

Facility Name & ID Number Manorcare of Oak Lawn West

0049551 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	192	Skilled (SNF)	192	70,080	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	192	TOTALS	192	70,080	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,101	2,737	28,103	44,941	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,101	2,737	28,103	44,941	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.13%

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 14,871

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:

06/01/14

Ending:

05/31/15

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	257,264	39,431	142,761	439,456		439,456	439,456			1
2	Food Purchase		296,868		296,868		296,868	(393)	296,475		2
3	Housekeeping	196,817	31,148	1,631	229,596		229,596		229,596		3
4	Laundry	56,959	36,942	1,322	95,223		95,223		95,223		4
5	Heat and Other Utilities			237,839	237,839	3,350	241,189		241,189		5
6	Maintenance	47,645	14,349	293,039	355,033		355,033		355,033		6
7	Other (specify):* Med Waste			3,874	3,874		3,874		3,874		7
8	TOTAL General Services	558,685	418,738	680,466	1,657,889	3,350	1,661,239	(393)	1,660,846		8
	B. Health Care and Programs										
9	Medical Director			64,870	64,870		64,870		64,870		9
10	Nursing and Medical Records	4,572,802	488,489	165,930	5,227,221	11,413	5,238,634		5,238,634		10
10a	Therapy	1,997,609	12,292	34,494	2,044,395		2,044,395		2,044,395		10a
11	Activities	94,157	10,266	940	105,363		105,363		105,363		11
12	Social Services	240,170	29	7	240,206		240,206		240,206		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,904,738	511,076	266,241	7,682,055	11,413	7,693,468		7,693,468		16
	C. General Administration										
17	Administrative	138,920		863,712	1,002,632	(396,674)	605,958		605,958		17
18	Directors Fees										18
19	Professional Services			46,658	46,658		46,658	(46,658)			19
20	Dues, Fees, Subscriptions & Promotions			117,932	117,932		117,932	(52,375)	65,557		20
21	Clerical & General Office Expenses	521,460	87,290	794,462	1,403,212		1,403,212	(616,834)	786,378		21
22	Employee Benefits & Payroll Taxes			1,199,936	1,199,936	62,029	1,261,965		1,261,965		22
23	Inservice Training & Education			519	519		519		519		23
24	Travel and Seminar			1,486	1,486		1,486		1,486		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			530,169	530,169		530,169		530,169		26
27	Other (specify):*										27
28	TOTAL General Administration	660,380	87,290	3,554,874	4,302,544	(334,645)	3,967,899	(715,867)	3,252,032		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,123,803	1,017,104	4,501,581	13,642,488	(319,882)	13,322,606	(716,260)	12,606,346		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 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	
	D. Ownership											
30	Depreciation			486,123	486,123	22,150	508,273		508,273			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,799,106	2,799,106	297,732	3,096,838	(2,807,974)	288,864			32
33	Real Estate Taxes			678,381	678,381		678,381		678,381			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,503	49,503		49,503		49,503			35
36	Other (specify):*											36
37	TOTAL Ownership			4,013,113	4,013,113	319,882	4,332,995	(2,807,974)	1,525,021			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		791,509	1,090	792,599		792,599		792,599			39
40	Barber and Beauty Shops			5,575	5,575		5,575		5,575			40
41	Coffee and Gift Shops	25,646			25,646		25,646		25,646			41
42	Provider Participation Fee			284,948	284,948		284,948		284,948			42
43	Other (specify):* IV Therapy		122,984	155,607	278,591		278,591		278,591			43
44	TOTAL Special Cost Centers	25,646	914,493	447,220	1,387,359		1,387,359		1,387,359			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,149,449	1,931,597	8,961,914	19,042,960		19,042,960	(3,524,234)	15,518,726			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(393)	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	(17)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(90)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(55)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(18,860)	21		18
19	Entertainment				19
20	Contributions	(3,020)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,062)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(597,428)	21		24
25	Fund Raising, Advertising and Promotional	(52,375)	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 Page 5a	(2,840,934)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,524,234)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,524,234)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Manorcare of Oak Lawn West

Report Period Beginning: 06/01/14
 Ending: 05/31/15

ID# 0049551

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Activity Income	\$	11	1
2	Misc. Income		21	2
3	Vending Income	(1,140)	21	3
4	Accounting/Collection Fees	(31,820)	19	4
5	Collection Agency		19	5
6	Loss on Disposal of Fixed Asset		36	6
7	HCP Lease Interest	(2,807,974)	32	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,840,934)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn West

0049551

Report Period Beginning:

06/01/14

Ending:

05/31/15

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

	Operating Expenses	PAGES	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	(393)	0	0	0	0	0	0	0	0	0	0	(393)	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	(393)	0	(393)	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	(42,882)	0	0	0	0	0	0	0	0	0	0	(42,882)	19
20	Fees, Subscriptions & Promotions	(52,375)	0	0	0	0	0	0	0	0	0	0	(52,375)	20
21	Clerical & General Office Expenses	(620,610)	0	0	0	0	0	0	0	0	0	0	(620,610)	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	(715,867)	0	(715,867)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(716,260)	0	(716,260)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Oak Lawn West

0049551

Report Period Beginning:

06/01/14 Ending:

05/31/15

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

	Capital Expense	PAGES	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	(2,807,974)	0	0	0	0	0	0	0	0	0	0	(2,807,974)	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	(2,807,974)	0	(2,807,974)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(3,524,234)	0	0	0	0	0	0	0	0	0	0	(3,524,234)	45

VII. RELATED PARTIES

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

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

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						1
2	V	Page 8						2
3	V							3
4	V	1-44						4
5	V	10a						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		\$ 9,033,208			\$ 9,033,208	\$ *	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:

06/01/14

Ending:

05/31/15

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 Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				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

Facility Name & ID Number

Manorcare of Oak Lawn West

0049551

Report Period Beginning:

06/01/14

Ending:

05/31/15

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			Heartland of Champaign IL, LLC	Champaign				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
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27								27
28								28
29								29
30								30

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/14 Ending: 05/31/15

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

06/01/14

Ending: 05/31/15

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 Summitt 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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	564 NFs, HHs, & R	\$ 700,139	\$	18,993,243	\$ 3,350	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	356 NFs			18,993,243	0	2
3	5	Utilities - Direct to Western Div S	Accumulated Cost	45 NFs			18,993,243	0	3
4	10	Nursing - Pooled	Accumulated Cost	564 NFs, HHs, & R	365,628	262,581	18,993,243	1,750	4
5	10	Nursing - Direct to all SNFs	Accumulated Cost	356 NFs	1,781,417	1,228,977	18,993,243	9,663	5
6	10	Nursing - Direct to Western Div S	Accumulated Cost	45 NFs			18,993,243	0	6
7	17	Gen & Admin - Pooled	Accumulated Cost	564 NFs, HHs, & R	68,653,771	35,393,585	18,993,243	328,506	7
8	17	Gen & Admin - Direct to all SNFs	Accumulated Cost	356 NFs	12,665,127	2,400,695	18,993,243	68,703	8
9	17	Gen & Admin-Direct to MW Div	Accumulated Cost	40 NFs Jan-Sept	1,411,275		14,244,932	57,961	9
10	17	Gen & Admin - Direc toW Div SN	Accumulated Cost	45 NFs Oct-Dec	536,860		4,748,311	11,869	10
11	22	Employee Ben - Pooled	Accumulated Cost	564 NFs, HHs, & R	5,418,631		18,993,243	25,928	11
12	22	Employee Ben - Direct to SNFs	Accumulated Cost	356 NFs	6,655,045		18,993,243	36,101	12
13	22	Employee Ben - Direct to W Div S	Accumulated Cost	45 NFs			18,993,243	0	13
14	30	Deprec - Pooled	Accumulated Cost	564 NFs, HHs, & R	3,871,414		18,993,243	18,525	14
15	30	Deprec - Direct to all SNFs	Accumulated Cost	356 NFs	668,272		18,993,243	3,625	15
16	30	Deprec - Direct to W Div SNFs	Accumulated Cost	45 NFs			18,993,243	0	16
17									17
18									18
19	32	Pooled Interest	Accumulated Cost		25,971,677		18,993,243	124,274	19
20	32	Directly Assigned Interest	Not Allocated		17,184,434			173,458	20
21									21
22	24	H/O costs Allocated to non-SNF & Other Divisions			33,870,689				22
23									23
24									24
25	TOTALS				\$ 179,754,380	\$ 39,285,837		\$ 863,712	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		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	\$ 2,639,793		0.0657	\$ 173,458	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7	Pooled Interest									124,274	7							
8	Interest Expense / Interest Income									(8,868)	8							
9	TOTAL Facility Related					\$ 2,639,793	\$ 2,639,793			\$ 288,864	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$ 2,639,793	\$ 2,639,793			\$ 288,864	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																															
1. Real Estate Tax accrual used on 2014 report.		\$ 617,083	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.)		\$ 710,693	2																												
3. Under or (over) accrual (line 2 minus line 1).		\$ 93,610	3																												
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 617,591	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.)		\$ 15,030	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 \$ 47,850 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ (47,850)	6																												
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 678,381	7																												
Real Estate Tax History:																															
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2010</td><td>586,009</td><td>8</td></tr> <tr><td>2011</td><td>648,568</td><td>9</td></tr> <tr><td>2012</td><td>686,419</td><td>10</td></tr> <tr><td>2013</td><td>702,080</td><td>11</td></tr> <tr><td>2014</td><td>708,519</td><td>12</td></tr> </table>	2010	586,009	8	2011	648,568	9	2012	686,419	10	2013	702,080	11	2014	708,519	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2014 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2010	586,009	8																													
2011	648,568	9																													
2012	686,419	10																													
2013	702,080	11																													
2014	708,519	12																													
FOR BHF USE ONLY																															
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																													
14	PLUS APPEAL COST FROM LINE 5 \$	14																													
15	LESS REFUND FROM LINE 6 \$	15																													
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																													
Line 2: \$710,693.54 = \$324,549.62 for 2nd half 2013 + \$386,143.92 for 1st half 2014																															
Line 4: \$617,590.87 = \$322,375.04 for 2nd half 2014 + \$295,215.83 for Jan - May 2015																															
Line 5: \$15,029.84 = Worsek & Vihon invs- \$167-2012 Spec Obj & \$8,507-2014 Tax Assmt appeal and Rock Fusco Connelly inv \$6,355.84-2009 RE Taxes																															
Line 6: \$(47,850.42)=Worsek Vihon \$204.56-2012 Rate Appeal, Maria Pappas \$22,222.50 & \$25,423.36 2008-09 PTAB refunds																															

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.

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 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	<u>Facility</u>		<u>1981</u>	<u>\$ 820,000</u>	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	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	98	1981	1962	\$ 313,600	\$ 26,232		\$ 26,232	\$	\$ 1,951,043
5	75	1981	1969	658,575					
6	9		1987	448,818					
7	10		1999	1,235,114					
8									
Improvement Type**									
9	Current Year Depreciation				265,016		265,016		5,190,202
10			1985	2,374					
11			1986	5,308					
12			1987	5,756					
13			1988	251,787					
14			1989	94,354					
15			1990	20,764					
16			1991	63,572					
17			1992	143,258					
18			1993	317,964					
19			1994	192,466					
20			1995	469,304					
21			1996	340,114					
22			1997	203,364					
23			1998	544,751					
24			1999	207,547					
25			2000	106,678					
26			2001	44,153					
27	HVAC & ELECTRIC		2002	37,140					
28	WALLCOVERING, PAINT, & FLOORING		2002	60,964					
29	WALL REPLACEMENT		2002	5,327					
30	CARPENTRY & MILLWORK		2002	59,438					
31	CARPET & WALLCOVERING		2002	13,156					
32	HVAC & ELECTRICAL		2002	18,957					
33	ELECTRICAL WORK		2002	2,768					
34	EMERGENCY POWER UPGRADE CIRCUIT		2002	215,884					
35	DRAINAGE WORK		2002	23,290					
36	CARPET		2003	2,365					

*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:

06/01/14

Ending:

05/31/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALLCOVERING, BORDERS, & PAINTING	2003	\$ 8,019	\$		\$	\$	\$	37
38	WINDOW TREATMENTS	2003	3,647						38
39	TILE, CABINETS, COUNTER TOP, SINK (Soiled Utility room)	2003	36,272						39
40	HAND RAILS	2003	7,409						40
41	DOORS & FRAMES (9)	2003	17,938						41
42	TILE FLOOR & WALLS, PAINT, (Shower/Tub room)	2003	19,535						42
43	FLOOR TILE (Resident rooms)	2003	31,272						43
44	WALLCOVERING, BORDERS, & PAINTING	2003	38,430						44
45	ELECTRICAL WORK & LIGHT FIXTURES	2003	15,897						45
46	CONSTRUCTION DEPARTMENT COST & INTEREST	2003	25,344						46
47	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	Fencing & 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	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	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:

06/01/14

Ending:

05/31/15

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		\$ 6,594,254	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	1
2	Renov. - General Overhead	2005	5,242						2
3	Renov. - Interest on Construction Imp	2005	320						3
4	Renov. - Freight Costs	2005	476						4
5	Renov. - Resilient Flooring	2005	9,106						5
6	Renov. - Carpeting, Pads & installation	2005	10,655						6
7	Renov. - Wallcovering and corner guards	2005	6,655						7
8	Renov. - Carpentry SubContracting	2005	24,882						8
9	Renov. - HM Doors & Frames	2005	4,310						9
10	30 AMP, 208V circuit	2005	2,399						10
11	Resident Room Doors	2005	31,770						11
12	Doors	2005	1,600						12
13	Sealing coat	2005	2,240						13
14	Renov - General Overhead	2006	2,695						14
15	Renov - Interest on Const - Impr	2006	243						15
16	Renov - Ceramic Tile	2006	6,000						16
17	Renov - Resilient Flooring	2006	29,972						17
18	Renov - Wallcovering	2006	2,840						18
19	Renov - Plumbing	2006	8,655						19
20	lochinvar heater	2006	23,225						20
21	conduit / wiring	2006	2,054						21
22	waterproofing	2006	2,888						22
23	vct	2006	1,672						23
24	windows	2006	6,878						24
25	VWC	2006	11,546						25
26	kitchen wall	2006	7,470						26
27	flooring / painting	2006	40,883						27
28	Conference room paint	2006	2,583						28
29	sidewalk	2006	1,362						29
30	plumbing, electrical, cabinetry for breakroom	2007	6,440						30
31	drains & downspouts	2007	20,196						31
32	Renov - General Overhead	2007	19,230						32
33	Renov - Interest on Const - Impr	2007	1,312						33
34	TOTAL (lines 1 thru 33)		\$ 6,892,053	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	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:

06/01/14

Ending:

05/31/15

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	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	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	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	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:

06/01/14

Ending:

05/31/15

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	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	1
2	GREASE TRAP	2011	4,500						2
3	PAINTING	2011	4,340						3
4	WATER HEATER	2011	2,583						4
5	2 STORM DRAINS	2011	5,760						5
6	RENOV - GEN OVRHEAD & INTEREST	2011	17,856						6
7	RENOV - RESILIENT FLOORING	2011	119,408						7
8	RENOV - GEN OVRHEAD & INTEREST	2011	53,045						8
9	RENOV - CARPENTRY/SUBCONT	2011	15,762						9
10	RENOV - RESILIENT FLOORING	2011	37,415						10
11	RENOV - CARPETING	2011	6,479						11
12	RENOV - WALLCOVERING & CORNER GUARDS	2011	255,739						12
13	RENOV - BASIC ELECTRICAL	2011	90,834						13
14	RENOV - FIRE ALARM SYSTEM	2011	16,084						14
15	RENOV - PAINTING	2011	800						15
16	RENOV - ADDITIONAL FIRE ALARM SYSTEM	2011	9,644						16
17	RENOV - ADDITIONAL CARPENTRY	2011	4,425						17
18	concrete patio off main lobby	2012	13,457						18
19	masonry work - 21 new brick window sills	2012	16,325						19
20	2 hm doors arcadia dining	2012	9,265						20
21	sewer line - 2 resident rooms in west wing	2012	21,925						21
22	2 elec panels in west wing	2012	5,182						22
23	Kitchen door	2013	3,385						23
24	Smoke Wall Upgrds - 3 EZ path dev w/faceplates in 3 smoke walls.								24
25	ReAlign 3 sets of double acting smoke doors	2013	4,875						25
26	hot water tank	2013	4,590						26
27	DOOR ALARM SYSTEM COMPUTER	2014	1,801						27
28	mitsubishi ductless heat pump for basement	2014	5,895						28
29	Carpeting for ADON office	2014	3,568						29
30	Carpeting for MD office	2014	1,784						30
31	HVAC heat pump replacement	2014	4,138						31
32	wire to repair cut slab conduits	2014	1,705						32
33	replace smoke alarms with addressables	2014	3,596						33
34	TOTAL (lines 1 thru 33)		\$ 8,692,037	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	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:

06/01/14

Ending:

05/31/15

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	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	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 flood	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									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,899,349	\$ 291,248		\$ 291,248	\$	\$ 7,141,245	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	\$ 3,909,755	\$ 194,875	\$ 194,875	\$		\$ 3,628,089	71
72	Current Year Purchases	155,628						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			22,150	22,150			74
75	TOTALS	\$ 4,065,383	\$ 194,875	\$ 217,025	\$ 22,150		\$ 3,628,089	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)	\$ 13,796,839	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 486,123	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 508,273	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,150	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,781,441	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	CIP	\$ 2,210,414	92
93			93
94			94
95		\$ 2,210,414	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.

Facility Name & ID Number Manorcare of Oak Lawn West

0049551

Report Period Beginning: 06/01/14

Ending: 05/31/15

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

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 49,503 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	Patient Transportation		\$	\$	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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist	10a	9623	hrs	\$ 381,965		\$	\$		9,623	\$ 381,965	1
2	Licensed Speech and Language Development Therapist	10a	6352	hrs	252,152					6,352	252,152	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10a	13158	hrs	522,286					13,158	522,286	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 prescripts					791,509		791,509	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Other (specify): <u>Inalation Therapist</u>	10a, 3 & 43, 2	1334		52,949	125	3,981	6,981		1,459	63,911	12
13	Other (specify): <u>IV Drugs/X-Ray/Lab</u>	10a,3 & 43,2&3					155,607	150,134			305,741	13
14	TOTAL				\$ 1,209,352	125	\$ 159,588	\$ 948,624		30,592	\$ 2,317,564	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.

Facility Name & ID Number Manorcare of Oak Lawn West

0049551

Report Period Beginning: 06/01/14

Ending:

05/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 24,925	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (725,838))	1,420,039		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,384		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,451,348	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	820,000		13
14	Buildings, at Historical Cost	8,899,350		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,077,489		16
17	Accumulated Depreciation (book methods)	(10,781,441)		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) <u>OMIT</u>	84,877		22
23	Other(specify): <u>CIP</u>	2,210,414		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,396,984	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,848,332	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 262,607	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	546,151		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	617,591		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payables</u>	174,920		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,601,269	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,639,793		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,639,793	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,241,062	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,607,270	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,848,332	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,189,276	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,189,276	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,791,929)	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)	\$ (2,791,929)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	3,209,923	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3,209,923	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,607,270	24 *

* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 17,682,780	1	
2	Discounts and Allowances for all Levels	(10,187,211)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,495,569	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	6,780,546	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,780,546	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	1,195	12	
13	Barber and Beauty Care	6,492	13	
14	Non-Patient Meals	393	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,571,371	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	186,860	19	
20	Radiology and X-Ray	114,109	20	
21	Other Medical Services	94,479	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,974,899	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>	17	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,251,031	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,657,889	31	
32	Health Care	7,682,055	32	
33	General Administration	4,302,544	33	
B. Capital Expense				
34	Ownership	4,013,113	34	
C. Ancillary Expense				
35	Special Cost Centers	1,102,411	35	
36	Provider Participation Fee	284,948	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,042,960	40	
41	Income before Income Taxes (line 30 minus line 40)**	(2,791,929)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,791,929)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,683,048	44
45	Private Pay - Net Inpatient Revenue	936,965	45
46	Medicare - Net Inpatient Revenue	2,796,872	46
47	Other-(specify) <u>Hospice</u>	562,506	47
48	Other-(specify) <u>Insurance</u>	516,178	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,495,569	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.

Facility Name & ID Number Manorcare of Oak Lawn West

0049551

Report Period Beginning:

06/01/14

Ending:

05/31/15

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	2,013	2,155	\$ 94,651	\$ 43.92	1
2	Assistant Director of Nursing	6,652	7,120	247,362	34.74	2
3	Registered Nurses	53,785	57,570	1,978,936	34.37	3
4	Licensed Practical Nurses	28,672	30,689	774,849	25.25	4
5	CNAs & Orderlies	107,418	115,149	1,438,422	12.49	5
6	CNA Trainees	405	434	4,723	10.88	6
7	Licensed Therapist	33,298	35,627	1,414,198	39.69	7
8	Rehab/Therapy Aides	20,270	21,688	583,411	26.90	8
9	Activity Director	6,507	6,953	94,157	13.54	9
10	Activity Assistants					10
11	Social Service Workers	8,342	8,935	240,170	26.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,846	19,110	257,264	13.46	15
16	Dishwashers					16
17	Maintenance Workers	2,135	2,287	47,645	20.83	17
18	Housekeepers	17,501	18,738	196,817	10.50	18
19	Laundry	5,226	5,598	56,959	10.17	19
20	Administrator	2,080	2,080	85,082	40.90	20
21	Assistant Administrator	1,866	1,866	53,838	28.85	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,867	26,593	521,460	19.61	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	1,893	2,028	33,859	16.70	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,980	2,121	25,646	12.09	33
34	TOTAL (lines 1 - 33)	342,756	366,741	\$ 8,149,449 *	\$ 22.22	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	64,870	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)	\$	64,870		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Justine Humber</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 85,082</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 99,602</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
<u>Stephanie Johnson</u>	<u>Asst. Admin</u>	<u>0</u>	<u>53,838</u>	<u>Unemployment Compensation Insurance</u>	<u>103,206</u>	<u>Advertising: Employee Recruitment</u>	<u>29,464</u>	
				<u>FICA Taxes</u>	<u>596,574</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>389,263</u>	<u>(Indicate # of checks performed <u>510</u>)</u>	<u>10,238</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks <u>924</u></u>	<u>9,240</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>4,627</u>	
				<u>Employee Appreciation</u>		<u>Association Dues</u>	<u>10,967</u>	
				<u>401K</u>	<u>16,411</u>	<u>Advertising</u>	<u>48,285</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 138,920	<u>Oth Empl Benefits, Mktg Adj, & Disability Pymt</u>	<u>(12,798)</u>	<u>Other Licenses & Permits</u>	<u>3,121</u>	
(List each licensed administrator separately.)				<u>Tuition Reimbursement</u>	<u>1,789</u>	<u>Less: Non-allowable Assn. Dues</u>	<u>(4,090)</u>	
				<u>SMSP Match</u>	<u>104</u>	<u>Less: Public Relations Expense</u>	<u>()</u>	
				<u>Employee Uniforms</u>	<u>5,785</u>	<u>Non-allowable advertising</u>	<u>(48,285)</u>	
				<u>Home Office Allocation</u>	<u>62,029</u>	<u>Yellow page advertising</u>	<u>()</u>	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 65,557	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,261,965			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Various Home Office Services</u>			<u>\$ 863,712</u>				<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	<u>1,486</u>
							<u>Includes travel expense to the Home Office in Toledo, OH for regional meetings.</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 863,712				<u>Seminar Expense</u>	
(Attach a copy of any management service agreement)								
							<u>Entertainment Expense</u>	<u>()</u>
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,486
C. Professional Services				TOTAL		\$		
Vendor/Payee	Type		Amount					
<u>Elvidge Kelley Atty @ Law</u>	<u>Legal Fees</u>		<u>\$ 5,832</u>					
<u>Ggreenburg Traurig</u>	<u>Legal Fees</u>		<u>2,050</u>					
<u>McVey & Parsky LLC</u>	<u>Legal Fees</u>		<u>2,205</u>					
<u>SNF Global</u>	<u>Legal Fees</u>		<u>975</u>					
<u>(Legal Fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)</u>								
<u>Heathlink Inc</u>	<u>Collection Services</u>		<u>1,091</u>					
<u>Meyers & Flowers LLC</u>	<u>Collection Services</u>		<u>30,070</u>					
<u>Transworld Systems Ince</u>	<u>Collection Services</u>		<u>659</u>					
<u>(Collection Costs were adjusted off via Page 5a, Line 6)</u>								
<u>Southwest Nephrology Assc SC</u>	<u>Clinical Consulting</u>		<u>3,747</u>					
<u>VHS Genesis Lab Inc</u>	<u>Clinical Consulting</u>		<u>29</u>					
<u>(Consulting Fees reassessed to Line 21).</u>								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 46,658					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

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

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICHA \$4,142 & AHCA \$2,736
- (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. \$ 81,846 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. \$ 284,948
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. \$ 393
- (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.