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.

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

I. IDPH License ID Number: 0049551

Facility Name: Manorcare of Oak Lawn West

Address: 6300 West 95th Street (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: 11/01/81

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 06/01/09 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 West # 0049551 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	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	20,887	8,719	29,567	59,173	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,887	8,719	29,567	59,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.44%

D. How many bed-hold days during this year were paid by the Department?
6 (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 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 192 and days of care provided 22,570

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: 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: 06/01/09 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	482,022	40,520	5,607	528,149	15,002	543,151		543,151			1
2	Food Purchase		343,314		343,314		343,314	(453)	342,861			2
3	Housekeeping	209,616	30,905	1,539	242,060		242,060		242,060			3
4	Laundry	63,162	34,556	603	98,321		98,321		98,321			4
5	Heat and Other Utilities			274,476	274,476	4,175	278,651		278,651			5
6	Maintenance	74,639	25,069	92,379	192,087		192,087		192,087			6
7	Other (specify):* Med Waste			1,503	1,503		1,503		1,503			7
8	**TOTAL General Services**	829,439	474,364	376,107	1,679,910	19,177	1,699,087	(453)	1,698,634			8
	B. Health Care and Programs											
9	Medical Director			57,400	57,400		57,400		57,400			9
10	Nursing and Medical Records	4,966,415	472,393	122,686	5,561,494	5,510	5,567,004		5,567,004			10
10a	Therapy	1,742,719	36,475	193,269	1,972,463		1,972,463		1,972,463			10a
11	Activities	128,891	6,578	27	135,496		135,496		135,496			11
12	Social Services	166,642	297		166,939		166,939		166,939			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	7,004,667	515,743	373,382	7,893,792	5,510	7,899,302		7,899,302			16
	C. General Administration											
17	Administrative	145,810		779,814	925,624	(249,752)	675,872		675,872			17
18	Directors Fees											18
19	Professional Services			38,560	38,560		38,560	(36,580)	1,980			19
20	Dues, Fees, Subscriptions & Promotions			71,922	71,922		71,922	(39,037)	32,885			20
21	Clerical & General Office Expenses	497,194	69,301	412,554	979,049		979,049	(318,920)	660,129			21
22	Employee Benefits & Payroll Taxes			1,460,445	1,460,445	124,546	1,584,991		1,584,991			22
23	Inservice Training & Education			2,373	2,373		2,373		2,373			23
24	Travel and Seminar			5,218	5,218		5,218		5,218			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			476,197	476,197		476,197		476,197			26
27	Other (specify):*											27
28	**TOTAL General Administration**	643,004	69,301	3,247,083	3,959,388	(125,206)	3,834,182	(394,537)	3,439,645			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,477,110	1,059,408	3,996,572	13,533,090	(100,519)	13,432,571	(394,990)	13,037,581			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: 06/01/09 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			383,229	383,229	33,301	416,530		416,530			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(20,707)	(20,707)	67,218	46,511		46,511			32
33	Real Estate Taxes			576,268	576,268		576,268		576,268			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			254,992	254,992		254,992		254,992			35
36	Other (specify):*											36
37	TOTAL Ownership			1,193,782	1,193,782	100,519	1,294,301		1,294,301			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,924	8,924		8,924		8,924			38
39	Ancillary Service Centers		833,601		833,601		833,601		833,601			39
40	Barber and Beauty Shops			12,682	12,682		12,682		12,682			40
41	Coffee and Gift Shops	23,491			23,491		23,491		23,491			41
42	Provider Participation Fee			105,120	105,120		105,120		105,120			42
43	Other (specify):* IV Ther, EKG, Xray, Lab		83,063	263,016	346,079		346,079		346,079			43
44	TOTAL Special Cost Centers	23,491	916,664	389,742	1,329,897		1,329,897		1,329,897			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,500,601	1,976,072	5,580,096	16,056,769		16,056,769	(394,990)	15,661,779			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: 06/01/09 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 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	(453)	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	(250)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(159)	21		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	(36,580)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(316,693)	21		24
25	Fund Raising, Advertising and Promotional	(39,037)	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	(1,162)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (394,990)		$	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))**	$ (394,990)		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

Manorcare of Oak Lawn West

ID# 0049551

Report Period Beginning: 06/01/09

Ending: 05/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,105)	21	1
2	Miscellaneous Income	(57)	21	2
3				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**	(1,162)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(453)	0	0	0	0	0	0	0	0	0	0	(453)	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**	(453)	0	0	0	0	0	0	0	0	0	0	(453)	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	(36,580)	0	0	0	0	0	0	0	0	0	0	(36,580)	19
20	Fees, Subscriptions & Promotions	(39,037)	0	0	0	0	0	0	0	0	0	0	(39,037)	20
21	Clerical & General Office Expenses	(318,920)	0	0	0	0	0	0	0	0	0	0	(318,920)	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**	(394,537)	0	0	0	0	0	0	0	0	0	0	(394,537)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(394,990)	0	0	0	0	0	0	0	0	0	0	(394,990)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 **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)**	(394,990)	0	0	0	0	0	0	0	0	0	0	(394,990)	45

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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
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 Pg 8	Home Office Allocation	$ 779,814	HCR Manor Care, Inc.	100.00%	$ 779,814	$	1
2	V								2
3	V								3
4	V								4
5	V	10a	Therapy Management	56,617	Heartland Management Services	100.00%	56,617		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			$ 836,431			$ 836,431	$ *	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: 06/01/09 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 West # 0049551 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 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	1	Dietary - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	$ 2,826,629	$ 1,585,087	15,166,805	$ 15,002	1
2	1	Dietary - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			15,166,805	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs,HHs, Rehab			15,166,805	0	3
4	5	Utilities - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs			15,166,805	0	4
5	5	Utilities - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			15,166,805	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	911,333		15,166,805	4,175	6
7	10	Nursing - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	632,689	715,152	15,166,805	3,358	7
8	10	Nursing - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs			15,166,805	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	469,810		15,166,805	2,152	9
10	17	Gen/Admin - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	35,518,981		15,166,805	188,508	10
11	17	Gen/Admin - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	1,045,204		15,166,805	22,932	11
12	17	Gen/Admin - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	69,554,530	79,745,671	15,166,805	318,622	12
13	22	Empl Bnfts -Direct to All SNFs	Accumulated Cost	2,857,768,524	359 NFs	6,239,311		15,166,805	33,113	13
14	22	Empl Bnfts -Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	2,434,366		15,166,805	53,410	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	8,300,418		15,166,805	38,023	15
16	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,857,768,524	359 NFs	102,714		15,166,805	545	16
17	30	Deprec - Direct to Central Div	Accumulated Cost	691,284,298	95 NFs	43,612		15,166,805	957	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 Nfs,HHs, Rehab	6,941,685		15,166,805	31,799	18
19										19
20	32	Directly Assigned Interest				21,122,019			67,218	20
21		Non Central Div Nrsg Hm				25,797,439				21
22										22
23										23
24										24
25	TOTALS					$ 181,940,740	$ 82,045,910		$ 779,814	25

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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** 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		0.0255	$ 67,218	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income / Expense Other										(20,707)	8
9	TOTAL Facility Related						$ 2,639,793	$ 2,639,793			$ 46,511	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			$ 46,511	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:** 06/01/09 **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.**	$ 548,428	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.)		$ 602,371	2
3. Under or (over) accrual (line 2 minus line 1).		$ 53,943	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 530,562	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.**		$ 19,370	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** $ 27,608 **For** 2006 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (27,608)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 576,268	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	460,425	8
	2006	486,443	9
	2007	495,385	10
	2008	548,428	11
	2009	587,433	12

Line 2: $602,370.69 = $301,635.30 for 1st half of 2009 + $300,735.39 for 2nd half of 2008

Line 4: 530,562 = $285,798.12 for 2nd half 2009 + $244,763.93 for Jan -May 2010

Line 5: Worsek & Vihon Invoices ($159 & $9211.50) and Rock, Fusco & Assoc invoice $10,000.05

Line 6: 2006 RE Tax Appeal Refund

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 West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049551

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.	24-05-302-005-0000	See Attached	$ 587,433.42	$ 587,433.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 587,433.42	$ 587,433.42

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 West # 0049551 Report Period Beginning: 06/01/09 Ending: 05/31/10

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? [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).

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: 06/01/09 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	98		1981	1962	$ 313,600	$ 29,964		$ 29,964	$	$ 1,804,954	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					156,361		156,361		3,957,743	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: 06/01/09 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	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	$ 186,325		$ 186,325	$	$ 5,762,697	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: 06/01/09 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		$ 6,594,254	$ 186,325		$ 186,325	$	$ 5,762,697	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	$ 186,325		$ 186,325	$	$ 5,762,697	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: 06/01/09 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		$ 6,892,053	$ 186,325		$ 186,325	$	$ 5,762,697	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									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)		$ 7,106,309	$ 186,325		$ 186,325	$	$ 5,762,697	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: 06/01/09 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	$ 2,969,404	$ 196,904	$ 196,904	$		$ 2,489,746	71
72	Current Year Purchases	145,858						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			33,301	33,301			74
75	TOTALS	$ 3,115,262	$ 196,904	$ 230,205	$ 33,301		$ 2,489,746	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	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)	$ 11,053,678	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 383,229	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 416,530	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,301	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,264,550	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	$ 41,168	92
93			93
94			94
95		$ 41,168	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: 06/01/09 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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ $254992 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: 06/01/09 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 West

STATE OF ILLINOIS
0049551 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	9038	hrs	$ 369,654	32	$ 1,643	$ 2,450	9,070	$ 373,747	1
2	Licensed Speech and Language Development Therapist	10a	5560	hrs	202,982	272	13,865	6	5,832	216,853	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	5181	hrs	215,958	1,837	93,685	34,019	7,018	343,662	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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Inhal Therapy	10a	2388		55,810				2,388	55,810	12
13	Other (specify): IV Ther/Xray/Lab/EK(	43, 2 & 3					83,063	263,016		346,079	13
14	TOTAL				$ 844,404	2,141	$ 192,256	$ 299,491	24,308	$ 1,336,151	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:** 06/01/09 **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	$ 87,696	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,014,077))	2,972,662		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,873		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,066,231	$	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	7,106,310		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,127,368		16
17	Accumulated Depreciation (book methods)	(8,264,550)		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	41,168		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,830,296	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,896,527	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 284,789	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	792,031		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	530,562		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	83,799		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,691,181	$	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	301,664		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,941,457	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,632,638	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,263,889	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,896,527	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 **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**	$ 3,997,299	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,997,299	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,041,321	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)**	$ 4,041,321	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(6,774,731)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (6,774,731)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,263,889	24 *

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

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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	$ 20,474,640	1
2	Discounts and Allowances for all Levels	(6,759,497)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,715,143	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,949,003	6
7	Oxygen	64	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,949,067	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	1,264	12
13	Barber and Beauty Care	13,750	13
14	Non-Patient Meals	453	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,013,968	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	256,906	19
20	Radiology and X-Ray	44,898	20
21	Other Medical Services	101,585	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,432,824	23
	D. Non-Operating Revenue		
24	Contributions	999	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 999	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	57	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 57	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,098,090	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,679,910	31
32	Health Care	7,893,792	32
33	General Administration	3,959,388	33
	B. Capital Expense		
34	Ownership	1,193,782	34
	C. Ancillary Expense		
35	Special Cost Centers	1,224,777	35
36	Provider Participation Fee	105,120	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,056,769	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,041,321	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,041,321	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.**

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	2,029	2,184	$ 89,153	$ 40.82	1
2	Assistant Director of Nursing	7,104	7,650	256,937	33.59	2
3	Registered Nurses	54,156	58,312	2,015,036	34.56	3
4	Licensed Practical Nurses	31,711	34,145	869,501	25.46	4
5	CNAs & Orderlies	139,777	150,685	1,702,836	11.30	5
6	CNA Trainees					6
7	Licensed Therapist	24,766	26,694	1,021,453	38.27	7
8	Rehab/Therapy Aides	26,424	28,481	721,266	25.32	8
9	Activity Director	10,802	11,617	128,891	11.10	9
10	Activity Assistants					10
11	Social Service Workers	6,854	7,364	166,642	22.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,594	38,047	482,022	12.67	15
16	Dishwashers					16
17	Maintenance Workers	3,701	3,984	74,639	18.73	17
18	Housekeepers	19,835	21,361	209,616	9.81	18
19	Laundry	6,347	6,832	63,162	9.25	19
20	Administrator	2,080	2,080	102,814	49.43	20
21	Assistant Administrator	979	979	42,996	43.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,356	28,608	497,194	17.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,325	2,501	32,952	13.18	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitality	2,004	2,158	23,491	10.89	33
34	TOTAL (lines 1 - 33)	402,844	433,682	$ 8,500,601 *	$ 19.60	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	57,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,675	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)		$ 61,075		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	(32)	$ (1,728)	10, 3	50
51	Licensed Practical Nurses	(15)	(600)	10, 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	(47)	$ (2,328)		53

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 Report Period Beginning: 06/01/09 Ending: 05/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JoMarie Silver	Administrator	0	$ 49,721
Karen Petyko	Administrator	0	53,093
Katie Slench	Assistant Admin	0	30,877
Scott Hochstadt	Assistant Admin	0	12,119
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 145,810

B. Administrative - Other

Description	Amount
Management Fees	$ 779,814
TOTAL (agree to Schedule V, line 17, col. 3)	$ 779,814
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, & Flowers, LLC	Legal	$ 28,696
United Collections Bureau Inc.	Fees for Collections	7,884
Quality Care Consulting Svcs	Consulting	1,980
Legal fees were adjusted off on Schedule VI, Page 5, Line 22.		
Therefore, no legal invoices are attached.		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 38,560

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 146,949
Unemployment Compensation Insurance	85,121
FICA Taxes	619,259
Employee Health Insurance	536,601
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	
401K	49,953
Other Employee Benefits	7,932
Tuition Program	30
SMSP Match	5,785
Employee Uniforms	8,815
Home Office Allocation	124,546
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,584,991

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 334
Advertising: Employee Recruitment	16,180
Health Care Worker Background Check	
(Indicate # of checks performed 66)	3,126
Patient Background Checks 608	6,080
Dues & Subscriptions	85
Association Dues	15,051
Advertising	31,066
Public Relations	
Less: Non-Allowable Association Dues	(7,971)
Less: Public Relations Expense	( )
Non-allowable advertising	(31,066)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,885

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,218
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)	$ 5,218

**See instructions.

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 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													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare of Oak Lawn West # 0049551 **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. **ICHA $7,080**

(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 $7971**

(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. $ **116,015** 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. $ **105,120**
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? 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. $ **453**

(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.