



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	192	Skilled (SNF)	192	70,272	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	70,272	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,992	2,292	24,448	44,732	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,992	2,292	24,448	44,732	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**

ACCRUAL  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
	<b>A. General Services</b>										
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):* <b>Med Waste</b>			3,248	3,248		3,248		3,248		7
8	<b>TOTAL General Services</b>	693,924	406,420	327,726	1,428,070	3,605	1,431,675	(655)	1,431,020		8
	<b>B. Health Care and Programs</b>										
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	<b>TOTAL Health Care and Programs</b>	6,877,228	480,678	274,347	7,632,253	12,099	7,644,352		7,644,352		16
	<b>C. General Administration</b>										
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	<b>TOTAL General Administration</b>	662,572	73,307	3,978,560	4,714,439	(349,656)	4,364,783	(836,306)	3,528,477		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	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.

Facility Name & ID Number Manorcare of Oak Lawn West

#0049551

Report Period Beginning:

06/01/15

Ending:

05/31/16

## 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	
	<b>D. Ownership</b>											
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	<b>TOTAL Ownership</b>			2,387,590	2,387,590	333,952	2,721,542	(1,067,173)	1,654,369			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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):* <b>IV   X-Ray &amp; Lab</b>		43,989	156,684	200,673		200,673		200,673			43
44	<b>TOTAL Special Cost Centers</b>	26,245	807,714	452,983	1,286,942		1,286,942		1,286,942			44
45	<b>GRAND TOTAL COST</b> (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.)

		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	(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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (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	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)		10a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</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	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Manorcare of Oak Lawn West

ID# 0049551

Report Period Beginning: 06/01/15

Ending: 05/31/16

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
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	<b>Total</b>	(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	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	<b>TOTAL General Services</b>	<b>(655)</b>	<b>0</b>	<b>(655)</b>	<b>8</b>									
<b>B. Health Care and Programs</b>														
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
<b>C. General Administration</b>														
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	<b>TOTAL General Administration</b>	<b>(836,306)</b>	<b>0</b>	<b>(836,306)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(836,961)</b>	<b>0</b>	<b>(836,961)</b>	<b>29</b>									

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	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	<b>TOTAL Ownership</b>	<b>(1,067,173)</b>	<b>0</b>	<b>(1,067,173)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,904,134)</b>	<b>0</b>	<b>(1,904,134)</b>	<b>45</b>									

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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 &amp; 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

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			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

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization HCR Manor Care Services LLC  
 Street Address 333 North Summit Street  
 City / State / Zip Code Toledo, OH 43604-2617  
 Phone Number ( 419) 252-5500  
 Fax Number ( 419) 254-5495

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	\$ 818,127	\$ 17,291,897	\$ 3,605	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs		17,291,897	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs		17,291,897	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	314,713	212,796	17,291,897	1,387
6	10	Nursing - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	2,144,378	1,338,476	17,291,897	10,712
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs		17,291,897	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	60,268,030	28,103,285	17,291,897	265,538
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	14,494,897	5,630,812	17,291,897	72,409
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs	3,257,281		17,291,897	60,687
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	5,205,729		17,291,897	22,936
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	6,264,775		17,291,897	31,296
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	928,114,340	85 NFs			17,291,897	0
16									16
17	30	Depreciation - Pooled	Accumulated Cost	3,924,650,842	559 NFs, HHs, & Re	3,394,861		17,291,897	14,958
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	3,461,495,908	357 NFs	702,366		17,291,897	3,509
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	928,114,340	85 NFs			17,291,897	0
20									20
21									21
22	32	Pooled Interest	Accumulated Cost	3,924,650,842		28,376,750		17,291,897	125,027
23	32	Directly Assigned Interest	Not Allocated			18,868,647			190,458
24		H/O Costs Allocated to Non-SNFs and Other Divisions				33,166,797			
25	TOTALS					\$ 177,277,351	\$ 35,285,370	\$ 802,522	25

Facility Name & ID Number

Manorcare of Oak Lawn West

# 0049551

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**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Conv. Sub. Debentures		X				\$ 2,639,793	\$ 2,522,268			0.0755	\$ 190,458						
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6																		
7	Pooled Interest											125,027						
8	Interest Expense / Interest Income											(1,575)						
9	<b>TOTAL Facility Related</b>						\$ 2,639,793	\$ 2,522,268				\$ 313,910						
<b>B. Non-Facility Related*</b>																		
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 2,639,793	\$ 2,522,268				\$ 313,910						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 report.	\$	<b>617,591</b>	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.)	\$	<b>712,060</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>94,469</b>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>623,062</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	<b>22,734</b>	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. <b>TOTAL REFUND \$ <u>94,930</u> For <u>11</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	<b>(94,930)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>645,333</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<b>648,568</b>	8
	2012	<b>686,419</b>	9
	2013	<b>702,080</b>	10
	2014	<b>708,519</b>	11
	2015	<b>714,881</b>	12

**Line 2: \$712,060.47 = \$322,375.04 for 2nd half 2014 + \$389,685.43 for 1st half 2015**

**Line 4: \$325,195.43= \$0 for 2nd half 2015 + \$297,866.67 for Jan - May 2016**

**Line 5: \$22,734 = Worsek & Vihon invs: \$198 for 2013 Spec Obj & \$22.536 for 2011 Specific Obj #13-COTO-2578**

**Line 6: \$(94,930) = Worsek & Vihon 2011 Specific Objections #13-COTO-2578 refund from Cook Co Treasurer, Maria Pappas**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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



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**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).

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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 Use	2 Square Feet	3 Year Acquired	4 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	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	\$ 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
	<b>Improvement Type**</b>										
9	<b>Current Year Depreciation</b>					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

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# 0049551

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## 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	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.

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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	<b>Totals from Page 12A, Carried Forward</b>		\$ 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	<b>TOTAL (lines 1 thru 33)</b>		\$ 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.

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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	<b>Totals from Page 12B, Carried Forward</b>		\$ 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	<b>TOTAL (lines 1 thru 33)</b>		\$ 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.

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## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 7,945,872	\$ 446,180		\$ 446,180	\$	\$ 7,587,425	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 ALAM 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	<b>TOTAL (lines 1 thru 33)</b>		\$ 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 &amp; 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	<b>Totals from Page 12D, Carried Forward</b>		\$ 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 floo	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 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.

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	<b>Totals from Page 12E, Carried Forward</b>		\$ 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	<b>INTERIOR REMOVATION CONSISTING OF THE FOLLOWING:</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$ 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.

Facility Name & ID Number Manorcare of Oak Lawn West

# 0049551

Report Period Beginning:

06/01/15

Ending:

05/31/16

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	<b>TOTAL</b>				\$			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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	<b>TOTAL</b>		\$	\$	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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	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 prescripts				763,725		763,725	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>InhalationTherapist</u>	10a, 1 & 43, 2	468	18,768	241	13,613		709	32,381	12
13	Other (specify): <u>IV Therapy/X-Ray/Lab</u>	43, 2 & 3				156,684	43,989		200,673	13
14	<b>TOTAL</b>			\$ 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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **05/31/16**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,226,621	\$	10
	<b>B. Long-Term Assets</b>			
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 (spe OMIT)	57,042		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 15,565,582	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 17,792,203	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accounts Payable</u>	148,574		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,652,048	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,522,268		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,522,268	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,174,316	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 13,617,887	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 17,792,203	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>13,607,270</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>13,607,270</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,884,014)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,884,014)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change in Interdivision</b>	<b>1,894,631</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>1,894,631</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>13,617,887</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 17,373,048	1
2	Discounts and Allowances for all Levels	(10,778,865)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,594,183	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,069,194	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 7,069,194	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,901,792	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Discount</u>	111	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 111	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,565,280	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,428,070	31
32	Health Care	7,632,253	32
33	General Administration	4,714,439	33
<b>B. Capital Expense</b>			
34	Ownership	2,387,590	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	998,815	35
36	Provider Participation Fee	288,127	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 17,449,294	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,884,014)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 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.

Facility Name & ID Number Manorcare of Oak Lawn West

# 0049551

Report Period Beginning:

06/01/15

Ending:

05/31/16

**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) <u>Hospitality</u>	1,989	2,134	26,245	12.30	33
34	TOTAL (lines 1 - 33)	348,002	373,061	\$ 8,259,969 *	\$ 22.14	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	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

**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		
Justine Humber	Administrator	0	\$ 29,946	Workers' Compensation Insurance	\$ 98,881	IDPH License Fee	\$ 1,990		
Stephanie Johnson	Acting Admin	0	3,500	Unemployment Compensation Insurance	98,664	Advertising: Employee Recruitment	35,207		
Renee Mills	Administrator	0	30,817	FICA Taxes	596,253	Health Care Worker Background Check (Indicate # of checks performed 507)	13,187		
				Employee Health Insurance	399,917	Patient Background Checks	10,490		
				Employee Meals		Dues & Subscriptions	3,995		
Stephanie Johnson	Asst Admin	0	60,350	Illinois Municipal Retirement Fund (IMRF)*		Association Dues	11,400		
				Disability Payments	5,087	Advertising	19,143		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 124,613	401K & Mktg Adj	15,283	Other Licenses and Permits	5,567		
				Appreciation, Oth Benefits	2,181	Less: Non-Allowable Association Dues	(3,922)		
B. Administrative - Other				Tuition Program	5,100	Less: Public Relations Expense	( )		
Description			Amount	SMSP Match	1,931	Non-allowable advertising	(19,143)		
Various Home Office Services - See Page 8 for breakdown			\$ 802,522	Employee Uniforms	9,984	Yellow page advertising	( )		
				Home Office Allocation	54,232				
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,287,513	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 77,914	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 802,522	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount			\$			
Anspach Meeks Ellenberger LLP	Legal Fees		\$ 69				Out-of-State Travel	\$	
Elvidge Kelley Atty @ Law	Legal Fees		2,450						
Greenberg Traurig	Legal Fees		14,331				In-State Travel		
Polsinelli Shughart/SNF Global	Legal Fees		30,478				Includes travel expense to the Home Office in Toledo, OH for regional meetings	1,589	
(Legal fees were adjusted off via Page 5, Line 22; therefore no invoices are attached)							Seminar Expense		
Healthlink /Meyers & Flowers LLC	Collection Services		44,082						
National Eligibility Solutions	Collection Services		30				Entertainment Expense	( )	
Transworld Systems Inc	Collection Services		10,524				(agree to Sch. V, line 24, col. 8)		
(Collection Costs were adjusted off via Page 5a, Line 6)							TOTAL	\$ 1,589	
Jay M Brooker	Clinical Consulting		32,100						
Southwest Nephrology Assoc. SC	Clinical Consulting		3,354						
(Consulting Fees reclassified to Line 21)				TOTAL		\$			
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 137,419						

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Manorcare of Oak Lawn West# 0049551

Report Period Beginning:

06/01/15

Ending:

05/31/16**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