FICA Taxes

596,253

Employee Health Insurance

399,917

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Disability Payments

5,087

401K & Mktg Adj

15,283

Appreciation, Oth Benefits

2,181

Tuition Program

5,100

SMSP Match

1,931

Employee Uniforms

9,984

Home Office Allocation

54,232

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

\$ 1,287,513

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

35,207

Health Care Worker Background Check

(Indicate # of checks performed 507)

13,187

Patient Background Checks

1049

10,490

Dues & Subscriptions

3,995

Association Dues

11,400

Advertising

19,143

Other Licensesand Permits

5,567

Less: Non-Allowable Association Dues

(3,922)

Less: Public Relations Expense

()

Non-allowable advertising

(19,143)

Yellow page advertising

()

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

\$ 77,914

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Includes travel expense to the Home

1,589

Office in Toledo, OH for regional meetings

Seminar Expense

Entertainment Expense

()

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

TOTAL

\$ 1,589

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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 \$4,744 & ACHA \$2,734
- (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. \$ 75,920 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. \$ 288,127
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. \$ 655
- (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