

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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

<p>I. IDPH License ID Number: <u>0049668</u></p> <p>Facility Name: <u>Manor Care of Oak Lawn (East) IL, LLC</u></p> <p>Address: <u>9401 S. Kostner Ave.</u> <u>Oak Lawn</u> <u>60453</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 423-7882</u> Fax # <u>(708) 423-7947</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1977</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Gary Geise</u> Telephone Number: <u>(419) 252-5731</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/10</u> to <u>05/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u></td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Barry A. Lazarus</u> (Title) <u>Vice President, Reimbursement</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Manor Care of Oak Lawn (East) IL, LLC

0049668 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	<u>122</u>	Skilled (SNF)	<u>122</u>	<u>44,530</u>	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	<u>122</u>	TOTALS	<u>122</u>	<u>44,530</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>9,072</u>	<u>3,756</u>	<u>29,669</u>	<u>42,497</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,072</u>	<u>3,756</u>	<u>29,669</u>	<u>42,497</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.43%

D. How many bed-hold days during this year were paid by the Department? 1 (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 04/07/11 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 122 and days of care provided 23,240

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 Manor Care of Oak Lawn (East) IL, LLC # 0049668 Report Period Beginning: 06/01/10 Ending: 05/31/11

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	389,753	35,323	2,273	427,349	11,984	439,333		439,333		1
2	Food Purchase		295,388		295,388		295,388	(381)	295,007		2
3	Housekeeping	176,281	33,644	2,550	212,475		212,475		212,475		3
4	Laundry	64,168	23,256	515	87,939		87,939		87,939		4
5	Heat and Other Utilities			165,084	165,084	3,231	168,315		168,315		5
6	Maintenance	56,062	20,880	101,548	178,490		178,490		178,490		6
7	Other (specify):* Medical Waste			1,547	1,547		1,547		1,547		7
8	TOTAL General Services	686,264	408,491	273,517	1,368,272	15,215	1,383,487	(381)	1,383,106		8
	B. Health Care and Programs										
9	Medical Director			48,524	48,524		48,524		48,524		9
10	Nursing and Medical Records	4,113,321	461,722	175,819	4,750,862	14,216	4,765,078		4,765,078		10
10a	Therapy	1,328,522	21,227	802,416	2,152,165		2,152,165		2,152,165		10a
11	Activities	86,480	4,694	1,655	92,829		92,829		92,829		11
12	Social Services	201,488	41	92	201,621		201,621		201,621		12
13	CNA Training										13
14	Program Transportation			262	262		262		262		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,729,811	487,684	1,028,768	7,246,263	14,216	7,260,479		7,260,479		16
	C. General Administration										
17	Administrative	107,827		634,881	742,708	(123,699)	619,009		619,009		17
18	Directors Fees										18
19	Professional Services			66,163	66,163	(546)	65,617	(65,617)			19
20	Dues, Fees, Subscriptions & Promotions			91,905	91,905		91,905	(38,193)	53,712		20
21	Clerical & General Office Expenses	474,054	76,672	218,183	768,909	546	769,455	(119,000)	650,455		21
22	Employee Benefits & Payroll Taxes			1,281,181	1,281,181	54,595	1,335,776		1,335,776		22
23	Inservice Training & Education			2,356	2,356		2,356		2,356		23
24	Travel and Seminar			3,533	3,533		3,533		3,533		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			364,745	364,745		364,745		364,745		26
27	Other (specify):*										27
28	TOTAL General Administration	581,881	76,672	2,662,947	3,321,500	(69,104)	3,252,396	(222,810)	3,029,586		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,997,956	972,847	3,965,232	11,936,035	(39,673)	11,896,362	(223,191)	11,673,171		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 Manor Care of Oak Lawn (East) IL, LLC

#0049668

Report Period Beginning:

06/01/10

Ending:

05/31/11

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			417,112	417,112	18,929	436,041		436,041		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			208,068	208,068	20,744	228,812	(210,265)	18,547		32
33	Real Estate Taxes			561,643	561,643		561,643		561,643		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			108,231	108,231		108,231		108,231		35
36	Other (specify):*										36
37	TOTAL Ownership			1,295,054	1,295,054	39,673	1,334,727	(210,265)	1,124,462		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			768	768		768		768		38
39	Ancillary Service Centers		868,311	500	868,811		868,811		868,811		39
40	Barber and Beauty Shops			12,037	12,037		12,037		12,037		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			60,789	60,789		60,789		60,789		42
43	Other (specify):* IV X-Ray & Lab		176,741	235,215	411,956		411,956		411,956		43
44	TOTAL Special Cost Centers		1,045,052	309,309	1,354,361		1,354,361		1,354,361		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,997,956	2,017,899	5,569,595	14,585,450		14,585,450	(433,456)	14,151,994		45

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

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(381)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,250)	21		18
19	Entertainment				19
20	Contributions	(1,000)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(65,617)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,604)	21		24
25	Fund Raising, Advertising and Promotional	(38,193)	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	(229,282)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (433,456)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (433,456)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Manor Care of Oak Lawn (East) IL, LLC

ID# 0049668

Report Period Beginning: 06/01/10

Ending: 05/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Wages - Marketing	\$ (13,731)	21	1
2	Employee benefits - Marketing	(4,128)	21	2
3	HCP Lease Interest	(210,265)	32	3
4	Vending Income	(1,017)	21	4
5	Misc. Income	(141)	21	5
6	Activity Income	0	11	6
7	Loss on Disposal of Fixed Assets	0	36	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	(229,282)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manor Care of Oak Lawn (East) IL, LLC# 0049668

Report Period Beginning:

06/01/10

Ending:

05/31/11

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	(381)	0	0	0	0	0	0	0	0	0	0	(381)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(381)	0	(381)	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	(65,617)	0	0	0	0	0	0	0	0	0	0	(65,617)	19
20	Fees, Subscriptions & Promotions	(38,193)	0	0	0	0	0	0	0	0	0	0	(38,193)	20
21	Clerical & General Office Expenses	(119,000)	0	0	0	0	0	0	0	0	0	0	(119,000)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(222,810)	0	(222,810)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(223,191)	0	(223,191)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manor Care of Oak Lawn (East) IL, LLC# 0049668

Report Period Beginning:

06/01/10

Ending:

05/31/11

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	(210,265)	0	0	0	0	0	0	0	0	0	0	(210,265)	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	(210,265)	0	0	0	0	0	0	0	0	0	0	(210,265)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(433,456)	0	0	0	0	0	0	0	0	0	0	(433,456)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR Manor Care, LLC	100			HCR Manor Care Svcs	Toledo	home office
				HL Empl Svcs, LLC	Toledo	personnel
				HL Rehab Svcs, LLC	Toledo	therapy mgmt svcs
				HL Rehab Svcs, LLC	Toledo	therapy services
				HL Home Health Care	Toledo	nursing staff
		See PG6-Supp for list of related nursing homes in Illinois				

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 Office Allocation	\$ 634,881	HCR Manor Care Services, LLC	100.00%	\$ 634,881	\$	1
2	V	Page 8						2
3	V							3
4	V	1-44 Personnel	6,997,956	Heartland Employment Services, LLC	100.00%	6,997,956		4
5	V	10a Therapy Management	11,003	Heartland Rehabilitation Services, LLC	100.00%	11,003		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 7,643,840			\$ 7,643,840	\$ *	14

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

Facility Name & ID Number

Manor Care of Oak Lawn (East) IL, LLC

0049668

Report Period Beginning:

06/01/10

Ending:

05/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Heartland of Canton IL, LLC	Canton				1
2			Heartland of Champaign IL, LLC	Champaign				2
3			Heartland of Decatur IL, LLC	Decatur				3
4			Heartland of Galesburg IL, LLC	Galesburg				4
5			Heartland of Henry IL, LLC	Henry				5
6			Heartland of Macomb IL, LLC	Macomb				6
7			Heartland of Moline IL, LLC	Moline				7
8			Heartland of Normal IL, LLC	Normal				8
9			Heartland of Paxton IL, LLC	Paxton				9
10			Heartland of Peoria IL, LLC	Peoria				10
11			Heartland-Riverview of East Peoria IL (SNF), L	East Peoria				11
12			Manor Care at Arlington Heights	Arlington Heights				12
13			Manor Care of Elgin IL, LLC	Elgin				13
14			Manor Care of Elk Grove Village IL, LLC	Elk Grove Village				14
15			Manor Care - Highland Park	Highland Park				15
16			Manor Care of Hinsdale IL, LLC	Hinsdale				16
17			Manor Care of Homewood IL, LLC	Homewood				17
18			Manor Care of Kankakee IL, LLC	Kankakee				18
19			Manor Care of Libertyville IL, LLC	Libertyville				19
20			Manor Care of Naperville IL, LLC	Naperville				20
21			Manor Care of Northbrook IL, LLC	Northbrook				21
22			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				22
23			Manor Care of Palos Heights IL, LLC	Palos Heights				23
24			Manor Care of Palos Heights (West) IL, LLC	Palos Heights				24
25			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				25
26			Manor Care of South Holland IL, LLC	South Holland				26
27			Manor Care of Westmont IL, LLC	Westmont				27
28			Manor Care of Wilmette IL, LLC	Wilmette				28
29			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				29
30			Arden Courts of Geneva IL, LLC	Geneva				30

Facility Name & ID Number Manor Care of Oak Lawn (East) IL, LLC # 0049668 Report Period Beginning: 06/01/10 Ending: 05/31/11

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 Manor Care of Oak Lawn (East) IL, LLC

0049668

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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 Services, LLC
 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 to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	\$ 2,652,139	\$ 1,448,591	13,182,039	\$ 11,984	1
2	1	Dietary - Direct to Central Divisio	Accumulated Cost	692,663,974	92NFs	0	0	13,182,039	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	0	0	13,182,039	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	0	0	13,182,039	0	4
5	5	Utilities - Direct to Central Divisio	Accumulated Cost	692,663,974	92NFs	0	0	13,182,039	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	817,551	0	13,182,039	3,231	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	2,699,818	1,331,445	13,182,039	12,200	7
8	10	Nursing - Direct to Central Divisio	Accumulated Cost	692,663,974	92NFs	0	0	13,182,039	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	510,057	376,446	13,182,039	2,016	9
10	17	General & Admin - Direct to All S	Accumulated Cost	2,917,243,659	353 NFs	24,740,566	19,625,790	13,182,039	111,794	10
11	17	General & Admin - Direct to Cent	Accumulated Cost	692,663,974	92NFs	1,871,124	5,027,701	13,182,039	35,609	11
12	17	General & Admin - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	92,052,254	34,999,867	13,182,039	363,779	12
13	22	Employee Benefits - Direct to All S	Accumulated Cost	2,917,243,659	353 NFs	7,290,309	0	13,182,039	32,942	13
14	22	Employee Benefits - Direct to Cent	Accumulated Cost	692,663,974	92NFs	0	0	13,182,039	0	14
15	22	Employee Benefits - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	5,479,146	0	13,182,039	21,653	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,917,243,659	353 NFs	285,954	0	13,182,039	1,292	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	692,663,974	92NFs	0	0	13,182,039	0	17
18	30	Depreciation - Pooled	Accumulated Cost	3,335,641,627	727 NFs, HHs, & Re	4,462,801	0	13,182,039	17,637	18
19										19
20	32	Directly Assigned Interest				12,736,052			20,744	20
21		Non Central Division Nursing Home Allocation				29,513,406				21
22										22
23										23
24										24
25	TOTALS					\$ 185,111,177	\$ 62,809,840		\$ 634,881	25

Facility Name & ID Number

Manor Care of Oak Lawn (East) IL, LLC

0049668

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Conv. Sub Debentures		X	Various				\$ 461,443	\$ 461,443		4.4955	\$ 20,744	1							
2													2							
3													3							
4													4							
5													5							
Working Capital																				
6													6							
7													7							
8	Interest Income Other											(2,197)	8							
9	TOTAL Facility Related						\$ 461,443	\$ 461,443				\$ 18,547	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				\$ 18,547	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 2010 report.	\$	555,294	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.)	\$	635,358	2
3. Under or (over) accrual (line 2 minus line 1).	\$	80,064	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	514,049	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.)	\$	10,490	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 \$ 42,961 For 2007 & 2000 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(42,960)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	561,643	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	520,237	8
	2007	534,299	9
	2008	537,091	10
	2009	600,486	11
	2010	595,989	12

Line 2: \$635,358 = \$305,089 for 2nd half of 2009 + \$330,269 for the 1st half of 2010 paid in Feb. 2011.

Line 4: \$514,049 = \$265,720 2nd half 2010 + \$248,329 for Jan-May 2011.

Line 6: \$42,960 = \$41,926.69 for 2007 + \$1,033.88 for 2000.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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 Manor Care of Oak Lawn (East) IL, LLC

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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).

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 and Improvement Costs-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	122		1977	1977	\$ 2,247,698	\$ 62,436		\$ 62,436	\$	\$ 2,091,479	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					185,026		185,026		2,696,159	9
10			1981		18,089						10
11			1986		2,797						11
12			1988		19,012						12
13			1989		14,714						13
14			1990		202,653						14
15			1991		69,401						15
16			1992		114,373						16
17			1993		63,254						17
18			1994		648,943						18
19			1995		220,796						19
20			1996		238,261						20
21			1997		230,127						21
22			1998		319,666						22
23			1999		57,192						23
24			2000		71,071						24
25			2001		106,534						25
26			2002		6,355						26
27			2002		4,782						27
28			2002		24,092						28
29			2002		61,624						29
30			2002		3,401						30
31			2003		19,000						31
32			2003		20,585						32
33			2003		2,572						33
34			2003								34
35			2003		19,427						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Manor Care of Oak Lawn (East) IL, LLC

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XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 247,462		\$ 247,462	\$	\$ 4,787,638	70

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

Facility Name & ID Number Manor Care of Oak Lawn (East) IL, LLC

0049668

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XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 247,462		\$ 247,462	\$	\$ 4,787,638	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	\$ 247,462		\$ 247,462	\$	\$ 4,787,638	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward		\$ 6,158,203	\$ 247,462		\$ 247,462	\$	\$ 4,787,638	1
2	Renov. - Carpentry-Subcontractor	2009	230,010						2
3	Renov. - Corner Guards	2009	793						3
4	Renov. - Basic Electrical	2009	12,590						4
5	Renov. - Arch & Engineer	2007	(547)						5
6	Metal Soffit on Front Porch	2009	22,019						6
7	Renov. Elevator Upgrade	2009	56,360						7
8	Renov. - Fire Spinklers	2009	21,042						8
9	Renov. - Basic Electrical	2009	5,486						9
10	Renov. Elevator Upgrade-Smoke Detectors	2009	3,187						10
11	Add Hand railings in 3 Stairwells	2010	11,330						11
12									12
13	Seal coat parking lot	2010	8,527						13
14	Sprinkler Heads (3 stair landings)	2010	3,297						14
15	Renov. - Ductwork & Fire Dampers	2010	240,695						15
16	Fire Dampers (2)	2010	15,295						16
17	HM Doors	2010	6,405						17
18	7.5 ton Rooftop compressor	2011	20,488						18
19	Renov. - Roof Replacement	2011	203,010						19
20	Painting & Wall Covering (1st FL PAT RMS)	2011	6,900						20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,025,090	\$ 247,462		\$ 247,462	\$	\$ 4,787,638	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,767,370	\$ 169,650	\$ 169,650	\$		\$ 2,266,056	71
72	Current Year Purchases	184,681						72
73	Fully Depreciated Assets							73
74	Allocated H.O. Depr. (see page 8)			18,929	18,929			74
75	TOTALS	\$ 2,952,051	\$ 169,650	\$ 188,579	\$ 18,929		\$ 2,266,056	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	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)	\$ 10,271,479	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 417,112	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 436,041	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,929	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,090,358	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	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? YES NO

16. Rental Amount for movable equipment: \$ 108,231 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			\$ _____	\$ _____	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. _____/2012 \$ _____

13. _____/2013 \$ _____

14. _____/2014 \$ _____

* 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, 1	9,020	hrs	\$ 358,231	3,585	\$ 163,470	\$ 5,254	12,605	\$ 526,955	1
2	Licensed Speech and Language Development Therapist	10a, 1	4,571	hrs	181,547	762	34,746	274	5,333	216,567	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	5,982	hrs	237,615	10,900	497,039	15,699	16,882	750,353	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				868,311		868,311	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						176,741		176,741	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3					235,215			235,215	13
14	TOTAL				\$ 777,393	15,247	\$ 930,470	\$ 1,066,279	34,820	\$ 2,774,142	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 Manor Care of Oak Lawn (East) IL, LLC

0049668

Report Period Beginning: 06/01/10

Ending: 05/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/11

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,727	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>490,892</u>)	2,674,634		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,576		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,682,937	\$	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	7,025,090		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,988,715		16
17	Accumulated Depreciation (book methods)	(7,090,358)		17
18	Deferred Charges	13,499,579		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>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,680,700	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,363,637	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 296,554	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	750,043		30
31	Accrued Taxes Payable (excluding real estate taxes)	107,389		31
32	Accrued Real Estate Taxes(Sch.IX-B)	514,049		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payables</u>	174,699		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,842,734	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	35,626,707		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	6,727		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 35,633,434	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 37,476,168	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (18,112,531)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,363,637	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,875,863	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,875,863	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,219,502	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 4,219,502	17
	B. Transfers (Itemize):		
18	Change in Interdivison	(25,207,896)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (25,207,896)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (18,112,531)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manor Care of Oak Lawn (East) IL, LLC

0049668

Report Period Beginning: 06/01/10

Ending: 05/31/11

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	\$ 19,023,242	1
2	Discounts and Allowances for all Levels	(6,312,655)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,710,587	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,003,151	6
7	Oxygen	2,267	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,005,418	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,017	12
13	Barber and Beauty Care	11,790	13
14	Non-Patient Meals	381	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	869,976	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	108,222	19
20	Radiology and X-Ray	55,805	20
21	Other Medical Services	40,686	21
22	Laundry	929	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,088,806	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	141	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 141	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,804,952	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,368,272	31
32	Health Care	7,246,263	32
33	General Administration	3,321,500	33
B. Capital Expense			
34	Ownership	1,295,054	34
C. Ancillary Expense			
35	Special Cost Centers	1,293,572	35
36	Provider Participation Fee	60,789	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,585,450	40
41	Income before Income Taxes (line 30 minus line 40)**	4,219,502	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,219,502	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 **Manor Care of Oak Lawn (East) IL, LLC**

0049668

Report Period Beginning:

06/01/10

Ending:

05/31/11

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	1,709	1,862	\$ 72,031	\$ 38.68	1
2	Assistant Director of Nursing	4,840	5,273	191,531	36.32	2
3	Registered Nurses	47,471	51,718	1,693,930	32.75	3
4	Licensed Practical Nurses	30,226	32,930	878,818	26.69	4
5	CNAs & Orderlies	94,639	103,266	1,251,111	12.12	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	19,574	21,292	845,642	39.72	7
8	Rehab/Therapy Aides	19,643	21,368	482,880	22.60	8
9	Activity Director	5,931	6,469	86,480	13.37	9
10	Activity Assistants					10
11	Social Service Workers	8,109	8,839	201,488	22.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,746	29,158	389,753	13.37	15
16	Dishwashers					16
17	Maintenance Workers	1,993	2,173	56,062	25.80	17
18	Housekeepers	15,119	16,479	176,281	10.70	18
19	Laundry	5,610	6,113	64,168	10.50	19
20	Administrator	2,080	2,080	107,827	51.84	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,027	25,074	456,195	18.19	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	1,914	2,087	25,900	12.41	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	308,631	336,181	\$ 6,980,097 *	\$ 20.76	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	48,524	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	175	9,218	10, 1	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)	175	\$ 57,742		49

C. CONTRACT NURSES

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

Facility Name & ID Number Manor Care of Oak Lawn (East) IL, LLC

0049668

Report Period Beginning: 06/01/10

Ending: 05/31/11

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 \$5006
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 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? Yes
If YES, give effective date of lease. 04/07/11
- (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. \$ 60,789
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. \$ 381
- (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.