FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0049668

Facility Name: Manorcare of Oak Lawn East

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

County: Cook

Telephone Number: (708) 423-7882 **Fax #** (708) 723-7947

HFS ID Number:

Date of Initial License for Current Owners: 1977

Type of Ownership:

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

IRS Exemption Code 501(c)(3)

In the event there are further questions about this report, please contact:
Name: A. Dean Shipman **Telephone Number:** (419) 254-7841
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 06/01/2019 to 05/31/2020 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) Martin D. Allen
(Title) Director

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: 06/01/2019 Ending: 05/31/2020

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	122	Skilled (SNF)	122	44,652	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,652	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	13,501	2,969	20,291	36,761	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,501	2,969	20,291	36,761	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.33%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 / /

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/25/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 9,191

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31 Fiscal Year: 5/31

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

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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	431,356	34,213	283	465,852		465,852		465,852			1
2	Food Purchase		248,461		248,461		248,461	(136)	248,325			2
3	Housekeeping	210,946	22,698	148	233,792		233,792		233,792			3
4	Laundry	81,613	23,096		104,709		104,709		104,709			4
5	Heat and Other Utilities			140,515	140,515	3,836	144,351		144,351			5
6	Maintenance	70,358	14,657	104,632	189,647		189,647		189,647			6
7	Other (specify):* Security & Waste			20,935	20,935		20,935		20,935			7
8	TOTAL General Services	794,273	343,125	266,513	1,403,911	3,836	1,407,747	(136)	1,407,611			8
	B. Health Care and Programs											
9	Medical Director			11,685	11,685		11,685		11,685			9
10	Nursing and Medical Records	4,110,635	354,325	81,236	4,546,196	177	4,546,373		4,546,373			10
10a	Therapy	1,601,313	15,106	27,130	1,643,549		1,643,549		1,643,549			10a
11	Activities	92,687	3,754	2,094	98,535		98,535		98,535			11
12	Social Services	231,319	716		232,035		232,035		232,035			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,035,954	373,901	122,145	6,532,000	177	6,532,177		6,532,177			16
	C. General Administration											
17	Administrative	154,228		522,201	676,429	(93,363)	583,066		583,066			17
18	Directors Fees											18
19	Professional Services			85,513	85,513		85,513	(85,513)				19
20	Dues, Fees, Subscriptions & Promotions			81,321	81,321		81,321	(18,648)	62,673			20
21	Clerical & General Office Expenses	404,466	70,616	943,596	1,418,678		1,418,678	(848,058)	570,620			21
22	Employee Benefits & Payroll Taxes			1,150,481	1,150,481	66,343	1,216,824		1,216,824			22
23	Inservice Training & Education			2,596	2,596		2,596		2,596			23
24	Travel and Seminar			2,554	2,554		2,554		2,554			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,284,499	1,284,499		1,284,499		1,284,499			26
27	Other (specify):*											27
28	TOTAL General Administration	558,694	70,616	4,072,761	4,702,071	(27,020)	4,675,051	(952,219)	3,722,832			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,388,921	787,642	4,461,419	12,637,982	(23,007)	12,614,975	(952,355)	11,662,620			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: 06/01/2019 Ending: 05/31/2020

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			276,597	276,597	27,264	303,861		303,861			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(4,453)	(4,453)	(4,257)	(8,710)		(8,710)			32
33	Real Estate Taxes			658,374	658,374		658,374		658,374			33
34	Rent-Facility & Grounds			656,034	656,034		656,034	(656,034)				34
35	Rent-Equipment & Vehicles			61,832	61,832		61,832		61,832			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,648,384	1,648,384	23,007	1,671,391	(656,034)	1,015,357			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		545,009		545,009		545,009		545,009			39
40	Barber and Beauty Shops			2,507	2,507		2,507		2,507			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			219,722	219,722		219,722		219,722			42
43	Other (specify):* IV Therp|Xray|Lab		93,548	177,770	271,318		271,318		271,318			43
44	**TOTAL Special Cost Centers**		638,557	399,999	1,038,556		1,038,556		1,038,556			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,388,921	1,426,199	6,509,802	15,324,922		15,324,922	(1,608,389)	13,716,533			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: 06/01/2019 Ending: 05/31/2020

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	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(136)	2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	(401)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(99)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(56,456)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(845,643)	21		24
25	Fund Raising, Advertising and Promotional	(18,648)	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 Pg 5a	(687,006)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,608,389)		$	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))**	$ (1,608,389)		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	Exeptional 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 East

ID# 0049668

Report Period Beginning: 06/01/2019

Ending: 05/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activity Income	$	11	1
2	Misc. Income		21	2
3	Vending Income	(1,915)	21	3
4	Donations Revenue		21	4
5	Accouning/Collection Fees	(29,057)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest		32	8
9	WT Rent Expense	(656,034)	34	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**	(687,006)		49

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	Home Office
				HL Empl Svcs, LLC	Toledo	Personnel
				HL Home Health Care	Toledo	Nursing Staff

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 522,201	HCR Manor Care Services, LLC	0.00%	$ 522,201	$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	7,388,921	Heartland Employment Services, LLC	0.00%	7,388,921		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 7,911,122			$ 7,911,122	$ *	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: 06/01/2019 Ending: 05/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Galesburg IL, LLC	Galesburg				1
2			Heartland of Henry IL, LLC	Henry				2
3			Heartland of Macomb IL, LLC	Macomb				3
4			Heartland of Moline IL, LLC	Moline				4
5			Manor Care at Arlington Heights	Arlington Heights				5
6			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				6
7			Manor Care of Hinsdale IL, LLC	Hinsdale				7
8			Manor Care of Homewood IL, LLC	Homewood				8
9			Manor Care of Libertyville IL, LLC	Libertyville				9
10			Manor Care of Oak Lawn (East) IL, LLC	Oak Lawn				10
11			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				11
12			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				12
13			Manor Care of Palos Heights (East) IL, LLC	Palos Heights				13
14			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Arden Courts of Geneva IL, LLC	Geneva				15
16			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				16
17			Arden Courts of Northbrook IL, LLC	Northbrook				17
18			Arden Courts of Palos Heights IL, LLC	Palos Heights				18
19			Arden Courts of South Holland IL, LLC	South Holland				19
20								20
21		REMEMBER TO DELETE THE FACILTY YOU ARE WORKING ON AND THIS COMMENT!						21
22								22
23								23
24	Martin D. Allen	BOD						24
25	Lynne Davis	BOD						25
26	Kathryn S. Hoops	BOD						26
27	Thomas Kile	BOD						27
28	Patricia McCormick	BOD						28
29	Rami Ubaydi	BOD						29
30								30

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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: 06/01/2019 Ending: 5/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, &	$ 709,073	$ 0	14,263,551	$ 3,836	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs		0	14,263,551	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	14,263,551	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	32,137	0	14,263,551	174	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	454	0	14,263,551	3	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	14,263,551	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	57,708,481	23,053	14,263,551	312,175	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	7,841,321	0	14,263,551	52,958	10
11	17	Gen/Admin-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs	2,818,405	0	14,263,551	63,705	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	5,631,859	35,913,957	14,263,551	30,466	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	5,312,192	1,179,502	14,263,551	35,877	14
15	22	Empl Bnfts-Direct to West Div SN	Accumulated Cost	631,044,941	54 NFs		0	14,263,551	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	4,013,110	0	14,263,551	21,709	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	822,456	0	14,263,551	5,555	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	14,263,551	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	2,636,740,077		(782,905)		14,263,551	(4,235)	22
23	32	Directly Assigned Interest	Not Allocated			(8,038)			(22)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,182,124				24
25	TOTALS					$ 118,280,668	$ 37,116,512		$ 522,201	25

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Pooled Interest Expense										(4,257)	6
7	Interest Income / Interest Expense										(4,453)	7
8												8
9	TOTAL Facility Related						$	$			$ (8,710)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (8,710)	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: 06/01/2019 Ending: 05/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 553,572	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.)		$ 636,671	2
3. Under or (over) accrual (line 2 minus line 1).		$ 83,098	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 575,047	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.)		$ 229	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 $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 658,374	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	525,198	8
	2016	530,987	9
	2017	598,852	10
	2018	623,242	11
	2019	647,880	12

Line 2: $636,670.68 = $293887.82 for 2nd half 2018+ $342,782.86 for 1st half 2019

Line 4: $575,046.66= $305,096.66 for 2nd half 2019 + $269,950 for 1st half 2020

Line 5: Worsek & Vihon Inv: Specific Objections - 2017 Taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 A. Dean Shipman

TELEPHONE (419) 254-7841 FAX #: (800) 422-2089

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-03-400-032-0000	See Attached	$ 647,879.52	$ 647,879.52
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 647,879.52	$ 647,879.52

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 06/01/2019 Ending: 05/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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		87,550	1977	$ 257,674	1
2					2
3	TOTALS	87,550		$ 257,674	3

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	122		1977	1977	$ 2,247,698	$		$	$	$ 2,247,698	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					196,555		196,555		4,834,855	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				2001	106,534						25
26				2002	102,826						26
27				2003	72,047						27
28				2004	98,601						28
29											29
30				2005	44,449						30
31				2006	3,728						31
32				2006	18,089						32
33				2007	271,561						33
34											34
35											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: 06/01/2019 Ending: 05/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Metal Door	2008	$ 8,440	$		$	$	$	37
38	Door and Frame	2008	3,177						38
39	Water Heater	2008	22,725						39
40	Renov. - Capentry-Subcontractor	2008	713,268						40
41	7/1/2019 Capital Rate Adjustment 12A L57	2008	(1,472)						41
42	Renov. - Mill Work	2008	38,340						42
43	Renov. - Plumbing	2008	6,830						43
44	Renov. - HVAC	2008	8,969						44
45	Renov. - Fire Alarm System	2008	17,940						45
46	Renov. - Nurse Call System	2008	4,647						46
47	Elevator Door Restrictors	2008	8,100						47
48	Annunciator Panel for Generator	2008	2,969						48
49									49
50	consolidated per aud1t papers	2009	417,856						50
51	consolidated per aud1t papers	2010	488,559						51
52	consolidated per aud1t papers	2011	121,160						52
53	consolidated per aud1t papers	2012	80,525						53
54	consolidated per aud1t papers	2013	500,712						54
55	consolidated per aud1t papers	2014	418,907						55
56									56
57	Life Safety Elelctrical Panel & related electrical work	2015	30,308						57
58	Electric circuits, 3 phase - disposals (2) & blender (Kitchen)	2015	14,558						58
59	Blower section - Trane rooftop unit	2015	7,070						59
60	Drywall & paint firewalls-Med. Rm, Clean Utility, & Corridor	2015	3,490						60
61	Life Safety Elelctrical Panel & related electrical work	2015	19,650						61
62	Electric circuits, 3 phase - disposals (2) & blender (Kitchen)	2015	3,650						62
63	Blower section - Trane rooftop unit	2015	7,150						63
64	Compressor/condensor/crankcase heater-walk in cooler	2015	3,780						64
65									65
66	Door/frame, exterior 1.5 hr fire rated - Kitchen	2015	2,460						66
67	Windows, (10) dbl hung: 2nd flr-215, 217, 219 in W wing.								67
68	and 227, 229, 232-236 in S wing	2015	18,780						68
69	Heat Exchgr, RTU HVAC for 1st & 2nd flr dining & Ofc areas	2015	11,880						69
70	TOTAL (lines 4 thru 69)		$ 8,240,310	$ 196,555		$ 196,555	$	$ 7,082,553	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: 06/01/2019 Ending: 05/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,240,310	$ 196,555		$ 196,555	$	$ 7,082,553	1
2	Door, hollow metal - kitchen	2016	4,821						2
3	Elec panel kitchen: prep area, next to fridge, food stg rm (2)	2016	9,850						3
4	Flooring, vinyl plank both elevators	2016	3,105						4
5	RTU Coil & Fan Blades, lobby/front ofcs/laundry/dining/activites/	2016	12,170						5
6									6
7	AC unit, mini split in phone rm	2016	3,975						7
8	Notifier for fire system	2016	4,466						8
9	RTU compressor-2nd flr nurse station	2017	5,065						9
10	Electric, Poles, & Lights (2), S & W side Drive/Lot & near Flagpol	2016	16,963						10
11	Limestone Corners (19) on bldg & tuck pointing	2017	7,700						11
12									12
13	Plumbing-Mixing Valve & copper return line -Boiler	2017	8,321						13
14	Doors - sprinkler room	2017	3,415						14
15	Compressor, 7.5T for Kitchen	2017	8,652						15
16	Painting -2nd Flr Therapy & Dining	2017	5,200						16
17	Electrical circuit breakers (2) - for Kitchen ovens	2017	2,950						17
18	Heater - South Entrance Ceiling	2018	4,875						18
19	Concrete sidewalk 75' & pad at front entrance	2017	7,708						19
20	Asphalt Paving	2017	7,364						20
21									21
22	Condenser Electrical Feed -Walk-in Cooler	2018	4,475						22
23	Condensing unit and evaporator- Walk-in Cooler	2018	10,435						23
24	RTU -5T	2018	18,435						24
25	Plumbing -1st flr central bath & Hot water plumbing 2nd flr centr	2018	3,759						25
26	Valve on tub 1st flr central bath	2018	4,288						26
27	Door on 2nd flr shower room	2018	3,298						27
28	West Canopy LED Lights (5) and NE Parking lot pole light	2018	3,622						28
29	Painting & Doors, closet -rms 118 and 229	2018	6,160						29
30									30
31	LED fixtures 100W (3)- pole lights in East parking lot	2019	4,427						31
32	Asphalt, 38,556 sq ft parking lot	2019	9,360						32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,169	$ 196,555		$ 196,555	$	$ 7,082,553	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: 06/01/2019 Ending: 05/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,425,169	$ 196,555		$ 196,555	$	$ 7,082,553	1
2	Wallpaper - Employee break Rm	2019	2,590						2
3	Evaporator -RTU above 2nd flr Nurses station area	2019	5,985						3
4	LED vapor-tight Lights- 8ft (12)/4ft (8) - Kitchen, storage rm, & d	2019	12,938						4
5	42 circuit breaker panelboard-1st flr storage closet -maint	2019	3,645						5
6	Painting - Kitchen	2019	5,096						6
7	Doors, HM exterior - E stairwell & Lounge to ctyd	2020	11,711						7
8	Check Valve, 4in @ Fire Dept connection	2019	3,032						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	TOTAL (lines 1 thru 33)		$ 8,470,166	$ 196,555		$ 196,555	$	$ 7,082,553	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: 06/01/2019 Ending: 05/31/2020

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 3,723,076	$ 80,042	$ 80,042	$		$ 3,471,755	71
72	Current Year Purchases	59,086						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			27,264	27,264			74
75	TOTALS	$ 3,782,162	$ 80,042	$ 107,306	$ 27,264		$ 3,471,755	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 12,510,002	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 276,597	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 303,861	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 27,264	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,554,308	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	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 61,832 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 East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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.

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	7341 hrs	$ 305,191		$	$ 10,469	7,341	$ 315,660	1
2	Licensed Speech and Language Development Therapist	10a	4461 hrs	185,471			2,678	4,461	188,149	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	7922 hrs	329,375			1,959	7,922	331,334	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				545,009		545,009	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Inhal Therapy	10a, 3	1353	56,237	65	3,880		1,418	60,117	12
13	Other (specify): X-Ray & Lab | IV	43, 2 & 3				177,770	93,548		271,318	13
14	TOTAL			$ 876,274	65	$ 181,650	$ 653,663	21,142	$ 1,711,587	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/2020 (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	$ (960)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (698,786))	1,126,891		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,868		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,130,799	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	257,674		13
14	Buildings, at Historical Cost	8,470,166		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,782,162		16
17	Accumulated Depreciation (book methods)	(10,554,308)		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 (spe OMIT	185,797		22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,141,491	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,272,290	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 209,239	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	612,826		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,965		31
32	Accrued Real Estate Taxes(Sch.IX-B)	575,047		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	122,325		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,525,402	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,525,402	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,746,888	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,272,290	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,186,501	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,186,501	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(355,671)	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)**	$ (355,671)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(83,942)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (83,942)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,746,888	24 *

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

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,522,140	1
2	Discounts and Allowances for all Levels	(8,222,513)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,299,627	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,391,849	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,391,849	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	1,915	12
13	Barber and Beauty Care	1,683	13
14	Non-Patient Meals	136	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,187,257	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	166,385	19
20	Radiology and X-Ray	118,009	20
21	Other Medical Services	56,815	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,532,200	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	Purchase Discount	745,575	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 745,575	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,969,251	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,403,911	31
32	Health Care	6,532,000	32
33	General Administration	4,702,071	33
	B. Capital Expense		
34	Ownership	1,648,384	34
	C. Ancillary Expense		
35	Special Cost Centers	818,834	35
36	Provider Participation Fee	219,722	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,324,922	40
41	**Income before Income Taxes (line 30 minus line 40)****	(355,671)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (355,671)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,495,879	44
45	Private Pay - Net Inpatient Revenue	905,344	45
46	Medicare - Net Inpatient Revenue	2,218,356	46
47	Other-(specify) Hospice	317,698	47
48	Other-(specify) Insurance	1,362,350	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,299,627	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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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	2,085	2,235	$ 123,960	$ 55.46	1
2	Assistant Director of Nursing	3,947	4,232	172,417	40.74	2
3	Registered Nurses	48,730	52,248	1,857,652	35.55	3
4	Licensed Practical Nurses	18,389	19,716	579,731	29.40	4
5	CNAs & Orderlies	82,425	88,505	1,352,768	15.28	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	24,442	26,127	1,086,256	41.58	7
8	Rehab/Therapy Aides	15,697	16,779	515,057	30.70	8
9	Activity Director	5,367	5,741	92,687	16.14	9
10	Activity Assistants					10
11	Social Service Workers	8,560	9,175	231,319	25.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,119	26,954	431,356	16.00	15
16	Dishwashers					16
17	Maintenance Workers	2,147	2,278	70,358	30.89	17
18	Housekeepers	14,066	15,069	210,946	14.00	18
19	Laundry	5,191	5,545	81,613	14.72	19
20	Administrator	2,080	2,080	154,228	74.15	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,754	19,275	404,466	20.98	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	1,590	1,708	24,107	14.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	277,589	297,667	$ 7,388,921 *	$ 24.82	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	11,685	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 11,685		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kelly Ciger (January)	Administrator	0	$ 8,786
Jennifer Benco (Feb -Dec)	Administrator	0	145,442
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 154,228

B. Administrative - Other

Description	Amount
Various Home Office Services - See Page 8 for breakdown	$ 522,201
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 522,201

C. Professional Services

Vendor/Payee	Type	Amount
Various	Legal Fees	$ 56,456
Legal Fees were adjusted off via Page 5, Line 22, therefore, no detail schedule is attached.		
Various	Collections	29,057
AR Collection Costs were adjusted off via Page 5A, Lines 6 & 7, therefore, no detail schedule is attached.		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 85,513

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,032
Unemployment Compensation Insurance	13,181
FICA Taxes	539,862
Employee Health Insurance	495,296
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Payments	
401K	47,614
Oth Benefits & Mktg Adj	858
Tuition Program	2,500
Employee Appreciation	5,194
Employee Uniforms	7,944
Home Office Allocation	66,343
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,216,824

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	$ 0
Advertising: Employee Recruitment	16,657
Health Care Worker Background Check (Indicate # of checks performed 505)	14,079
Patient Background Checks 546	5,460
Dues & Subscriptions	4,375
Association Dues	7,939
Advertising	16,452
Other Licenses and Permits	16,359
Less: Non-Allowable Association Dues	(2,196)
Less: Public Relations Expense	( )
Non-allowable advertising	(16,452)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 62,673

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,554
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)	$ 2,554

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare of Oak Lawn East # 0049668 Report Period Beginning: 06/01/2019 Ending: 05/31/2020

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 $3,917 & AHCA $1,826**

(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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **53,645** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **YES**
If YES, give effective date of lease. **7/28/18**

(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. $ **219,722**
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. $ **136**

(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?
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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **NO**
Attach invoices and a summary of services for all architect and appraisal fees.