

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0049668

Facility Name: Manorcare of Oak Lawn East

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

County: Cook

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

HFS ID Number: _____

Date of Initial License for Current Owners: 1977

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Garv Geise Telephone Number: (419) 252-5731
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/13 to 05/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Barry Lazarus</u>	
	(Title) <u>Vice President, Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title)	_____
	(Firm Name & Address)	_____
	(Telephone) <u>()</u> Fax # <u>()</u>	

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668 Report Period Beginning: 06/01/13 Ending: 05/31/14

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	122	Skilled (SNF)	122	44,530	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	122	TOTALS	122	44,530	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	10,894	1,866	25,315	38,075	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,894	1,866	25,315	38,075	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.50%

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 1977

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/07/11 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 122 and days of care provided 16,180

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31 Fiscal Year: 05/31

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

Facility Name & ID Number

Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

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	109,649	22,900	299,047	431,596		431,596	431,596			1
2	Food Purchase		241,253		241,253		241,253	(1,242)	240,011		2
3	Housekeeping	185,257	31,930		217,187		217,187		217,187		3
4	Laundry	57,442	20,523		77,965		77,965		77,965		4
5	Heat and Other Utilities			163,765	163,765	2,733	166,498		166,498		5
6	Maintenance	56,216	26,677	137,454	220,347		220,347		220,347		6
7	Other (specify):* Medical Waste			1,556	1,556		1,556		1,556		7
8	TOTAL General Services	408,564	343,283	601,822	1,353,669	2,733	1,356,402	(1,242)	1,355,160		8
	B. Health Care and Programs										
9	Medical Director			91,327	91,327		91,327		91,327		9
10	Nursing and Medical Records	3,665,771	396,171	174,690	4,236,632	34,615	4,271,247		4,271,247		10
10a	Therapy	2,139,736	24,396	83,505	2,247,637		2,247,637		2,247,637		10a
11	Activities	86,163	2,827	1,345	90,335		90,335		90,335		11
12	Social Services	311,513		118	311,631		311,631		311,631		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,203,183	423,394	350,985	6,977,562	34,615	7,012,177		7,012,177		16
	C. General Administration										
17	Administrative	102,905		626,540	729,445	(226,106)	503,339		503,339		17
18	Directors Fees										18
19	Professional Services			234,627	234,627	(22,701)	211,926	(211,926)			19
20	Dues, Fees, Subscriptions & Promotions			68,175	68,175		68,175	(19,423)	48,752		20
21	Clerical & General Office Expenses	484,040	85,377	694,805	1,264,222		1,264,222	(549,697)	714,525		21
22	Employee Benefits & Payroll Taxes			1,064,566	1,064,566	60,085	1,124,651		1,124,651		22
23	Inservice Training & Education			2,805	2,805		2,805		2,805		23
24	Travel and Seminar			17,266	17,266		17,266		17,266		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			602,476	602,476		602,476		602,476		26
27	Other (specify):*										27
28	TOTAL General Administration	586,945	85,377	3,311,260	3,983,582	(188,722)	3,794,860	(781,046)	3,013,814		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,198,692	852,054	4,264,067	12,314,813	(151,374)	12,163,439	(782,288)	11,381,151		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			406,587	406,587	20,222	426,809		426,809		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,264,435	1,264,435	131,152	1,395,587	(1,297,724)	97,863		32
33	Real Estate Taxes			458,667	458,667		458,667		458,667		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			86,365	86,365		86,365		86,365		35
36	Other (specify):*										36
37	TOTAL Ownership			2,216,054	2,216,054	151,374	2,367,428	(1,297,724)	1,069,704		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		694,192		694,192		694,192		694,192		39
40	Barber and Beauty Shops			8,235	8,235		8,235		8,235		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			199,654	199,654		199,654		199,654		42
43	Other (specify):* IV X-Ray & Lab		175,464	217,243	392,707		392,707		392,707		43
44	TOTAL Special Cost Centers		869,656	425,132	1,294,788		1,294,788		1,294,788		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,198,692	1,721,710	6,905,253	15,825,655		15,825,655	(2,080,012)	13,745,643		45

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning: 06/01/13

Ending: 05/31/14

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,242)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	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	(59,430)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(194,978)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(488,311)	21		24
25	Fund Raising, Advertising and Promotional	(19,423)	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	(1,316,569)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,080,012)		\$	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)		10a	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,080,012)		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						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 East

Report Period Beginning: 06/01/13
 Ending: 05/31/14

ID# 0049668

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	HCP Lease Interest	\$ (1,297,724)	32	1
2	Vending Income	(1,897)	21	2
3	Misc. Income	0	21	3
4	Activity Income	0	11	4
5	Loss on Disposal of Fixed Assets	0	36	5
6	Acct. Fees for Collections	(16,948)	19	6
7	Collection Agency Fees	0	19	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	(1,316,569)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,242)	0	0	0	0	0	0	0	0	0	0	(1,242)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,242)	0	0	0	0	0	0	0	0	0	0	(1,242)	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	(211,926)	0	0	0	0	0	0	0	0	0	0	(211,926)	19
20	Fees, Subscriptions & Promotions	(19,423)	0	0	0	0	0	0	0	0	0	0	(19,423)	20
21	Clerical & General Office Expenses	(549,697)	0	0	0	0	0	0	0	0	0	0	(549,697)	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	(781,046)	0	0	0	0	0	0	0	0	0	0	(781,046)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(782,288)	0	0	0	0	0	0	0	0	0	0	(782,288)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13 Ending:

05/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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	(1,297,724)	0	0	0	0	0	0	0	0	0	0	(1,297,724)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,297,724)	0	0	0	0	0	0	0	0	0	0	(1,297,724)	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)	(2,080,012)	0	0	0	0	0	0	0	0	0	0	(2,080,012)	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 Home Office Allocation	\$ 626,540	HCR Manor Care Services, LLC	100.00%	\$ 626,540	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	7,198,692	Heartland Employment Services, LLC	100.00%	7,198,692		4
5	V	10a Therapy Management	13,041	Heartland Rehabilitation Services, LLC	100.00%	13,041		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 7,838,273			\$ 7,838,273	\$ *	14

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

Facility Name & ID Number

Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL (SNF), L	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 (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (West) 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 East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

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 East # 0049668 Report Period Beginning: 06/01/13 Ending: 05/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13

Ending: 05/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	702 NFs,HHs,R	\$ 702,082	\$	15,259,883	\$ 2,733	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	357 NFs			15,259,883	0	2
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	48 NFs			15,259,883	0	3
4									4
5	10	Nursing - Pooled	Accumulated Cost	702 NFs,HHs,Rehat	421,070	303,971	15,259,883	1,639	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	357 NFs	2,331,970	10,787,378	15,259,883	10,275	6
7	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	48 NFs			15,259,883	0	7
8									8
9	17	Gen/Admin-Pooled	Accumulated Cost	702 NFs,HHs,Rehat	66,712,258	34,047,414	15,259,883	259,704	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	357 NFs	18,712,683	6,531,152	15,259,883	82,451	10
11	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	48 NFs	1,887,403	1,136,236	15,259,883	58,279	11
12									12
13	22	Empl Bnfts-Pooled	Accumulated Cost	702 NFs,HHs,Rehat	7,831,139		15,259,883	30,486	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	357 NFs	6,717,577		15,259,883	29,599	14
15	22	Empl Bnfts-Direct to MW Div SN	Accumulated Cost	48 NFs			15,259,883	0	15
16									16
17	30	Depreciation - Pooled	Accumulated Cost	702 NFs,HHs,Rehat	4,454,722		15,259,883	17,341	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	357 NFs	653,747		15,259,883	2,881	18
19	30	Depr - Direct to MW Div SNFs	Accumulated Cost	48 NFs			15,259,883	0	19
20									20
21									21
22	32	Pooled Interest	Accumulated Cost		25,923,280		15,259,883	100,917	22
23	32	Directly Assigned Interest	Not Allocated		18,563,246			30,235	23
24		H/O Costs Allocated to Non-SNFs & Other Divisions			30,324,259				24
25	TOTALS				\$ 185,235,436	\$ 52,806,151		\$ 626,540	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1	Conv. Sub. Debentures		X	Various			\$ 461,443	\$ 461,443		6.5523	\$ 30,235	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6	Home Office Pooled Interest Expense										100,917	6				
7	Interest Income / Interest Expense										(33,289)	7				
8												8				
9	TOTAL Facility Related						\$ 461,443	\$ 461,443			\$ 97,863	9				
	B. Non-Facility Related*															
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 461,443	\$ 461,443			\$ 97,863	15				

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.		\$	<u>393,634</u>	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.)		\$	<u>451,734</u>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>58,100</u>	3															
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>391,284</u>	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.)		\$	<u>10,577</u>	5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND <u>\$1,294.14</u> For <u>2003</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	<u>(1,294)</u>	6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>458,667</u>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>600,486</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	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	<u>595,989</u>	9																
	2011	<u>406,685</u>	10																
	2012	<u>435,749</u>	11																
	2013	<u>445,374</u>	12																
Line 2: \$451,734 = \$212,072 for the 2nd half of 2012 + \$239,662 for the 1st half of 2013.																			
Line 4: \$391,284 = \$205,712 for the 2nd half 2013 + \$185,572 estimate for Jan-May 2014.																			
Line 5: \$10,577 = \$4,000 Uran Real Estate Research + \$167 Worssek & Vihon + \$5,978.16 Rock Fusco + \$431.37 Worssek.																			
Line 6: \$1,294.14 = \$1,043.62 tax refund + \$250.52 interest.																			

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Oak Lawn East COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0049668
 CONTACT PERSON REGARDING THIS REPORT Gary Geise
 TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-03-400-032-0000</u>	<u>See attached</u>	\$ <u>445,373.81</u>	\$ <u>445,373.81</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>445,373.81</u></u>	\$ <u><u>445,373.81</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

Facility Name & ID Number Manorcare of Oak Lawn East

0049668 Report Period Beginning:

06/01/13 Ending:

05/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,616 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (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>1977</u>	\$ <u>257,674</u>	1
2					2
3	TOTALS			\$ <u>257,674</u>	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	122		1977	1977	\$ 2,247,698	\$ 31,298		\$ 31,298	\$	\$ 2,247,649
5										
6										
7										
8										
	Improvement Type**									
9	Current Year Depreciation					223,030		223,030		3,333,278
10			1981		18,089					
11			1986		2,797					
12			1988		19,012					
13			1989		14,714					
14			1990		202,653					
15			1991		69,401					
16			1992		114,373					
17			1993		63,254					
18			1994		648,943					
19			1995		220,796					
20			1996		238,261					
21			1997		230,127					
22			1998		319,666					
23			1999		57,192					
24			2000		71,071					
25		Reclass \$2,957 artwork to Equip. Disallow \$17,709	2001		106,534					
26		STEEL GATES FOR DUMSTERS	2002		6,355					
27		WINDOW TREATMENTS	2002		4,782					
28		Renovation - General Construction per audit \$4,171 disallowed	2002		24,092					
29		Renovation - Wallcovering per audit \$10,669 disallowed	2002		61,624					
30		Renovation - HVAC & Electrical per audit \$589 disallowed	2002		3,401					
31		ROOFING ON WEST SECTION	2003		19,000					
32		Sink, Tile, Wallcovering & Paint	2003		20,585					
33		Light Fixtures per audit change year from 2003 to 2002	2003		2,572					
34		Construction Department Cost & Interest Disallowed per audit	2003							
35		Ceramic Floor Tile & Related Concrete Work	2003		19,427					
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Carpeting & Wallcovering</u> per audit \$4,001 disallowed	2003	\$ 5,263	\$		\$	\$	\$	37
38	<u>Sheet Vinyl Flooring</u>	2003	1,295						38
39	<u>Carpeting</u>	2003	738						39
40	<u>Metal Doors</u>	2003	5,739						40
41	<u>Kitchen Renov - Stain Steel Wall Plating & Sinks</u>	2004	5,086						41
42	<u>Doors (4) Fire rated</u>	2004	6,608						42
43	<u>Exhauster, Duct Work, & Fire Damper</u>	2004	5,810						43
44	<u>Renov - General Construct. O/H & Int. disallowed per audit</u>	2004							44
45	<u>Renov - Painting</u>	2004	10,565						45
46	<u>Renov - Wall Covering</u>	2004	23,222						46
47	<u>Renov. - Doors & Frames</u>	2004	11,010						47
48	<u>Renov - Drywall & Studs</u>	2004	2,405						48
49	<u>Flooring</u>	2004	30,990						49
50	<u>Ceiling Tile</u>	2004	585						50
51	<u>Awing</u>	2004	2,320						51
52	<u>Flooring</u>	2005	885						52
53	<u>Fire Shutter Door</u>	2005	2,170						53
54	<u>Roofing</u>	2005	17,500						54
55	<u>2005 per audit - Doors for front entrance</u>	2005	8,732						55
56	<u>2005 per audit - Metal Access Doors</u>	2005	3,183						56
57	<u>2005 per audit - Asphalt Driveway, Seal Coat, & Stripe</u>	2005	11,979						57
58	<u>2006 per audit - Electric work for emergency light & feed</u>	2006	894						58
59	<u>2006 per audit - Doors & closers</u>	2006	2,834						59
60									60
61	<u>A/C for Elevator Room</u>	2006	5,960						61
62	<u>Electrical circuits for emergency generator system</u>	2006	8,530						62
63	<u>Electrical circuits - Kitchen & 2nd floor Nurse Station</u>	2006	3,599						63
64									64
65	<u>Renov - Flooring</u>	2007	20,080						65
66	<u>Renov - Wallcovering</u>	2007	1,786						66
67	<u>Renov - Carpentry</u>	2007	2,826						67
68	<u>Renov - Electrical</u>	2007	15,000						68
69	<u>Windows in lounge</u>	2007	3,310						69
70	TOTAL (lines 4 thru 69)		\$ 5,027,323	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	70

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,027,323	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	1
2	Roofing	2007	3,500						2
3	Metal Door	2008	8,440						3
4	Door and Frame	2008	3,177						4
5	Water Heater	2008	22,725						5
6									6
7	Renov. - Architech & Engineering	2007	78,362						7
8	Renov. - Plan Reviews	2007	3,660						8
9	Renov. - Capentry-Subcontractor	2008	713,268						9
10	Renov. - Mill Work	2008	38,340						10
11	Renov. - HM Doors & Frames	2009	5,637						11
12	Renov. - Reslient Flooring	2007	55,865						12
13	Renov. - Wallcovering	2007	51,819						13
14	Renov. - Corner Guards	2009	8,604						14
15	Renov. - Fire Sprinkler System	2007	35,900						15
16	Renov. - Plumbing	2008	6,830						16
17	Renov. - Plumbing Specilities	2009	636						17
18	Renov. - HVAC	2008	8,969						18
19	Renov. - Basic Electrical	2009	23,190						19
20	Renov. - Fire Alarm System	2008	17,940						20
21	Renov. - Nurse Call System	2008	4,647						21
22									22
23	Elevator Door Restrictors	2008	8,100						23
24	Annunciator Panel for Generator	2008	2,969						24
25	Door & Ceiling in Vestibule	2009	11,286						25
26	Door Panic Hardware on service door	2009	2,401						26
27	Sprinkler Heads And Piping	2009	5,277						27
28	Eletrical Work - Explosion Proof	2009	4,338						28
29	Door in Vestibule	2009	5,000						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,158,203	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	34

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,158,203	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	1
2	Renov. - Carpentry-Subcontractor	2009	230,010						2
3	Renov. - Corner Guards	2009	793						3
4	Renov. - Basic Electrical	2009	12,590						4
5	Renov. - Arch & Engineer	2007	(547)						5
6	Metal Soffit on Front Porch	2009	22,019						6
7	Renov. Elevator Upgrade	2009	56,360						7
8	Renov. - Fire Spinklers	2009	21,042						8
9	Renov. - Basic Electrical	2009	5,486						9
10	Renov. Elevator Upgrade-Smoke Detectors	2009	3,187						10
11	Add Hand railings in 3 Stairwells	2010	11,330						11
12									12
13	Seal coat parking lot	2010	8,527						13
14	Sprinkler Heads (3 stair landings)	2010	3,297						14
15	Renov. - Ductwork & Fire Dampers	2010	240,695						15
16	Fire Dampers (2)	2010	15,295						16
17	HM Doors	2010	6,405						17
18	7.5 ton Rooftop compressor	2011	20,488						18
19	Renov. - Roof Replacement	2011	203,010						19
20	Painting & Wall Covering (1st FL PAT RMS)	2011	6,900						20
21									21
22	Carpet (main entrance, courtyard patio, and front office)	2011	10,206						22
23	Countertops & Overhead Cabinets (physian offices #1 & #2)	2011	15,395						23
24	Privacy Fencing, white PVC, 6 Ft (courtyard & generator areas)	2011	13,786						24
25	Repl 14 double hung windows & sills (6 offices & 6 resident rms.)	2011	19,555						25
26	A/C Compressor in 5 ton RTU (PT area)	2011	4,654						26
27	Wander System at Elevator	2011	8,966						27
28	Repl circulation pump on Lochnivar boiler	2011	3,672						28
29	Door HM (2nd Flr Linen Rm)	2011	4,078						29
30	Electrical for out door lights	2011	13,460						30
31	Concrete Pads (Front of Facility)	2012	7,929						31
32	Countertop Upgrade (1st Flr Nurse Station)	2012	2,115						32
33	Rooftop Unit, 7 1/2 ton	2012	21,125						33
34	TOTAL (lines 1 thru 33)		\$ 7,150,031	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	34

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,150,031	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	1
2	Stairwell Door	2012	4,230						2
3	Electrical Panel and Wiring consisting of:	2012	29,375						3
4	Replace 200 amp distribution panel with 400 amp panel								4
5	200 amp feed from new panel to 2nd floor Linen Closet								5
6	42 circuit panel board to replace existing 20 fuse panel								6
7	Wiring and conduit to Roof Top Unit #3 & #4 from 2nd floor Linen Closet								7
8	Wiring and conduit to Roof Top Unit #1 (PT) from main electric room								8
9	Asphalt Paving, Sealer, & Striping	2012	14,387						9
10	Electrical Panel, 30 circuits (in main electric room)	2012	1,364						10
11	Renovations to the PT & OT rooms, Training bathroom, and 1st floor offices (5) consisting of:								11
12	Carpentry, Millwork, Drywall, Handrails - Renov. 05-11C	2013	286,556						12
13	Wallcovering, Flooring, Carpet - Renov. 05-11C	2013	6,710						13
14	Engineering & Consulting on Renov. - Renov. 05-11C	2013	38,723						14
15	Light fixtures (58) - Renov. 05-11C	2013	8,835						15
16									16
17	Renovations to the PT & OT rooms, Training bathroom, and 1st floor offices (5) consisting of (additional costs) consisting of:								17
18	Engineering & Consulting on Renov. - Renov. 05-11C	2013	4,229						18
19	Carpentry, Millwork, Drywall, Handrails - Renov. 05-11C	2013	144,053						19
20	Wallcovering, Flooring, Carpet - Renov. 05-11C	2013	1,617						20
21	Light fixture upgrade to whole building	2013	9,989						21
22	Electrical upgrade to Med Rms, Kiosks, & Nurse Station	2014	4,580						22
23	Hot water line & circulating pump	2014	5,897						23
24	Wallcovering & Handrails in Café, PT corridor, lounge, & corrido	2014	9,683						24
25	Renovate front offices and 33 2nd floor resident rooms consisting of:								25
26	Carpentry, Millwork	2014	138,676						26
27	Fire Sprinkler System	2014	3,920						27
28	Plumbing	2014	1,949						28
29	Basic Electrical	2014	44,354						29
30	Resilient Flooring	2014	57,568						30
31	Carpeting	2014	4,583						31
32	Painting	2014	86,160						32
33	Wallcovering	2014	17,334						33
34	TOTAL (lines 1 thru 33)		\$ 8,074,803	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,074,803	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	1
2	EM Electrical Upgrades to Boiler, Sprinkler, Oxgen Rms.	2014	7,354						2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,082,157	\$ 254,328		\$ 254,328	\$	\$ 5,580,927	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	\$ 3,202,611	\$ 152,259	\$ 152,259	\$		\$ 2,732,022	71
72	Current Year Purchases	261,028						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			20,222	20,222			74
75	TOTALS	\$ 3,463,639	\$ 152,259	\$ 172,481	\$ 20,222		\$ 2,732,022	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	Residents	1996 Dodge Van	1996	\$ 36,664	\$	\$	\$		\$ 36,664	76
77										77
78										78
79										79
80	TOTALS			\$ 36,664	\$	\$	\$		\$ 36,664	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)	\$ 11,840,134	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 406,587	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 426,809	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,222	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,349,613	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.

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning: 06/01/13

Ending: 05/31/14

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 86,062 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		\$	\$ 303	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 303	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? <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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	10013	hrs	\$ 401,881	380	\$ 27,110	\$ 4,265	10,393	\$ 433,256	1	
2	Licensed Speech and Language Development Therapist	10a	5468	hrs	219,476			553	5,468	220,029	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10a	12771	hrs	512,545	111	7,915	19,578	12,882	540,038	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				694,192		694,192	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Other (specify): <u>IV Therapy</u>	43, 2						175,464		175,464	12	
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					217,243			217,243	13	
14	TOTAL				\$ 1,133,902	491	\$ 252,268	\$ 894,052	28,743	\$ 2,280,222	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 East

0049668

Report Period Beginning: 06/01/13

Ending:

05/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/14 (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	\$ 455	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>672,904</u>)	2,113,855		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,071		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,118,381	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	257,674		13
14	Buildings, at Historical Cost	8,082,157		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,500,303		16
17	Accumulated Depreciation (book methods)	(8,349,613)		17
18	Deferred Charges	13,499,579		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>OMIT</u>)			22
23	Other(specify): <u>CIP</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,990,100	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,108,481	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 190,257	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	493,776		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	391,284		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>	185,910		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,261,227	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	461,443		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)	\$ 461,443	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,722,670	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,385,811	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,108,481	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 17,019,620	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 17,019,620	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(783,033)	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)	\$ (783,033)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	1,149,224	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,149,224	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 17,385,811	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	\$ 15,901,195	1
2	Discounts and Allowances for all Levels	(9,602,016)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,299,179	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,844,999	6
7	Oxygen	32	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,845,031	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	1,897	12
13	Barber and Beauty Care	9,454	13
14	Non-Patient Meals	1,242	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,386,235	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	227,270	19
20	Radiology and X-Ray	160,256	20
21	Other Medical Services	111,988	21
22	Laundry	70	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,898,412	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	Activity Income & Misc.		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,042,622	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,353,669	31
32	Health Care	6,977,562	32
33	General Administration	3,983,582	33
B. Capital Expense			
34	Ownership	2,216,054	34
C. Ancillary Expense			
35	Special Cost Centers	1,095,134	35
36	Provider Participation Fee	199,654	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,825,655	40
41	Income before Income Taxes (line 30 minus line 40)**	(783,033)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (783,033)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,529,776	44
45	Private Pay - Net Inpatient Revenue	467,313	45
46	Medicare - Net Inpatient Revenue	3,399,532	46
47	Other-(specify) <u>Hospice</u>	109,569	47
48	Other-(specify) <u>Insurance</u>	792,989	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,299,179	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 East

0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14

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	818	\$ 44,599	\$ 50.51	1
2	Assistant Director of Nursing	4,164	180,488	40.14	2
3	Registered Nurses	49,320	1,686,304	31.66	3
4	Licensed Practical Nurses	23,123	637,071	25.52	4
5	CNAs & Orderlies	79,987	1,090,039	12.59	5
6	CNA Trainees				6
7	Licensed Therapist	33,382	1,446,935	40.13	7
8	Rehab/Therapy Aides	24,629	692,801	26.05	8
9	Activity Director	6,006	86,163	13.28	9
10	Activity Assistants				10
11	Social Service Workers	11,244	311,513	25.65	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	7,967	109,649	12.75	15
16	Dishwashers				16
17	Maintenance Workers	1,933	56,216	26.91	17
18	Housekeepers	15,849	185,257	10.82	18
19	Laundry	5,106	57,442	10.41	19
20	Administrator	2,080	100,760	48.44	20
21	Assistant Administrator	67	2,145	32.01	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	23,441	484,040	19.08	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	1,938	27,270	13.02	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	291,054	\$ 7,198,692 *	\$ 22.90	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 91,327	9, 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	220	9,137	10, 1
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)	220	\$ 100,464	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	489	\$ 34,241	10, 3
51	Licensed Practical Nurses			10, 3
52	Certified Nurse Assistants/Aides			10, 3
53	TOTAL (lines 50 - 52)	489	\$ 34,241	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	
Hilda (Marie) Derzsy	Administrator	0	\$ 100,760	Workers' Compensation Insurance	\$ 46,054	IDPH License Fee	\$ 1,990	
Justine Humber	Assist. Admin.	0	2,145	Unemployment Compensation Insurance	93,925	Advertising: Employee Recruitment	8,035	
				FICA Taxes	525,023	Health Care Worker Background Check	5,812	
				Employee Health Insurance	360,568	(Indicate # of checks performed <u>298</u>)		
				Employee Meals		Patient Background Checks	1283	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	12,830	
				Disability Payments		Association Dues	5,699	
				401K	21,794	Advertising	17,695	
				Appreciation, Other Benefits & Marketing Adjust	13,327	Other Licenses & Permits	10,654	
TOTAL (agree to Schedule V, line 17, col. 1)				Tuition Program		Less Non-allowable Association Dues	(1,728)	
(List each licensed administrator separately.)			\$ 102,905	SMSP Match & RSU	197	Less: Public Relations Expense (
B. Administrative - Other				Employee Uniforms	3,678	Non-allowable advertising	(17,695)	
Description			Amount	Home Office Allocation	60,085	Yellow page advertising (
Various home office services - See page 8 for breakdown			\$ 626,540	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,124,651		\$ 48,752		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 626,540	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services							G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount					Description	Amount
Advance Discovery	Legal Fees	\$ 9,335					Out-of-State Travel	\$
C2 legal of Illinois	Legal Fees	10,369						
Various, see support schedule	Legal Fees	11,419						
Michael T. Mahoney, LTD	Legal Fees	39,144					In-State Travel	17,266
Reed Smith LLP	Legal Fees	114,394					Includes travel expense to the Home Office in Toledo, OH for regional meetings	
SNF Global	Legal Fees	10,317					Seminar Expense	
(Above Legal Fees were all adjusted off via Page 5, Line 22, therefore no invoices are attached)								
Michael T. Mahoney, LTD	Collection Services	13,444					Entertainment Expense (
Transworld & United Collections	Collection Services	3,504					(agree to Sch. V, line 24, col. 8)	
(Above Collection Service fees were all adjusted off via Page 5A, Line 6)							TOTAL	\$ 17,266
Jay N. Brooker, reclass to line 10	Orthopedic Physician Consultan	16,500						
Lynx It Solutions, reclass to ln 10	Communication Consultants	6,201						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(For legal fee disclosure, see page 39 of instructions)			\$ 234,627					

* 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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Manorcare of Oak Lawn East# 0049668

Report Period Beginning:

06/01/13

Ending:

05/31/14**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. IHCA \$2,458 & AHCA \$1,274
- (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. \$ 73,971 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. \$ 199,654
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,242
- (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.