

Facility Name & ID Number Manorcare of Oak Lawn East

0049668 Report Period Beginning: 06/01/08 Ending: 05/31/09

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	52,560	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	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	9,013	6,091	26,493	41,597		8
9	SNF/PED						9
10	ICF						10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	9,013	6,091	26,493	41,597		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.14%

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 1997

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 21,438

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 of Oak Lawn East # 0049668 Report Period Beginning: 06/01/08 Ending: 05/31/09

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
	A. General Services										
1	Dietary	323,181	28,615	3,980	355,776	3,900	359,676		359,676		1
2	Food Purchase		240,807		240,807		240,807	(385)	240,422		2
3	Housekeeping	194,434	29,532	8,352	232,318		232,318		232,318		3
4	Laundry	46,171	11,854	261	58,286		58,286	(1,836)	56,450		4
5	Heat and Other Utilities			175,588	175,588	7,393	182,981		182,981		5
6	Maintenance	80,749	20,344	82,655	183,748		183,748		183,748		6
7	Other (specify):* Medical Waste			1,501	1,501		1,501		1,501		7
8	TOTAL General Services	644,535	331,152	272,337	1,248,024	11,293	1,259,317	(2,221)	1,257,096		8
	B. Health Care and Programs										
9	Medical Director			41,592	41,592		41,592		41,592		9
10	Nursing and Medical Records	3,826,688	366,083	88,410	4,281,181	6,253	4,287,434		4,287,434		10
10a	Therapy	1,187,892	15,213	370,853	1,573,958		1,573,958		1,573,958		10a
11	Activities	76,120	4,425	1,615	82,160		82,160		82,160		11
12	Social Services	161,672			161,672		161,672		161,672		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,252,372	385,721	502,470	6,140,563	6,253	6,146,816		6,146,816		16
	C. General Administration										
17	Administrative	122,051		568,304	690,355	(126,558)	563,797		563,797		17
18	Directors Fees										18
19	Professional Services			42,148	42,148		42,148	(42,148)			19
20	Dues, Fees, Subscriptions & Promotions			87,271	87,271		87,271	(32,616)	54,655		20
21	Clerical & General Office Expenses	495,210	59,949	505,109	1,060,268		1,060,268	(390,765)	669,503		21
22	Employee Benefits & Payroll Taxes			1,122,746	1,122,746	65,551	1,188,297		1,188,297		22
23	Inservice Training & Education			13,899	13,899		13,899		13,899		23
24	Travel and Seminar			6,135	6,135		6,135		6,135		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			220,853	220,853		220,853		220,853		26
27	Other (specify):*							(48)	(48)		27
28	TOTAL General Administration	617,261	59,949	2,566,465	3,243,675	(61,007)	3,182,668	(465,577)	2,717,091		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,514,168	776,822	3,341,272	10,632,262	(43,461)	10,588,801	(467,798)	10,121,003		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:

06/01/08

Ending:

05/31/09

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					9	10	
	D. Ownership											
30	Depreciation			325,305	325,305	20,180	345,485		345,485			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(625)	(625)	23,281	22,656		22,656			32
33	Real Estate Taxes			521,236	521,236		521,236		521,236			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			148,267	148,267		148,267		148,267			35
36	Other (specify):*											36
37	TOTAL Ownership			994,183	994,183	43,461	1,037,644		1,037,644			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			220	220		220		220			38
39	Ancillary Service Centers		753,262		753,262		753,262		753,262			39
40	Barber and Beauty Shops			10,880	10,880		10,880		10,880			40
41	Coffee and Gift Shops	9,884			9,884		9,884		9,884			41
42	Provider Participation Fee			79,056	79,056		79,056		79,056			42
43	Other (specify):* IV X-Ray & Lab		100,438	109,929	210,367		210,367		210,367			43
44	TOTAL Special Cost Centers	9,884	853,700	200,085	1,063,669		1,063,669		1,063,669			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,524,052	1,630,522	4,535,540	12,690,114		12,690,114	(467,798)	12,222,316			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Manorcare of Oak Lawn East

ID# 0049668

Report Period Beginning: 06/01/08

Ending: 05/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (863)	21	1
2	Misc. Income	(815)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,678)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Oak Lawn East# 0049668

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(385)	0	0	0	0	0	0	0	0	0	0	(385)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,836)	0	0	0	0	0	0	0	0	0	0	(1,836)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,221)	0	(2,221)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(42,148)	0	0	0	0	0	0	0	0	0	0	(42,148)	19
20	Fees, Subscriptions & Promotions	(32,616)	0	0	0	0	0	0	0	0	0	0	(32,616)	20
21	Clerical & General Office Expenses	(390,765)	0	0	0	0	0	0	0	0	0	0	(390,765)	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):*	(48)	0	0	0	0	0	0	0	0	0	0	(48)	27
28	TOTAL General Administration	(465,577)	0	(465,577)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(467,798)	0	(467,798)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Oak Lawn East# 0049668

Report Period Beginning:

06/01/08 Ending:05/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(467,798)	0	0	0	0	0	0	0	0	0	0	(467,798)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	\$ 568,304	HCR Manor Care, Inc.	100.00%	\$ 568,304	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	50,332	Heartland Rehab Services, LLC	100.00%	50,332		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 618,636			\$ 618,636	\$ *	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: 06/01/08 Ending: 05/31/09

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 of Oak Lawn East

0049668

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

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

1	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	2,759,273,494	369 Nurs. Fac.	\$ 1,686	\$ 11,525,868	\$ 7	1	
2	1	Dietary - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,103,816	559,529	11,525,868	3,893	2
3	5	Utilities - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	287,502		11,525,868	1,201	3
4	5	Utilities - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,755,769		11,525,868	6,192	4
5	10	Nursing - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.			11,525,868	0	5
6	10	Nursing - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	1,773,058	1,106,606	11,525,868	6,253	6
7	17	General & Admin - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	30,646,209		11,525,868	128,013	7
8	17	General & Admin - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	88,964,011	51,489,483	11,525,868	313,733	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.	6,188,752		11,525,868	25,852	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	11,257,416		11,525,868	39,699	10
11	30	Depreciation - Direct	Accumulated Cost	2,759,273,494	369 Nurs. Fac.			11,525,868	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,268,346,175	369 Nurs. Fac.	5,722,441		11,525,868	20,180	12
13										13
14	32	Interest				10,928,075			23,281	14
15		Non-Nursing Home Allocations				28,224,463				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 186,853,198	\$ 53,155,618	\$	568,304	25

Facility Name & ID Number

Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/08

Ending:

05/31/09

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Conv. Sub Debentures		X	Facility			\$ 461,443	\$ 461,443		5.0453	\$ 23,281	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8	Interest Income Other										(625)	8							
9	TOTAL Facility Related						\$ 461,443	\$ 461,443			\$ 22,656	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 461,443	\$ 461,443			\$ 22,656	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

1. Real Estate Tax accrual used on 2008 report.		\$	501,258	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.)		\$	541,331	2
3. Under or (over) accrual (line 2 minus line 1).		\$	40,073	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	504,913	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.)		\$	15,861	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 \$ 39,611 For 2005 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(39,611)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	521,236	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	466,076	8	
	2005	504,076	9	
	2006	520,237	10	
	2007	534,299	11	
	2008	544,985	12	
Line 2:	\$541,331 = \$274,181 for 2nd half of 2007 paid in Nov. '08 + \$267,150 for 1st half of 2008 paid in Feb. '09.			
Line 4:	\$504,913 = \$227,077 estimate for Jan-May 2008 + \$277,836 estimate for 2nd half of 2008.			
Line 5:	\$15,861 = \$13,212 Worsek & Vihon LLP (1/3 of the \$39,611 refund) = \$2,500 JSO Valuation Group, LTD for appraisal + \$149 filing fees, Worsek & Vihon LLP			
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning:

06/01/08

Ending:

05/31/09

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:

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

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	144		1977	1977	\$ 2,247,698	\$ 62,437		\$ 62,437		\$ 1,966,607	
5											
6											
7											
8											
	Improvement Type**										
9	Current Year Depreciation					120,782		120,782		2,335,471	
10			1981		18,089						
11			1986		2,797						
12			1988		19,012						
13			1989		14,714						
14			1990		202,653						
15			1991		69,401						
16			1992		114,373						
17			1993		63,254						
18			1994		648,943						
19			1995		220,796						
20			1996		238,261						
21			1997		230,127						
22			1998		319,666						
23			1999		57,192						
24			2000		71,071						
25		Reclass \$2,957 artwork to Equip. Disallow \$17,709	2001		106,534						
26		STEEL GATES FOR DUMSTERS	2002		6,355						
27		WINDOW TREATMENTS	2002		4,782						
28		Renovation - General Construction per audit \$4,171 disallowed	2002		24,092						
29		Renovation - Wallcovering per audit \$10,669 disallowed	2002		61,624						
30		Renovation - HVAC & Electrical per audit \$589 disallowed	2002		3,401						
31		ROOFING ON WEST SECTION	2003		19,000						
32		Sink, Tile, Wallcovering & Paint	2003		20,585						
33		Light Fixtures per audit change year from 2003 to 2002	2003		2,572						
34		Construction Department Cost & Interest Disallowed per audit	2003								
35		Ceramic Floor Tile & Related Concrete Work	2003		19,427						
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:

06/01/08

Ending:

05/31/09

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	Carpeting & Wallcovering per audit \$4,001 disallowed	2003	\$ 5,263	\$		\$	\$	\$	37
38	Sheet Vinyl Flooring	2003	1,295						38
39	Carpeting	2003	738						39
40	Metal Doors	2003	5,739						40
41	Kitchen Renov - Stain Steel Wall Plating & Sinks	2004	5,086						41
42	Doors (4) Fire rated	2004	6,608						42
43	Exhauster, Duct Work, & Fire Damper	2004	5,810						43
44	Renov - General Construct. O/H & Int. disallowed per audit	2004							44
45	Renov - Painting	2004	10,565						45
46	Renov - Wall Covering	2004	23,222						46
47	Renov. - Doors & Frames	2004	11,010						47
48	Renov - Drywall & Studs	2004	2,405						48
49	Flooring	2004	30,990						49
50	Ceiling Tile	2004	585						50
51	Awing	2004	2,320						51
52	Flooring	2005	885						52
53	Fire Shutter Door	2005	2,170						53
54	Roofing	2005	17,500						54
55	2005 per audit - Doors for front entrance	2005	8,732						55
56	2005 per audit - Metal Access Doors	2005	3,183						56
57	2005 per audit - Asphalt Driveway, Seal Coat, & Stripe	2005	11,979						57
58	2006 per audit - Electric work for emergency light & feed	2006	894						58
59	2006 per audit - Doors & closers	2006	2,834						59
60									60
61	A/C for Elevator Room	2006	5,960						61
62	Electrical circuits for emergency generator system	2006	8,530						62
63	Electrical circuits - Kitchen & 2nd floor Nurse Station	2006	3,599						63
64									64
65	Renov - Flooring	2007	20,080						65
66	Renov - Wallcovering	2007	1,786						66
67	Renov - Carpentry	2007	2,826						67
68	Renov - Electrical	2007	15,000						68
69	Windows in lounge	2007	3,310						69
70	TOTAL (lines 4 thru 69)		\$ 5,027,323	\$ 183,219		\$ 183,219	\$	\$ 4,302,078	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:

06/01/08

Ending:

05/31/09

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	\$ 183,219		\$ 183,219	\$	\$ 4,302,078	1
2	Roofing	2007	3,500						2
3	Metal Door	2008	8,440						3
4	Door and Frame	2008	3,177						4
5	Water Heater	2008	22,725						5
6									6
7	Renov. - Architech & Engineering	2007	78,362						7
8	Renov. - Plan Reviews	2007	3,660						8
9	Renov. - Capentry-Subcontractor	2008	713,268						9
10	Renov. - Mill Work	2008	38,340						10
11	Renov. - HM Doors & Frames	2009	5,637						11
12	Renov. - Reslient Flooring	2007	55,865						12
13	Renov. - Wallcovering	2007	51,819						13
14	Renov. - Corner Guards	2009	8,604						14
15	Renov. - Fire Sprinkler System	2007	35,900						15
16	Renov. - Plumbing	2008	6,830						16
17	Renov. - Plumbing Specilities	2009	636						17
18	Renov. - HVAC	2008	8,969						18
19	Renov. - Basic Electrical	2009	23,190						19
20	Renov. - Fire Alarm System	2008	17,940						20
21	Renov. - Nurse Call System	2008	4,647						21
22									22
23	Elevator Door Restrictors	2008	8,100						23
24	Annunciator Panel for Generator	2008	2,969						24
25	Door & Ceiling in Vestibule	2009	11,286						25
26	Door Panic Hardware on service door	2009	2,401						26
27	Sprinkler Heads And Piping	2009	5,277						27
28	Eletrical Work - Explosion Proof	2009	4,338						28
29	DOOR IN VESTIBULE	2009	5,000						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,158,203	\$ 183,219		\$ 183,219	\$	\$ 4,302,078	34

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

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	\$ 2,467,124	\$ 142,086	\$ 142,086	\$		\$ 1,941,986	71
72	Current Year Purchases	190,488						72
73	Fully Depreciated Assets							73
74				20,180	20,180			74
75	TOTALS	\$ 2,657,612	\$ 142,086	\$ 162,266	\$ 20,180		\$ 1,941,986	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,110,153	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 325,305	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 345,485	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,180	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,280,728	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Various	\$ 13,907	92
93			93
94			94
95		\$ 13,907	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	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: _____ *

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

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 148,004 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

YES NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

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>
--	---	--

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)	
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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	9283	hrs	\$ 358,434	98	\$ 4,292	\$ 3,535	9,381	\$ 366,261	1
2	Licensed Speech and Language Development Therapist	10a	3553	hrs	137,197	45	1,992	433	3,598	139,622	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	4832	hrs	186,558	5,886	257,814	11,245	10,718	455,617	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 prescripts				753,262		753,262	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>IV Therapy</u>	43, 2						100,438		100,438	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					109,929			109,929	13
14	TOTAL				\$ 682,189	6,029	\$ 374,027	\$ 868,913	23,697	\$ 1,925,129	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: **06/01/08**

Ending:

05/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **05/31/09**

(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	\$ (131,901)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>595,632</u>)	2,197,096		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,405		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,069,600	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	257,674		13
14	Buildings, at Historical Cost	6,158,203		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,694,276		16
17	Accumulated Depreciation (book methods)	(6,280,728)		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>	13,907		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,843,332	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,912,932	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 171,153	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	688,724		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	504,913		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payable</u>	80,651		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,445,441	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	58,751		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 58,751	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,504,192	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,408,740	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,912,932	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,689,616	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,689,616	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,356,346	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,356,346	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(1,637,222)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,637,222)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,408,740	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning: 06/01/08

Ending: 05/31/09

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,877,463	1
2	Discounts and Allowances for all Levels	(1,070,267)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,807,196	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,271,078	6
7	Oxygen	7,916	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,278,994	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	911	12
13	Barber and Beauty Care	12,015	13
14	Non-Patient Meals	385	14
15	Telephone, Television and Radio	23	15
16	Rental of Facility Space		16
17	Sale of Drugs	830,229	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	62,737	19
20	Radiology and X-Ray	43,586	20
21	Other Medical Services	7,733	21
22	Laundry	1,836	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 959,455	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discounts	815	28
28a	Late Charges		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 815	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,046,460	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,248,024	31
32	Health Care	6,140,563	32
33	General Administration	3,243,675	33
B. Capital Expense			
34	Ownership	994,183	34
C. Ancillary Expense			
35	Special Cost Centers	984,613	35
36	Provider Participation Fee	79,056	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,690,114	40
41	Income before Income Taxes (line 30 minus line 40)**	2,356,346	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,356,346	43

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

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

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

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

Facility Name & ID Number **Manorcare of Oak Lawn East**

0049668

Report Period Beginning: **06/01/08**

Ending:

05/31/09

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		\$	\$	1	
2	Assistant Director of Nursing	6,710	7,312	273,279	37.37	2
3	Registered Nurses	46,776	50,969	1,618,244	31.75	3
4	Licensed Practical Nurses	28,781	31,361	837,257	26.70	4
5	CNAs & Orderlies	83,769	91,486	1,075,308	11.75	5
6	CNA Trainees					6
7	Licensed Therapist	17,668	19,253	743,405	38.61	7
8	Rehab/Therapy Aides	19,835	21,615	444,487	20.56	8
9	Activity Director	5,480	5,974	76,120	12.74	9
10	Activity Assistants					10
11	Social Service Workers	6,090	6,715	161,672	24.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,720	23,896	323,181	13.52	15
16	Dishwashers					16
17	Maintenance Workers	3,748	4,088	80,749	19.75	17
18	Housekeepers	17,103	18,659	194,434	10.42	18
19	Laundry	4,285	4,675	46,171	9.88	19
20	Administrator	2,080	2,080	92,579	44.51	20
21	Assistant Administrator	766	766	29,472	38.48	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,157	30,049	495,210	16.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,729	1,888	22,600	11.97	31
32	Other Health Care(specify)					32
33	Other(specify) B&B, Hospitality	831	906	9,884	10.91	33
34	TOTAL (lines 1 - 33)	294,528	321,692	\$ 6,524,052 *	\$ 20.28	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	41,592	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,165	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	47,757		49

C. CONTRACT NURSES

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

Facility Name & ID Number Manorcare of Oak Lawn East

0049668

Report Period Beginning: 06/01/08

Ending: 05/31/09

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 \$10576
- (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 \$5940
- (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. \$ 73,319 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. \$ 79,056
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. \$ 385
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.