



Facility Name & ID Number Manorcare at Oak Lawn/Kostner

# 0027557 Report Period Beginning: 06/01/07 Ending: 05/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	52,704	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,392	7,471	25,275	41,138	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,392	7,471	25,275	41,138	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.05%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 1977

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 144 and days of care provided 21,291

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number      Manorcare at Oak Lawn/Kostner      #      0027557      Report Period Beginning:      06/01/07      Ending:      05/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	324,597	26,229	2,299	353,125	4,192	357,317		357,317		1
2	Food Purchase		218,934		218,934		218,934	(541)	218,393		2
3	Housekeeping	200,139	22,698	227	223,064		223,064		223,064		3
4	Laundry	41,080	15,047		56,127		56,127	(2,411)	53,716		4
5	Heat and Other Utilities			163,561	163,561	9,615	173,176		173,176		5
6	Maintenance	78,948	20,074	89,430	188,452		188,452		188,452		6
7	Other (specify):* <b>Medical Waste</b>			1,607	1,607		1,607		1,607		7
8	<b>TOTAL General Services</b>	<b>644,764</b>	<b>302,982</b>	<b>257,124</b>	<b>1,204,870</b>	<b>13,807</b>	<b>1,218,677</b>	<b>(2,952)</b>	<b>1,215,725</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			45,058	45,058		45,058		45,058		9
10	Nursing and Medical Records	3,829,697	361,603	242,246	4,433,546	7,771	4,441,317		4,441,317		10
10a	Therapy	1,099,190	19,451	100,362	1,219,003		1,219,003		1,219,003		10a
11	Activities	70,049	2,799	2,858	75,706		75,706		75,706		11
12	Social Services	217,746	26		217,772		217,772		217,772		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>5,216,682</b>	<b>383,879</b>	<b>390,524</b>	<b>5,991,085</b>	<b>7,771</b>	<b>5,998,856</b>		<b>5,998,856</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	108,777		724,998	833,775	(163,715)	670,060		670,060		17
18	Directors Fees										18
19	Professional Services			73,750	73,750	(951)	72,799	(72,799)			19
20	Dues, Fees, Subscriptions & Promotions			174,382	174,382		174,382	(24,924)	149,458		20
21	Clerical & General Office Expenses	568,409	51,640	299,162	919,211	951	920,162	(214,692)	705,470		21
22	Employee Benefits & Payroll Taxes			1,037,197	1,037,197	98,293	1,135,490		1,135,490		22
23	Inservice Training & Education			472	472		472		472		23
24	Travel and Seminar			44,329	44,329		44,329		44,329		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			205,189	205,189		205,189		205,189		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>677,186</b>	<b>51,640</b>	<b>2,559,479</b>	<b>3,288,305</b>	<b>(65,422)</b>	<b>3,222,883</b>	<b>(312,415)</b>	<b>2,910,468</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>6,538,632</b>	<b>738,501</b>	<b>3,207,127</b>	<b>10,484,260</b>	<b>(43,844)</b>	<b>10,440,416</b>	<b>(315,367)</b>	<b>10,125,049</b>		<b>29</b>

\*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 at Oak Lawn/Kostner #0027557 Report Period Beginning: 06/01/07 Ending: 05/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			317,710	317,710	29,617	347,327	347,327			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(2,865)	(2,865)	14,227	11,362	11,362			32
33	Real Estate Taxes			488,285	488,285		488,285	488,285			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			110,701	110,701		110,701	110,701			35
36	Other (specify):* <b>Gain on Fixed Assets</b>										36
37	<b>TOTAL Ownership</b>			913,831	913,831	43,844	957,675	957,675			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			264	264		264	264			38
39	Ancillary Service Centers		792,044		792,044		792,044	792,044			39
40	Barber and Beauty Shops			10,290	10,290		10,290	10,290			40
41	Coffee and Gift Shops	10,125			10,125		10,125	10,125			41
42	Provider Participation Fee			78,840	78,840		78,840	78,840			42
43	Other (specify):* <b>IV   X-ray &amp; Lab</b>		169,687	154,313	324,000		324,000	324,000			43
44	<b>TOTAL Special Cost Centers</b>	10,125	961,731	243,707	1,215,563		1,215,563	1,215,563			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,548,757	1,700,232	4,364,665	12,613,654		12,613,654	(315,367)	12,298,287		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 at Oak Lawn/Kostner

# 0027557

Report Period Beginning: 06/01/07

Ending: 05/31/08

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(541)	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	(2,411)	4		8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(197)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(42)	21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(72,799)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(212,661)	21		24
25	Fund Raising, Advertising and Promotional	(24,924)	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 See Page 5A	(1,792)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (315,367)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)		10a	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (315,367)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Manorcare at Oak Lawn/Kostner

ID# 0027557

Report Period Beginning: 06/01/07

Ending: 05/31/08

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,792)	21	1
2	Misc. Income	0	21	2
3	Activity Income	0	11	3
4	Gain/Loss on Desposal of Fixed Assets	0	36	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,792)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Oak Lawn/Kostner

# 0027557

Report Period Beginning:

06/01/07

Ending:

05/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(541)	0	0	0	0	0	0	0	0	0	0	(541)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,411)	0	0	0	0	0	0	0	0	0	0	(2,411)	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	<b>TOTAL General Services</b>	<b>(2,952)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,952)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(72,799)	0	0	0	0	0	0	0	0	0	0	(72,799)	19
20	Fees, Subscriptions & Promotions	(24,924)	0	0	0	0	0	0	0	0	0	0	(24,924)	20
21	Clerical & General Office Expenses	(214,692)	0	0	0	0	0	0	0	0	0	0	(214,692)	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	<b>TOTAL General Administration</b>	<b>(312,415)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(312,415)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(315,367)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(315,367)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Oak Lawn/Kostner

# 0027557

Report Period Beginning:

06/01/07 Ending:

Summary B

05/31/08

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

	Capital Expense	PAGES	PAGE	SUMMARY											
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS		
		(to Sch V, col.7)													
30	Depreciation	0	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	0	31
32	Interest	0	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	0	33
34	Rent-Facility & Grounds	0	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	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>														
	<b>E. Special Cost Centers</b>														
38	Medically Necessary Transportation	0	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	0	39
40	Barber and Beauty Shops	0	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	0	41
42	Provider Participation Fee	0	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	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(315,367)</b>	<b>0</b>	<b>(315,367)</b>	<b>45</b>										

Facility Name & ID Number Manorcare at Oak Lawn/Kostner

# 0027557

Report Period Beginning:

06/01/07

Ending:

05/31/08

**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.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	See Home Allocation	\$ 724,998	HCR Manor Care, Inc.	100.00%	\$ 724,998	\$
2	V	Page					
3	V	8					
4	V						
5	V						
6	V	10a Therapy Management	55,920	Heartland Management Services	100.00%	55,920	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 780,918			\$ 780,918	\$ *

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

Facility Name & ID Number Manorcare at Oak Lawn/Kostner # 0027557 Report Period Beginning: 06/01/07 Ending: 05/31/08

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare at Oak Lawn/Kostner

# 0027557

Report Period Beginning: 06/01/07

Ending: 05/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.	\$ 59,848	\$ 12,472,274	\$ 265	1	
2	1	Dietary - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	1,061,370	577,717	12,472,274	3,927	2
3	5	Utilities - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.	497,772	12,472,274	2,206	3	
4	5	Utilities - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	2,002,556	12,472,274	7,409	4	
5	10	Nursing - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.		12,472,274	0	5	
6	10	Nursing - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	2,100,636	1,287,391	12,472,274	7,771	6
7	17	General & Admin - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.	41,222,846	32,327,667	12,472,274	182,730	7
8	17	General & Admin - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	102,324,370	42,519,840	12,472,274	378,553	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.	7,830,100	12,472,274	34,709	9	
10	22	Employee Benefits - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	17,187,062	12,472,274	63,584	10	
11	30	Depreciation - Direct	Accumulated Cost	2,813,673,080	369 Nurs. Fac.		12,472,274	0	11	
12	30	Depreciation - Pooled	Accumulated Cost	3,371,307,314	369 Nurs. Fac.	8,005,430	12,472,274	29,617	12	
13									13	
14	32	Interest				3,167,921		14,227	14	
15		Non-Nursing Home Allocations				23,250,237			15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 208,710,148	\$ 76,712,615	\$ 724,998	25	

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Conv. Sub. Debentures		X	Facility			\$ 461,443	\$ 461,443		3.0832	\$ 14,227	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8	Interest Income Other										(2,865)	8								
9	<b>TOTAL Facility Related</b>						\$ 461,443	\$ 461,443			\$ 11,362	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 461,443	\$ 461,443			\$ 11,362	15								

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

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

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

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

B. Real Estate Taxes

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.	\$	<u>529,650</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>528,317</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(1,333)</u>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>501,258</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	<u>6,017</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>17,657</u> For <u>2004</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	<u>(17,657)</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>488,285</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<u>438,226</u>	8
	2004	<u>466,076</u>	9
	2005	<u>504,076</u>	10
	2006	<u>520,237</u>	11
	2007	<u>534,299</u>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

Line 2: \$528,317 = \$268,199 for 2nd half of 2006 paid in Nov. '07 + \$260,118 for 1st half of 2007 paid in Feb. '08.

Line 4: \$501,257 = \$227,077 estimate for Jan-May 2008 + \$274,180 for 2nd half of 2007 Paid in Oct. '08.

Line 5: \$6,017 = \$5,984 + \$123 to Worssek & Vihon LLP for Legal Services for Tax Appeal. Refund received see line 6.

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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Manorcare at Oak Lawn/Kostner COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027557

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419)252-5740 FAX #: (419) 254-5495

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>24-03-400-032-0000</u>	<u>See Attached</u>	\$ <u>534,299.36</u>	\$ <u>534,299.36</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>534,299.36</u>	\$ <u>534,299.36</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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 at Oak Lawn/Kostner

# 0027557 Report Period Beginning:

06/01/07 Ending:

05/31/08

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1977</u>	<u>\$ 257,674</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 257,674</b>	3

Facility Name & ID Number **Manorcare at Oak Lawn/Kostner**

# **0027557**

Report Period Beginning:

**06/01/07**

Ending:

**05/31/08**

**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	144		1977	1977	\$ 2,247,698	\$ 62,436		\$ 62,436	\$	\$ 1,904,170	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>Current Year Depreciation</b>					126,594		126,594		2,214,689	9
10				1981	18,089						10
11				1986	2,797						11
12				1988	19,012						12
13				1989	14,714						13
14				1990	202,653						14
15				1991	69,401						15
16				1992	114,373						16
17				1993	63,254						17
18				1994	648,943						18
19				1995	220,796						19
20				1996	238,261						20
21				1997	230,127						21
22				1998	319,666						22
23				1999	57,192						23
24				2000	71,071						24
25		Reclass \$2,957 artwork to Equip. Disallow \$17,709		2001	106,534						25
26		STEEL GATES FOR DUMSTERS		2002	6,355						26
27		WINDOW TREATMENTS		2002	4,782						27
28		Renovation - General Construction per audit \$4,171 disallowed		2002	24,092						28
29		Renovation - Wallcovering per audit \$10,669 disallowed		2002	61,624						29
30		Renovation - HVAC & Electrical per audit \$589 disallowed		2002	3,401						30
31		ROOFING ON WEST SECTION		2003	19,000						31
32		Sink, Tile, Wallcovering & Paint		2003	20,585						32
33		Light Fixtures per audit change year from 2003 to 2002		2003	2,572						33
34		Construction Department Cost & Interest Disallowed per audit		2003							34
35		Ceramic Floor Tile & Related Concrete Work		2003	19,427						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Manorcare at Oak Lawn/Kostner

# 0027557

Report Period Beginning:

06/01/07

Ending:

05/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Carpeting &amp; Wallcovering</u> per audit \$4,001 disallowed	2003	\$ 5,263	\$		\$	\$	\$	37
38	<u>Sheet Vinyl Flooring</u>	2003	1,295						38
39	<u>Carpeting</u>	2003	738						39
40	<u>Metal Doors</u>	2003	5,739						40
41	<u>Kitchen Renov - Stain Steel Wall Plating &amp; Sinks</u>	2004	5,086						41
42	<u>Doors (4) Fire rated</u>	2004	6,608						42
43	<u>Exhauster, Duct Work, &amp; Fire Damper</u>	2004	5,810						43
44	<u>Renov - General Construct. O/H &amp; Int. disallowed per audit</u>	2004							44
45	<u>Renov - Painting</u>	2004	10,565						45
46	<u>Renov - Wall Covering</u>	2004	23,222						46
47	<u>Renov. - Doors &amp; Frames</u>	2004	11,010						47
48	<u>Renov - Drywall &amp; Studs</u>	2004	2,405						48
49	<u>Flooring</u>	2004	30,990						49
50	<u>Ceiling Tile</u>	2004	585						50
51	<u>Awing</u>	2004	2,320						51
52	<u>Flooring</u>	2005	885						52
53	<u>Fire Shutter Door</u>	2005	2,170						53
54	<u>Roofing</u>	2005	17,500						54
55	<u>2005 per audit - Doors for front entrance</u>	2005	8,732						55
56	<u>2005 per audit - Metal Access Doors</u>	2005	3,183						56
57	<u>2005 per audit - Asphalt Driveway, Seal Coat, &amp; Stripe</u>	2005	11,979						57
58	<u>2006 per audit - Electric work for emergency light &amp; feed</u>	2006	894						58
59	<u>2006 per audit - Doors &amp; closers</u>	2006	2,834						59
60									60
61	<u>A/C for Elevator Room</u>	2006	5,960						61
62	<u>Electrical circuits for emergency generator system</u>	2006	8,530						62
63	<u>Electrical circuits - Kitchen &amp; 2nd floor Nurse Station</u>	2006	3,599						63
64									64
65	<u>Renov - Flooring</u>	2007	20,080						65
66	<u>Renov - Wallcovering</u>	2007	1,786						66
67	<u>Renov - Carpentry</u>	2007	2,826						67
68	<u>Renov - Electrical</u>	2007	15,000						68
69	<u>Windows in lounge</u>	2007	3,310						69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 5,027,323	\$ 189,030		\$ 189,030	\$	\$ 4,118,859	70

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

Facility Name & ID Number Manorcare at Oak Lawn/Kostner

# 0027557

Report Period Beginning:

06/01/07

Ending:

05/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,027,323	\$ 189,030		\$ 189,030	\$	\$ 4,118,859	1
2	Roofing	2007	3,500						2
3	Renov - Electrical	2007	2,431						3
4	Renov - Plan Reviews	2007	3,660						4
5	Renov - Flooring	2007	55,865						5
6	Renov - Wallcovering	2007	49,848						6
7	Renov - Architech & Engineering Cost	2008	56,727						7
8	Metal Door	2008	8,440						8
9	Door and Frame	2008	3,177						9
10	Water Heater	2008	22,725						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)		\$ 5,233,696	\$ 189,030		\$ 189,030	\$	\$ 4,118,859	34

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

Facility Name & ID Number Manorcare at Oak Lawn/Kostner # 0027557 Report Period Beginning: 06/01/07 Ending: 05/31/08

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	\$ 2,175,069	\$ 128,680	\$ 128,680	\$		\$ 1,799,900	71
72	Current Year Purchases	292,055						72
73	Fully Depreciated Assets							73
74	Home Office Depr.			29,617	29,617			74
75	TOTALS	\$ 2,467,124	\$ 128,680	\$ 158,297	\$ 29,617		\$ 1,799,900	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENTS	1996 DODGE VAN	1996	\$ 36,664	\$	\$	\$		\$ 36,664	76
77										77
78										78
79										79
80	TOTALS			\$ 36,664	\$	\$	\$		\$ 36,664	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,995,158	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 317,710	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 347,327	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,617	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,955,423	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 110,423 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	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 at Oak Lawn/Kostner # 0027557 Report Period Beginning: 06/01/07 Ending: 05/31/08

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	8620 hrs	\$ 315,485	44	\$ 1,761	\$ 4,692	8,664	\$ 321,938	1
2	Licensed Speech and Language Development Therapist	10a	3015 hrs	110,353	67	2,645	245	3,082	113,243	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	6599 hrs	241,538	1,011	40,036	14,514	7,610	296,088	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				792,044		792,044	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>X-ray &amp; Lab   IV Ther</u>	43, 3 & 2				154,313	169,687		324,000	13
14	<b>TOTAL</b>			\$ 667,376	1,122	\$ 198,755	\$ 981,182	19,356	\$ 1,847,313	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 at Oak Lawn/Kostner# 0027557Report Period Beginning: 06/01/07

Ending:

05/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 05/31/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 22,686	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>388,943</u> )	2,020,283		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,402		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,047,371	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	257,674		13
14	Buildings, at Historical Cost	5,233,696		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,503,788		16
17	Accumulated Depreciation (book methods)	(5,955,423)		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): <u>CIP</u>	84,539		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,124,274	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,171,645	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 66,227	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	633,178		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	501,258		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Payable</u>	227,876		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,428,539	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	53,490		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 53,490	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,482,029	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,689,616	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,171,645	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,441,679	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,441,679	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	385,934	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)	\$ 385,934	17
<b>B. Transfers (Itemize):</b>			
18	Change in Interdivision	(2,137,997)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,137,997)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,689,616	24 *

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

Facility Name & ID Number Manorcare at Oak Lawn/Kostner# 0027557Report Period Beginning: 06/01/07Ending: 05/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,375,694	1
2	Discounts and Allowances for all Levels	(858,730)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,516,964	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,484,944	6
7	Oxygen	6,136	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,491,080	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,792	12
13	Barber and Beauty Care	8,922	13
14	Non-Patient Meals	541	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	861,038	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	73,216	19
20	Radiology and X-Ray	43,079	20
21	Other Medical Services	580	21
22	Laundry	2,411	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 991,579	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc. Income & Purchase Discounts	(35)	28
28a	Late Charges		28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (35)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,999,588	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,204,870	31
32	Health Care	5,991,085	32
33	General Administration	3,288,305	33
<b>B. Capital Expense</b>			
34	Ownership	913,831	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,136,723	35
36	Provider Participation Fee	78,840	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,613,654	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	385,934	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 385,934	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 at Oak Lawn/Kostner

# 0027557

Report Period Beginning:

06/01/07

Ending:

05/31/08

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	686	750	\$ 30,634	\$ 40.85	1
2	Assistant Director of Nursing	5,473	5,977	218,858	36.62	2
3	Registered Nurses	45,517	49,711	1,530,524	30.79	3
4	Licensed Practical Nurses	33,768	36,879	957,734	25.97	4
5	CNAs & Orderlies	84,546	92,522	1,068,874	11.55	5
6	CNA Trainees					6
7	Licensed Therapist	18,234	19,915	728,901	36.60	7
8	Rehab/Therapy Aides	17,641	19,268	370,289	19.22	8
9	Activity Director	5,485	6,016	70,049	11.64	9
10	Activity Assistants					10
11	Social Service Workers	8,368	9,203	217,746	23.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,373	24,669	324,597	13.16	15
16	Dishwashers					16
17	Maintenance Workers	3,828	4,199	78,948	18.80	17
18	Housekeepers	18,305	20,112	200,139	9.95	18
19	Laundry	4,020	4,411	41,080	9.31	19
20	Administrator	2,080	2,080	77,787	37.40	20
21	Assistant Administrator	806	806	30,990	38.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,740	30,862	568,409	18.42	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	1,811	1,987	23,073	11.61	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	875	960	10,125	10.55	33
34	TOTAL (lines 1 - 33)	301,556	330,327	\$ 6,548,757 *	\$ 19.83	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	45,058	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,497	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)		\$ 51,555		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,022	\$ 147,445	10, 3	50
51	Licensed Practical Nurses	88	4,292	10, 3	51
52	Certified Nurse Assistants/Aides			10, 3	52
53	TOTAL (lines 50 - 52)	3,110	\$ 151,737		53





**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 \$11856
- (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 \$3786
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 73,930 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 78,840  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 541
- (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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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.