FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0049551

Facility Name: Manorcare of Oak Lawn West

Address: 6300 West 95th St (Number) Oak Lawn (City) 60453 (Zip Code)

County: Cook

Telephone Number: (708) 559-8800 **Fax #** (708) 559-8820

HFS ID Number:

Date of Initial License for Current Owners: 11/1/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary 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) Barry A. Lazarus
(Title) Vice President, Reimbursement

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

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

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	192	Skilled (SNF)	192	70,080	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	192	TOTALS	192	70,080	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,003	3,518	27,713	49,234	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,003	3,518	27,713	49,234	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.25%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/07/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 191 and days of care provided 19,829

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

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: 06/01/13 Ending: 05/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	139,633	34,776	336,809	511,218		511,218		511,218			1
2	Food Purchase		298,416		298,416		298,416	(1,613)	296,803			2
3	Housekeeping	201,216	28,953	578	230,747		230,747		230,747			3
4	Laundry	79,659	26,783	488	106,930		106,930		106,930			4
5	Heat and Other Utilities			247,604	247,604	3,360	250,964		250,964			5
6	Maintenance	55,155	19,510	176,869	251,534		251,534		251,534			6
7	Other (specify):* Med Waste			3,329	3,329		3,329		3,329			7
8	TOTAL General Services	475,663	408,438	765,677	1,649,778	3,360	1,653,138	(1,613)	1,651,525			8
	B. Health Care and Programs											
9	Medical Director			56,498	56,498		56,498		56,498			9
10	Nursing and Medical Records	4,809,962	497,230	190,617	5,497,809	14,647	5,512,456		5,512,456			10
10a	Therapy	2,094,130	13,939	57,909	2,165,978		2,165,978		2,165,978			10a
11	Activities	171,775	10,806	2,047	184,628		184,628		184,628			11
12	Social Services	267,159			267,159		267,159		267,159			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,343,026	521,975	307,071	8,172,072	14,647	8,186,719		8,186,719			16
	C. General Administration											
17	Administrative	152,774		906,060	1,058,834	(413,769)	645,065		645,065			17
18	Directors Fees											18
19	Professional Services			113,010	113,010	(16,004)	97,006	(97,006)				19
20	Dues, Fees, Subscriptions & Promotions			58,326	58,326		58,326	(15,791)	42,535			20
21	Clerical & General Office Expenses	507,432	84,782	477,436	1,069,650	16,004	1,085,654	(310,434)	775,220			21
22	Employee Benefits & Payroll Taxes			1,310,970	1,310,970	73,867	1,384,837		1,384,837			22
23	Inservice Training & Education			761	761		761		761			23
24	Travel and Seminar			1,830	1,830		1,830		1,830			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			412,560	412,560		412,560		412,560			26
27	Other (specify):*											27
28	TOTAL General Administration	660,206	84,782	3,280,953	4,025,941	(339,902)	3,686,039	(423,231)	3,262,808			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,478,895	1,015,195	4,353,701	13,847,791	(321,895)	13,525,896	(424,844)	13,101,052			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: 06/01/13 Ending: 05/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			497,175	497,175	24,861	522,036		522,036			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,108,123	3,108,123	297,034	3,405,157	(3,176,436)	228,721			32
33	Real Estate Taxes			717,364	717,364		717,364		717,364			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,486	33,486		33,486		33,486			35
36	Other (specify):*											36
37	**TOTAL Ownership**			4,356,148	4,356,148	321,895	4,678,043	(3,176,436)	1,501,607			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		804,841	2,735	807,576		807,576		807,576			39
40	Barber and Beauty Shops			8,650	8,650		8,650		8,650			40
41	Coffee and Gift Shops	23,469			23,469		23,469		23,469			41
42	Provider Participation Fee			283,359	283,359		283,359		283,359			42
43	Other (specify):* IV Ther/Xray/Lab		114,729	182,227	296,956		296,956		296,956			43
44	**TOTAL Special Cost Centers**	23,469	919,570	476,971	1,420,010		1,420,010		1,420,010			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,502,364	1,934,765	9,186,820	19,623,949		19,623,949	(3,601,280)	16,022,669			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 West # 0049551 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,613)	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	(106)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(555)	21		18
19	Entertainment				19
20	Contributions	(2,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(85,070)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(306,090)	21		24
25	Fund Raising, Advertising and Promotional	(15,791)	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	(3,189,555)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,601,280)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,601,280)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Manorcare of Oak Lawn West

ID# **0049551**

Report Period Beginning: **06/01/13**

Ending: **05/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	HCP Lease Interest	$ (3,176,436)	32	1
2	Vending Income	(1,183)	21	2
3	Accounting / Collection Fees	(11,936)	19	3
4				4
5				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
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**	(3,189,555)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 **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 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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,613)	0	0	0	0	0	0	0	0	0	0	(1,613)	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**	(1,613)	0	0	0	0	0	0	0	0	0	0	(1,613)	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	(97,006)	0	0	0	0	0	0	0	0	0	0	(97,006)	19
20	Fees, Subscriptions & Promotions	(15,791)	0	0	0	0	0	0	0	0	0	0	(15,791)	20
21	Clerical & General Office Expenses	(310,434)	0	0	0	0	0	0	0	0	0	0	(310,434)	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**	(423,231)	0	0	0	0	0	0	0	0	0	0	(423,231)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(424,844)	0	0	0	0	0	0	0	0	0	0	(424,844)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(3,176,436)	0	0	0	0	0	0	0	0	0	0	(3,176,436)	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	(3,176,436)	0	0	0	0	0	0	0	0	0	0	(3,176,436)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,601,280)	0	0	0	0	0	0	0	0	0	0	(3,601,280)	45

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

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
		See Pg 6 Supp for list of related nursing homes in Illinois				

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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 906,060	HCR Manor Care Services, LLC	100.00%	$ 906,060	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	8,502,364	Heartland Employment Services, LLC	100.00%	8,502,364		4
5	V	10a	Therapy Management	20,522	Heartland Rehabilitation Services, LLC	100.00%	20,522		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			$ 9,428,946			$ 9,428,946	$ *	14

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

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 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, LLC	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights West IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights 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: 06/01/13 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 West # 0049551 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, &	$ 702,082	$	18,760,379	$ 3,360	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs			18,760,379	0	2
3	5	Utilities - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			18,760,379	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & Re	421,070	303,971	18,760,379	2,015	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	2,331,970	10,787,378	18,760,379	12,632	5
6	10	Nursing - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			18,760,379	0	6
7	17	Gen / Admin - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & Re	66,712,258	34,047,414	18,760,379	319,279	7
8	17	Gen / Admin - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	18,712,683	6,531,152	18,760,379	101,365	8
9	17	Gen/Admin-Direct to MW Div SN	Accumulated Cost	494,203,074	48 NFs	1,887,403	1,136,236	18,760,379	71,647	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & Re	7,831,139		18,760,379	37,479	10
11	22	Empl Benefits - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	6,717,577		18,760,379	36,388	11
12	22	Empl Benefits-Dir to MW Div SN	Accumulated Cost	494,203,074	48 NFs			18,760,379	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,919,925,578	702 NFs, HHs, & Re	4,454,722		18,760,379	21,320	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,463,307,562	357 NFs	653,747		18,760,379	3,541	14
15	30	Depr - Direct to MW Div SNFs	Accumulated Cost	494,203,074	48 NFs			18,760,379	0	15
16										16
17	32	Pooled Interest	Accumulated Cost	3,919,925,578		25,923,280		18,760,379	124,066	17
18	32	Directly Assigned Interest	Not Allocated			18,563,246			172,968	18
19										19
20		H/O Costs Allocated to Non-SNFs & Oth Div				30,324,259				20
21										21
22										22
23										23
24										24
25	TOTALS					$ 185,235,436	$ 52,806,151		$ 906,060	25

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Conv Sub Debentures		X	Various			$ 2,639,793	$ 2,639,793		0.0655	$ 172,968	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Pooled Interest										124,066	7
8	Interest Expense / Interest Income										(68,313)	8
9	TOTAL Facility Related						$ 2,639,793	$ 2,639,793			$ 228,721	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,639,793	$ 2,639,793			$ 228,721	15

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

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

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

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 615,714	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.)		$ 707,236	2
3. Under or (over) accrual (line 2 minus line 1).		$ 91,522	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 617,083	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 9,723	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 $ 964 For 2003 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (964)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 717,364	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	587,433	8
	2010	586,009	9
	2011	648,568	10
	2012	686,419	11
	2013	702,080	12

Line 2: $707,236.31 = $326,706.07 for 2nd half 2012 + $377,530.24 for 1st half of 2013
Line 4: $617,082.95 = $324,549.62 for 2nd half 2012 + $292,533.33 for Jan-May 2014
Line 5: $9,722.64=Worsek & Vihon-2012 Appeal-$167, Urban RE Search-2014 Appraisal-$4,000, & Rock Fusco-2008 Appeal-$5,555.64
Line 6: Worsek & Vihon 2003 Rate Refund of $964

	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

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 West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049551

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5494

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-05-302-005-0000	See Attached	$ 702,079.86	$ 702,079.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 702,079.86	$ 702,079.86

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 West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

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. [X] (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. [X] (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 [X] 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			1981	$ 820,000	1
2					2
3	TOTALS			$ 820,000	3

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1981	1962	$ 313,600	$ 29,964		$ 29,964	$	$ 1,924,811	4
5	75		1981	1969	658,575						5
6	9			1987	448,818						6
7	10			1999	1,235,114						7
8											8
	Improvement Type**										
9	Current Year Depreciation					262,852		262,852		4,925,186	9
10				1985	2,374						10
11				1986	5,308						11
12				1987	5,756						12
13				1988	251,787						13
14				1989	94,354						14
15				1990	20,764						15
16				1991	63,572						16
17				1992	143,258						17
18				1993	317,964						18
19				1994	192,466						19
20				1995	469,304						20
21				1996	340,114						21
22				1997	203,364						22
23				1998	544,751						23
24				1999	207,547						24
25				2000	106,678						25
26				2001	44,153						26
27	HVAC & ELECTRIC			2002	37,140						27
28	WALLCOVERING, PAINT, & FLOORING			2002	60,964						28
29	WALL REPLACEMENT			2002	5,327						29
30	CARPENTRY & MILLWORK			2002	59,438						30
31	CARPET & WALLCOVERING			2002	13,156						31
32	HVAC & ELECTRICAL			2002	18,957						32
33	ELECTRICAL WORK			2002	2,768						33
34	EMERGENCY POWER UPGRADE CIRCUIT			2002	215,884						34
35	DRAINAGE WORK			2002	23,290						35
36	CARPET			2003	2,365						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	PARKLING 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	$ 292,816		$ 292,816	$	$ 6,849,997	70

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

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 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	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 12A, Carried Forward		$ 6,594,254	$ 292,816		$ 292,816	$	$ 6,849,997	1
2	Renov. - General Overhead	2005	5,242						2
3	Renov. - Interest on Construction Imp	2005	320						3
4	Renov. - Freight Costs	2005	476						4
5	Renov. - Resilient Flooring	2005	9,106						5
6	Renov. - Carpeting, Pads & installation	2005	10,655						6
7	Renov. - Wallcovering and corner guards	2005	6,655						7
8	Renov. - Carpentry SubContracting	2005	24,882						8
9	Renov. - HM Doors & Frames	2005	4,310						9
10	30 AMP, 208V circuit	2005	2,399						10
11	Resident Room Doors	2005	31,770						11
12	Doors	2005	1,600						12
13	Sealing coat	2005	2,240						13
14	Renov - General Overhead	2006	2,695						14
15	Renov - Interest on Const - Impr	2006	243						15
16	Renov - Ceramic Tile	2006	6,000						16
17	Renov - Resilient Flooring	2006	29,972						17
18	Renov - Wallcovering	2006	2,840						18
19	Renov - Plumbing	2006	8,655						19
20	lochinvar heater	2006	23,225						20
21	conduit / wiring	2006	2,054						21
22	waterproofing	2006	2,888						22
23	vct	2006	1,672						23
24	windows	2006	6,878						24
25	VWC	2006	11,546						25
26	kitchen wall	2006	7,470						26
27	flooring / painting	2006	40,883						27
28	Conference room paint	2006	2,583						28
29	sidewalk	2006	1,362						29
30	plumbing, electrical, cabinetry for breakroom	2007	6,440						30
31	drains & downspouts	2007	20,196						31
32	Renov - General Overhead	2007	19,230						32
33	Renov - Interest on Const - Impr	2007	1,312						33
34	TOTAL (lines 1 thru 33)		$ 6,892,053	$ 292,816		$ 292,816	$	$ 6,849,997	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: 06/01/13 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 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 12B, Carried Forward		$ 6,892,053	$ 292,816		$ 292,816	$	$ 6,849,997	1
2	Renov - Phone System Upgrade	2007	81,244						2
3	electrical for pill Dispenser	2007	1,715						3
4	Renov - General Overhead	2007	1,071						4
5	Renov - Interest on constr -imp	2007	87						5
6	renov -carpentry-subcontr Dumb Waiter	2007	19,302						6
7	Renov- New DumbWaiter	2007	21,450						7
8	carpet for nurse station	2007	2,408						8
9	electrical work for lobby	2007	1,773						9
10	west corridor wall covering	2007	5,611						10
11	metal doors	2008	5,880						11
12	paving	2007	12,092						12
13	JANITOR CLOSET	2008	8,883						13
14	SEWER PIPE	2008	6,480						14
15	paint ext window trim	2008	6,736						15
16	KITCHEN DOOR	2008	3,430						16
17	140ft drainage pipes	2008	19,602						17
18	ASPHALT	2008	9,860						18
19	ASPHALT	2008	4,062						19
20	metal /glass front door	2009	2,572						20
21	fire access panels for 35 rooms	2010	8,550						21
22	additional for fire access panels	2010	8,539						22
23	conduit on roof	2010	36,482						23
24	roof replacement	2010	657,742						24
25	smoke door wall magnets	2010	3,975						25
26	vinyl flooring & base	2010	4,095						26
27	HM door and alarm	2010	5,124						27
28	Additional for roof replacement	2011	24,095						28
29	Additional for roof replacement	2011	23,456						29
30	Additional for roof replacement	2011	411						30
31	Renov - Millwork	2011	39,870						31
32	vinyl base(corridor & Pat Rm)	2011	19,739						32
33	8" backflow in drainline	2011	7,485						33
34	TOTAL (lines 1 thru 33)		$ 7,945,872	$ 292,816		$ 292,816	$	$ 6,849,997	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: 06/01/13 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 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 12C, Carried Forward		$ 7,945,872	$ 292,816		$ 292,816	$	$ 6,849,997	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 - WALLCOV ERING & 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	conrete patio off main lobby	2012	13,457						18
19	masonary 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									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,669,551	$ 292,816		$ 292,816	$	$ 6,849,997	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: 06/01/13 Ending: 05/31/14

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	$ 3,802,975	$ 204,359	$ 204,359	$		$ 3,433,214	71
72	Current Year Purchases	106,780						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			24,861	24,861			74
75	TOTALS	$ 3,909,755	$ 204,359	$ 229,220	$ 24,861		$ 3,433,214	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 GCH	1995	$ 12,107	$	$	$		$ 12,107	76
77		Paratransit								77
78										78
79										79
80	TOTALS			$ 12,107	$	$	$		$ 12,107	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,411,413	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 497,175	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 522,036	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 24,861	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,295,318	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 674,889	92
93			93
94			94
95		$ 674,889	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 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

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: *

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	$

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: $ 33,486 Description: O2 Concentrators, Wheelchairs, Geri Chairs, Elec Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	8122 hrs	$ 311,390		$	$ 950	8,122	$ 312,340	1
2	Licensed Speech and Language Development Therapist	10a	7650 hrs	293,300			320	7,650	293,620	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	13740 hrs	526,769			12,669	13,740	539,438	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				804,841		804,841	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhalation Therapist	10a	2479	95,036	449	24,270		2,928	119,306	12
13	Other (specify): IV Ther.Xray/Lab	43, 2 & 3				182,227	114,729		296,956	13
14	TOTAL			$ 1,226,495	449	$ 206,497	$ 933,509	32,440	$ 2,366,501	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.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 650	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (439,996))	2,528,203		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,407		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,535,260	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	820,000		13
14	Buildings, at Historical Cost	8,669,552		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,921,861		16
17	Accumulated Depreciation (book methods)	(10,295,318)		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	90,610		22
23	Other(specify): CIP	674,889		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,967,889	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,503,149	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 241,037	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	582,758		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	617,083		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	233,202		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,674,080	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,639,793		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,639,793	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,313,873	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,189,276	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,503,149	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,773,643	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,773,643	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,063,517)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,063,517)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	2,479,150	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,479,150	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 13,189,276	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,658,276	1
2	Discounts and Allowances for all Levels	(9,862,800)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,795,476	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,729,904	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,729,904	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	1,183	12
13	Barber and Beauty Care	9,756	13
14	Non-Patient Meals	1,613	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,611,075	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	175,994	19
20	Radiology and X-Ray	114,156	20
21	Other Medical Services	121,275	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,035,052	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			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)**	$ 17,560,432	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,649,778	31
32	Health Care	8,172,072	32
33	General Administration	4,025,941	33
	B. Capital Expense		
34	Ownership	4,356,148	34
	C. Ancillary Expense		
35	Special Cost Centers	1,136,651	35
36	Provider Participation Fee	283,359	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 19,623,949	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,063,517)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,063,517)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,773,268	44
45	Private Pay - Net Inpatient Revenue	940,968	45
46	Medicare - Net Inpatient Revenue	4,248,370	46
47	Other-(specify)	248,907	47
48	Other-(specify)	583,963	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,795,476	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: 06/01/13 Ending: 05/31/14

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,657	1,772	$ 78,593	$ 44.35	1
2	Assistant Director of Nursing	4,746	5,076	186,506	36.74	2
3	Registered Nurses	59,540	63,679	2,132,882	33.49	3
4	Licensed Practical Nurses	32,666	34,937	855,208	24.48	4
5	CNAs & Orderlies	115,965	124,185	1,522,425	12.26	5
6	CNA Trainees	456	488	5,857	12.00	6
7	Licensed Therapist	35,224	37,665	1,444,044	38.34	7
8	Rehab/Therapy Aides	22,651	24,221	650,086	26.84	8
9	Activity Director	10,338	11,065	171,775	15.52	9
10	Activity Assistants					10
11	Social Service Workers	8,282	8,861	267,159	30.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,018	10,696	139,633	13.05	15
16	Dishwashers					16
17	Maintenance Workers	2,524	2,699	55,155	20.44	17
18	Housekeepers	18,222	19,505	201,216	10.32	18
19	Laundry	7,364	7,876	79,659	10.11	19
20	Administrator	2,080	2,080	107,104	51.49	20
21	Assistant Administrator	1,461	1,461	45,670	31.26	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,714	25,406	507,432	19.97	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	1,673	1,790	28,491	15.92	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	1,858	1,988	23,469	11.81	33
34	TOTAL (lines 1 - 33)	360,439	385,450	$ 8,502,364 *	$ 22.06	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	56,498	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)		$ 56,498		49

C. CONTRACT NURSES

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

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Petyko	Administrator	0	$ 92,738
Justine Humber	Asst Admin	0	46,386
Justine Humber	Administrator	0	13,650
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 152,774

B. Administrative - Other

Description	Amount
Various Home Office Services	$ 906,060
TOTAL (agree to Schedule V, line 17, col. 3)	$ 906,060
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Constangy Brooks & Smith LLC	Legal Fees	$ 9,734
Elvidge Kelly/Greenburg Traurig	Legal Fees	2,720
Meyers & Flowers LLC/SNF Global	Legal Fees	74,936
United Collection Bureau Inc	Fees for Collections	354
Transworld Systems Inc	Fees for Collections	9,261
Legal & collection fees were adjusted off on Schedule VI, Page 5, Line 22. Therefore, no Invoices are attached.		
Dr. Soterios Polychronopoulos	Clinical Consulting	6,250
Lynx IT solutions	IT Consulting	5,915
MPRO	H/R Consulting	2,475
Southwest Nephrology Assc	Clinical Consulting	1,200
The Safe Dining Assn	Food Safety Consulting	164
Consulting Fees reclassed to Line 21		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 113,010

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,154
Unemployment Compensation Insurance	113,471
FICA Taxes	622,794
Employee Health Insurance	445,365
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	
401K	28,068
Oth Empl Benefits & Mktg Adj	(19,471)
Tuition Program	6,246
SMSP Match	1,182
Employee Uniforms	6,161
Home Office Allocation	73,867
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,384,837

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 7,736
Advertising: Employee Recruitment	6,611
Health Care Worker Background Check	
(Indicate # of checks performed 630)	11,933
Patient Background Checks 531	5,310
Dues & Subcriptions	5,073
Association Dues	8,595
Advertising	12,768
Public Relations	
Less: Non-Allowable Association Dues	(2,723)
Less: Public Relations Expense	(0)
Non-allowable advertising	(12,768)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,535

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,830
Includes travel expens to the Home	
Office in Toledo, OH for regional meetings.	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,830

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/13 Ending: 05/31/14

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	Amount of Expense Amortized Per Year								
					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 West # 0049551 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. ICHA $5,872

(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_$2723

(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. $ 89,589 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. $ 283,359
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. $ 1,613

(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.