FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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 South Kostner Avenue (Number) Oak Lawn (City) 60453 (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:

	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 06/01/09 to 05/31/10 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 East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	144	Skilled (SNF)	122	48,556	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	144	TOTALS	122	48,556	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	8,685	4,695	27,783	41,163	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,685	4,695	27,783	41,163	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.77%

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 1997

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 133 and days of care provided 22,610

Medicare Intermediary Highmark Medicare Services

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: 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: 06/01/09 Ending: 05/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	345,250	23,803	1,309	370,362	12,218	382,580		382,580			1
2	Food Purchase		259,358		259,358		259,358	(18)	259,340			2
3	Housekeeping	185,075	28,412	104	213,591		213,591		213,591			3
4	Laundry	58,300	18,359	797	77,456		77,456	(1,792)	75,664			4
5	Heat and Other Utilities			167,814	167,814	3,400	171,214		171,214			5
6	Maintenance	60,024	22,710	78,733	161,467		161,467		161,467			6
7	Other (specify):* Medical Waste			1,486	1,486		1,486		1,486			7
8	TOTAL General Services	648,649	352,642	250,243	1,251,534	15,618	1,267,152	(1,810)	1,265,342			8
	B. Health Care and Programs											
9	Medical Director			45,058	45,058		45,058		45,058			9
10	Nursing and Medical Records	4,077,706	422,516	69,751	4,569,973	4,488	4,574,461	(37)	4,574,424			10
10a	Therapy	1,259,358	18,035	219,358	1,496,751		1,496,751		1,496,751			10a
11	Activities	81,566	6,119	1,836	89,521		89,521		89,521			11
12	Social Services	148,709			148,709		148,709		148,709			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,567,339	446,670	336,003	6,350,012	4,488	6,354,500	(37)	6,354,463			16
	C. General Administration											
17	Administrative	84,612		592,103	676,715	(160,410)	516,305		516,305			17
18	Directors Fees											18
19	Professional Services			23,683	23,683		23,683	(23,683)				19
20	Dues, Fees, Subscriptions & Promotions			75,700	75,700		75,700	(36,998)	38,702			20
21	Clerical & General Office Expenses	452,246	56,953	499,363	1,008,562		1,008,562	(391,186)	617,376			21
22	Employee Benefits & Payroll Taxes			1,234,627	1,234,627	101,433	1,336,060		1,336,060			22
23	Inservice Training & Education			3,518	3,518		3,518		3,518			23
24	Travel and Seminar			3,590	3,590		3,590		3,590			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			338,235	338,235		338,235		338,235			26
27	Other (specify):*											27
28	TOTAL General Administration	536,858	56,953	2,770,819	3,364,630	(58,977)	3,305,653	(451,867)	2,853,786			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,752,846	856,265	3,357,065	10,966,176	(38,871)	10,927,305	(453,714)	10,473,591			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 East #0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

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			392,518	392,518	27,121	419,639		419,639			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(11,570)	(11,570)	11,750	180		180			32
33	Real Estate Taxes			588,607	588,607		588,607		588,607			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			163,461	163,461		163,461		163,461			35
36	Other (specify):*											36
37	TOTAL Ownership			1,133,016	1,133,016	38,871	1,171,887		1,171,887			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			90	90		90		90			38
39	Ancillary Service Centers		863,288		863,288		863,288		863,288			39
40	Barber and Beauty Shops			11,925	11,925		11,925		11,925			40
41	Coffee and Gift Shops	3,306			3,306		3,306		3,306			41
42	Provider Participation Fee			78,840	78,840		78,840		78,840			42
43	Other (specify):* IV | X-Ray & Lab		131,913	144,894	276,807		276,807		276,807			43
44	TOTAL Special Cost Centers	3,306	995,201	235,749	1,234,256		1,234,256		1,234,256			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,756,152	1,851,466	4,725,830	13,333,448		13,333,448	(453,714)	12,879,734			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: 06/01/09 Ending: 05/31/10

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18)	2		4
5	Telephone, TV & Radio in Resident Rooms	(385)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,792)	4		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	(146)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(37)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(656)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,683)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(388,372)	21		24
25	Fund Raising, Advertising and Promotional	(36,998)	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	(1,627)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (453,714)		$	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))**	$ (453,714)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manorcare of Oak Lawn East

ID# 0049668

Report Period Beginning: 06/01/09

Ending: 05/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,426)	21	1
2	Misc. Income	(201)	21	2
3	Activity Income	0	11	3
4	Loss on Disposal of Fixed Assets	0	36	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**	(1,627)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

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	(18)	0	0	0	0	0	0	0	0	0	0	(18)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,792)	0	0	0	0	0	0	0	0	0	0	(1,792)	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**	(1,810)	0	0	0	0	0	0	0	0	0	0	(1,810)	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	(37)	0	0	0	0	0	0	0	0	0	0	(37)	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**	(37)	0	0	0	0	0	0	0	0	0	0	(37)	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	(23,683)	0	0	0	0	0	0	0	0	0	0	(23,683)	19
20	Fees, Subscriptions & Promotions	(36,998)	0	0	0	0	0	0	0	0	0	0	(36,998)	20
21	Clerical & General Office Expenses	(391,186)	0	0	0	0	0	0	0	0	0	0	(391,186)	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**	(451,867)	0	0	0	0	0	0	0	0	0	0	(451,867)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(453,714)	0	0	0	0	0	0	0	0	0	0	(453,714)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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)**	(453,714)	0	0	0	0	0	0	0	0	0	0	(453,714)	45

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, Inc.	100	Health Care & Retirement Corporation of America (see H.O. Cost Report)				

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	$ 592,103	HCR Manor Care, Inc.	100.00%	$ 592,103	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	41,353	Heartland Rehab Services, LLC	100.00%	41,353		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 633,456			$ 633,456	$ *	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: 06/01/09 Ending: 05/31/10

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 East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

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, Inc.
Street Address: 333 North Summit St.
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	1	Dietary - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	$ 2,826,629	$ 1,585,087	12,352,173	$ 12,218	1
2	1	Dietary - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	12,352,173	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	0	0	12,352,173	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	0	0	12,352,173	0	4
5	5	Utilities - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	12,352,173	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	911,333	0	12,352,173	3,400	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	12,352,173	2,735	7
8	10	Nursing - Direct to Central Divisio	Accumulated Cost	691,284,298	95NFs	0	0	12,352,173	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	469,810	0	12,352,173	1,753	9
10	17	General & Admin - Direct to All S	Accumulated Cost	2,857,768,524	359 NFs	35,518,981	0	12,352,173	153,524	10
11	17	General & Admin - Direct to Cent	Accumulated Cost	691,284,298	95NFs	1,045,204	0	12,352,173	18,676	11
12	17	General & Admin - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	69,554,530	79,745,671	12,352,173	259,493	12
13	22	Employee Benefits - Direct to All S	Accumulated Cost	2,857,768,524	359 NFs	6,239,311	0	12,352,173	26,968	13
14	22	Employee Benefits - Direct to Cent	Accumulated Cost	691,284,298	95NFs	2,434,366	0	12,352,173	43,498	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	8,300,418	0	12,352,173	30,967	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714	0	12,352,173	444	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	691,284,298	95NFs	43,612	0	12,352,173	779	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs, & Re	6,941,685	0	12,352,173	25,898	18
19										19
20	32	Directly Assigned Interest				21,122,019			11,750	20
21		Non Central Division Nursing Home Allocation				25,797,439				21
22										22
23										23
24										24
25	TOTALS					$ 181,940,740	$ 82,045,910		$ 592,103	25

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Conv. Sub Debentures		X	Various			$ 461,443	$ 461,443		2.5464	$ 11,750	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income Other										(11,570)	8
9	TOTAL Facility Related						$ 461,443	$ 461,443			$ 180	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			$ 180	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 East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 504,913	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.)		$ 565,341	2
3. Under or (over) accrual (line 2 minus line 1).		$ 60,428	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 555,294	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.		$ 13,809	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** $ 40,924 **For** 2006 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ (40,924)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 588,607	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	504,076	8
	2006	520,237	9
	2007	534,299	10
	2008	537,091	11
	2009	600,486	12

Line 2: $565,341 = $269,941 for 2nd half of 2008 paid in Nov. '09 + $295,400 for 1st half of 2009 paid in Feb. 2010.

Line 4: $555,294 = $305,089 for 2nd half 2009 + $250,205 for Jan-May 2010.

Line 5: $13,809 = $13,650 Worsek & Vihon LLP (1/3 of the $40,924 refund) + $159.00 Worsek & Vihon LLP Filing Fees

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-03-400-032-0000		$ 600,486.37	$ 600,486.37
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 600,486.37	$ 600,486.37

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 06/01/09 Ending: 05/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,678 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (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).

None

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	Facility		1977	$ 257,674	1
2					2
3	TOTALS			$ 257,674	3

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	122		1977	1977	$ 2,247,698	$ 62,436		$ 62,436	$	$ 2,029,043	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					175,662		175,662		2,511,133	9
10				1981	18,089						10
11				1986	2,797						11
12				1988	19,012						12
13				1989	14,714						13
14				1990	202,653						14
15				1991	69,401						15
16				1992	114,373						16
17				1993	63,254						17
18				1994	648,943						18
19				1995	220,796						19
20				1996	238,261						20
21				1997	230,127						21
22				1998	319,666						22
23				1999	57,192						23
24				2000	71,071						24
25	Reclass $2,957 artwork to Equip. Disallow $17,709			2001	106,534						25
26	STEEL GATES FOR DUMSTERS			2002	6,355						26
27	WINDOW TREATMENTS			2002	4,782						27
28	Renovation - General Construction per audit $4,171 disallowed			2002	24,092						28
29	Renovation - Wallcovering per audit $10,669 disallowed			2002	61,624						29
30	Renovation - HVAC & Electrical per audit $589 disallowed			2002	3,401						30
31	ROOFING ON WEST SECTION			2003	19,000						31
32	Sink, Tile, Wallcovering & Paint			2003	20,585						32
33	Light Fixtures per audit change year from 2003 to 2002			2003	2,572						33
34	Construction Department Cost & Interest Disallowed per audit			2003							34
35	Ceramic Floor Tile & Related Concrete Work			2003	19,427						35
36											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: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Carpeting & Wallcovering per audit $4,001 disallowed	2003	$ 5,263	$		$	$	$	37
38	Sheet Vinyl Flooring	2003	1,295						38
39	Carpeting	2003	738						39
40	Metal Doors	2003	5,739						40
41	Kitchen Renov - Stain Steel Wall Plating & Sinks	2004	5,086						41
42	Doors (4) Fire rated	2004	6,608						42
43	Exhauster, Duct Work, & Fire Damper	2004	5,810						43
44	Renov - General Construct. O/H & Int. disallowed per audit	2004							44
45	Renov - Painting	2004	10,565						45
46	Renov - Wall Covering	2004	23,222						46
47	Renov. - Doors & Frames	2004	11,010						47
48	Renov - Drywall & Studs	2004	2,405						48
49	Flooring	2004	30,990						49
50	Ceiling Tile	2004	585						50
51	Awing	2004	2,320						51
52	Flooring	2005	885						52
53	Fire Shutter Door	2005	2,170						53
54	Roofing	2005	17,500						54
55	2005 per audit - Doors for front enterance	2005	8,732						55
56	2005 per audit - Metal Access Doors	2005	3,183						56
57	2005 per audit - Asphalt Driveway, Seal Coat, & Stripe	2005	11,979						57
58	2006 per audit - Electric work for emergency light & feed	2006	894						58
59	2006 per audit - Doors & closers	2006	2,834						59
60									60
61	A/C for Elevator Room	2006	5,960						61
62	Electrical circuits for emergency generator system	2006	8,530						62
63	Electrical circuits - Kitchen & 2nd floor Nurse Station	2006	3,599						63
64									64
65	Renov - Flooring	2007	20,080						65
66	Renov - Wallcovering	2007	1,786						66
67	Renov - Carpentary	2007	2,826						67
68	Renov - Electrical	2007	15,000						68
69	Windows in lounge	2007	3,310						69
70	TOTAL (lines 4 thru 69)		$ 5,027,323	$ 238,098		$ 238,098	$	$ 4,540,176	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: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 5,027,323	$ 238,098		$ 238,098	$	$ 4,540,176	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	$ 238,098		$ 238,098	$	$ 4,540,176	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: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 6,158,203	$ 238,098		$ 238,098	$	$ 4,540,176	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. Elvator Upgrade	2009	56,360						7
8	Renov. - Fire Spinklers	2009	21,042						8
9	Renov. - Basic Electrical	2009	5,486						9
10	Renov. Elvator Upgrade-Smoke Detectors	2009	3,187						10
11	Add Hand railings in 3 Stairwells	2010	11,330						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	TOTAL (lines 1 thru 33)		$ 6,520,473	$ 238,098		$ 238,098	$	$ 4,540,176	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: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 2,657,612	$ 154,420	$ 154,420	$		$ 2,096,406	71
72	Current Year Purchases	109,758						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			27,121	27,121			74
75	TOTALS	$ 2,767,370	$ 154,420	$ 181,541	$ 27,121		$ 2,096,406	75

D. Vehicle Depreciation (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)	$ 9,582,181	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 392,518	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 419,639	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 27,121	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,673,246	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	Various	$ 188,915	92
93			93
94			94
95		$ 188,915	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: 06/01/09 Ending: 05/31/10

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 [X] 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.		$
13.		$
14.		$

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: $ 163,461 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. 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	N/A		$	$	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 East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 East | STATE OF ILLINOIS # 0049668 | Report Period Beginning: 06/01/09 Ending: 05/31/10

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, 1	7347 hrs	$ 282,623	5	$ 200	$ 3,103	7,352	$ 285,926	1
2	Licensed Speech and Language Development Therapist	10a, 1	3970 hrs	152,734	160	6,702	759	4,130	160,195	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	5637 hrs	216,848	2,150	90,297	14,173	7,787	321,318	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				863,288		863,288	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): IV Theray	43, 2					131,913		131,913	12
13	Other (specify): X-Ray & Lab	43, 3				144,894			144,894	13
14	TOTAL			$ 652,205	2,315	$ 242,093	$ 1,013,236	19,269	$ 1,907,534	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 East # 0049668 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/10 (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	$ 9,145	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 741,413)	1,908,767		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,405		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,922,317	$	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	6,520,473		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,804,034		16
17	Accumulated Depreciation (book methods)	(6,673,246)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	188,915		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,097,850	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,020,167	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 303,459	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	707,449		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	555,294		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	57,908		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,624,110	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	461,443		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	58,751		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 520,194	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,144,304	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,875,863	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,020,167	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,408,740	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,408,740	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,850,244	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)**	$ 2,850,244	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(3,383,121)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3,383,121)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,875,863	24 *

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

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,063,604	1
2	Discounts and Allowances for all Levels	(5,643,690)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,419,914	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,630,486	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,630,486	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	1,463	12
13	Barber and Beauty Care	13,137	13
14	Non-Patient Meals	18	14
15	Telephone, Television and Radio	385	15
16	Rental of Facility Space		16
17	Sale of Drugs	929,898	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	76,247	19
20	Radiology and X-Ray	45,664	20
21	Other Medical Services	64,487	21
22	Laundry	1,792	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,133,091	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	Misc. Income & Purchase Discounts	201	28
28a	Late Charges		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 201	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,183,692	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,251,534	31
32	Health Care	6,350,012	32
33	General Administration	3,364,630	33
	B. Capital Expense		
34	Ownership	1,133,016	34
	C. Ancillary Expense		
35	Special Cost Centers	1,155,416	35
36	Provider Participation Fee	78,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,333,448	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,850,244	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,850,244	43

*** 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.**

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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
2	Assistant Director of Nursing	6,170	6,711	257,073	38.31	2
3	Registered Nurses	45,616	49,617	1,613,784	32.52	3
4	Licensed Practical Nurses	31,571	34,339	940,614	27.39	4
5	CNAs & Orderlies	94,454	102,954	1,243,092	12.07	5
6	CNA Trainees					6
7	Licensed Therapist	16,955	18,520	712,429	38.47	7
8	Rehab/Therapy Aides	23,557	25,733	546,929	21.25	8
9	Activity Director	6,011	6,594	81,566	12.37	9
10	Activity Assistants					10
11	Social Service Workers	6,182	6,739	148,709	22.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,187	24,544	345,250	14.07	15
16	Dishwashers					16
17	Maintenance Workers	2,466	2,694	60,024	22.28	17
18	Housekeepers	15,331	16,751	185,075	11.05	18
19	Laundry	5,327	5,819	58,300	10.02	19
20	Administrator	2,080	2,080	84,612	40.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,913	25,974	452,246	17.41	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	1,729	1,889	23,143	12.25	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	273	296	3,306	11.17	33
34	TOTAL (lines 1 - 33)	303,822	331,254	$ 6,756,152 *	$ 20.40	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	45,058	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,756	10, 3	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)		$ 47,814		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Petyko (June - Dec.)	Administrator	0	$ 55,377
Neal Glein (Jan. - May)	Administrator	0	29,235
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,612

B. Administrative - Other

Description	Amount
Management Fees	$ 592,103
TOTAL (agree to Schedule V, line 17, col. 3)	$ 592,103
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, & Flowers, LLC	Legal Fees	$ 19,442
Elvidge Kelley Attorney At Law	Legal Fees	4,123
Basware Legal	Legal Fees	125
United Collection & Trans World	Collection Services	(7)
(All the above were adjusted off via Page 5 Line 22, therefore no invoices are attached)		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 23,683

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 126,266
Unemployment Compensation Insurance	59,477
FICA Taxes	479,023
Employee Health Insurance	489,616
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	52,638
Appreiation & Other Employee Benefits	8,587
Tuition Program	13,443
SMSP Match & RSU	
Employee Uniforms	5,577
Home Office Allocation	101,433
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,336,060

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	$ 6,460
Advertising: Employee Recruitment	21,800
Health Care Worker Background Check	2,231
(Indicate # of checks performed 180)	
Patient Background Checks 588	
Dues & Subscriptions	2,950
Association Dues	11,215
Advertising	31,044
Relocation	
Less Non-allowable Association Dues	(5,954)
Less: Public Relations Expense	( )
Non-allowable advertising	(31,044)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,702

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,590
Includes travel expense to the Home	
Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,590

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

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													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 $5261**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **75,867** 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? **No**
If YES, give effective date of lease.

(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. $ **78,840**
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. $ **18**

(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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.