

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0049437

Facility Name: Manorcare of Homewood

Address: 940 Maple Ave Homewood 60430
Number City Zip Code

County: Cook

Telephone Number: (708) 799-0244 Fax # (708) 799-1505

HFS ID Number:

Date of Initial License for Current Owners: 06/18/90

Type of Ownership:

VOLUNTARY,NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Gary Geise Telephone Number: 419-252-5731
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid
Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Manorcare of Homewood# 0049437 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 5/17/2012

	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>120</u>	Skilled (SNF)	<u>132</u>	<u>46,680</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>120</u>	TOTALS	<u>132</u>	<u>46,680</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,366</u>	<u>2,064</u>	<u>17,366</u>	<u>37,796</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>18,366</u>	<u>2,064</u>	<u>17,366</u>	<u>37,796</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.97%

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?

YesG. 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 06/18/90

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 04/07/2011NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 132 and days of care provided 12,937Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31Fiscal Year: 12/31

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

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	294,494	21,242	3,005	318,741		318,741		318,741			1
2	Food Purchase		255,461		255,461		255,461	(283)	255,178			2
3	Housekeeping	126,375	19,966	2,964	149,305		149,305		149,305			3
4	Laundry	40,482	19,577		60,059		60,059	(2)	60,057			4
5	Heat and Other Utilities			193,491	193,491	2,303	195,794		195,794			5
6	Maintenance	46,323	7,688	150,354	204,365		204,365		204,365			6
7	Other (specify):* Medical Waste			1,328	1,328		1,328		1,328			7
8	TOTAL General Services	507,674	323,934	351,142	1,182,750	2,303	1,185,053	(285)	1,184,768			8
	B. Health Care and Programs											
9	Medical Director			24,839	24,839		24,839		24,839			9
10	Nursing and Medical Records	2,856,136	290,591	71,230	3,217,957	14,351	3,232,308		3,232,308			10
10a	Therapy	1,180,600	5,771	204,204	1,390,575		1,390,575		1,390,575			10a
11	Activities	70,073	2,202	2,128	74,403		74,403		74,403			11
12	Social Services	203,312	60		203,372		203,372		203,372			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,310,121	298,624	302,401	4,911,146	14,351	4,925,497		4,925,497			16
	C. General Administration											
17	Administrative	87,408		545,947	633,355	(234,331)	399,024		399,024			17
18	Directors Fees											18
19	Professional Services			39,162	39,162		39,162	(35,643)	3,519			19
20	Dues, Fees, Subscriptions & Promotions			49,571	49,571		49,571	(26,555)	23,016			20
21	Clerical & General Office Expenses	388,091	51,144	715,040	1,154,275		1,154,275	(672,527)	481,748			21
22	Employee Benefits & Payroll Taxes			816,562	816,562	44,448	861,010		861,010			22
23	Inservice Training & Education			1,701	1,701		1,701		1,701			23
24	Travel and Seminar			1,757	1,757		1,757		1,757			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			668,486	668,486		668,486		668,486			26
27	Other (specify):*											27
28	TOTAL General Administration	475,499	51,144	2,838,226	3,364,869	(189,883)	3,174,986	(734,725)	2,440,261			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,293,294	673,702	3,491,769	9,458,765	(173,229)	9,285,536	(735,010)	8,550,526			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			370,832	370,832	16,323	387,155		387,155			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,052,722	1,052,722	156,906	1,209,628	(1,055,711)	153,917			32
33	Real Estate Taxes			592,147	592,147		592,147		592,147			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,441	33,441		33,441		33,441			35
36	Other (specify):*											36
37	TOTAL Ownership			2,049,142	2,049,142	173,229	2,222,371	(1,055,711)	1,166,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		359,175	143	359,318		359,318		359,318			39
40	Barber and Beauty Shops			13,178	13,178		13,178		13,178			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			328,623	328,623		328,623		328,623			42
43	Other (specify):* IV, X-ray& Lab		80,334	80,486	160,820		160,820		160,820			43
44	TOTAL Special Cost Centers		439,509	422,430	861,939		861,939		861,939			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,293,294	1,113,211	5,963,341	12,369,846		12,369,846	(1,790,721)	10,579,125			45

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

		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	(283)	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	(2)	4		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	(69)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(35,643)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(633,536)	21		24
25	Fund Raising, Advertising and Promotional	(26,555)	20		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached pg 5A	(1,094,633)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,790,721)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,790,721)		37

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

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

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

Manorcare of Homewood

Report Period Beginning:

Ending:

ID#0049437

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Wages - Marketing	\$ (30,431)	21	1
2	P/R O/H Alloc- Mktg	(7,820)	21	2
3	HCP Lease Interest	(1,055,711)	32	3
4	Vending Income	(671)	21	4
5	Misc Income		21	5
6	Activity Income		11	6
7	Loss on disposal of Fixed Asset		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	(1,094,633)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Homewood # 0049437 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	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	(283)	0	0	0	0	0	0	0	0	0	0	(283)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2)	0	0	0	0	0	0	0	0	0	0	(2)	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	(285)	0	0	0	0	0	0	0	0	0	0	(285)	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	(35,643)	0	0	0	0	0	0	0	0	0	0	(35,643)	19
20	Fees, Subscriptions & Promotions	(26,555)	0	0	0	0	0	0	0	0	0	0	(26,555)	20
21	Clerical & General Office Expenses	(672,527)	0	0	0	0	0	0	0	0	0	0	(672,527)	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	(734,725)	0	0	0	0	0	0	0	0	0	0	(734,725)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(735,010)	0	0	0	0	0	0	0	0	0	0	(735,010)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,055,711)	0	0	0	0	0	0	0	0	0	0	(1,055,711)	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	(1,055,711)	0	0	0	0	0	0	0	0	0	0	(1,055,711)	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)	(1,790,721)	0	0	0	0	0	0	0	0	0	0	(1,790,721)	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 Svc	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 Heath Care	Toledo	Nursing Staff
		See Pg 6 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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 545,947	HCR Manor Care Services, LLC	100.00%	\$ 545,947	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	5,293,294	Heartland Employment Services, LLC	100.00%	5,293,294		4
5	V	10a	Therapy Management	14,179	Heartland Rehab Services, LLC	100.00%	14,179		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			\$ 5,853,420			\$ 5,853,420	\$ *	14

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

Facility Name & ID Number

Manorcare of Homewood

0049437

Report Period Beginning:

01/01/12

Ending:

12/31/12

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, LLC	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								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 (East) IL, LLC	Oak Lawn				22
23			Manor Care of Oak Lawn (West) IL, LLC	Oak Lawn				23
24			Manor Care of Palos Heights West IL, LLC	Palos Heights				24
25			Manor Care of Palos Heights IL, LLC	Palos Heights				25
26			Manor Care of Rolling Meadows IL, LLC	Rolling Meadows				26
27			Manor Care of South Holland IL, LLC	South Holland				27
28			Manor Care of Westmont IL, LLC	Westmont				28
29			Manor Care of Wilmette IL, LLC	Wilmette				29
30			Arden Courts of Elk Grove Village IL, LLC	Elk Grove Village				30

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			Arden Courts of Geneva IL, LLC	Geneva				1
2			Arden Courts of Glen Ellyn IL, LLC	Glen Ellyn				2
3			Arden Courts of Hazel Crest IL, LLC	Hazel Crest				3
4			Arden Courts of Northbrook IL, LLC	Northbrook				4
5			Arden Courts of Palos Heights IL, LLC	Palos Heights				5
6			Arden Courts of South Holland IL, LLC	South Holland				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

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

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 Services, LLC
Street Address 333 North Summit Street
City / State / Zip Code Toledo, OH 43604-2617
Phone Number (419-252-5500
Fax Number (419-254-5495

	1	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	5	Utilities - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	\$ 748,673	\$ 0	12,302,614	\$ 2,303	1
2	5	Utilities - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs		0	12,302,614	0	2
3	5	Utilities - Direct to Midwest Division	Accumulated Cost	517,936,312	48 NFs		0	12,302,614	0	3
4	10	Nursing - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	419,407	305,829	12,302,614	1,291	4
5	10	Nursing - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	3,769,374	11,422,621	12,302,614	13,060	5
6	10	Nursing - Direct to Midwest Division	Accumulated Cost	517,936,312	48 NFs			12,302,614	0	6
7	17	General & Administrative - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	66,682,648	33,182,703	12,302,614	205,118	7
8	17	General & Administrative - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	18,146,595	4,833,950	12,302,614	62,876	8
9	17	General & Administrative - Direct to Midwest Division	Accumulated Cost	517,936,312	48 NFs	1,836,474	1,251,308	12,302,614	43,622	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	7,480,805	0	12,302,614	23,011	10
11	22	Employee Benefits - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	6,187,019	0	12,302,614	21,437	11
12	22	Employee Benefits - Direct to Midwest Division	Accumulated Cost	517,936,312	48 NFs		0	12,302,614	0	12
13	30	Depreciation - Pooled	Accumulated Cost	3,999,514,966	682 NFs, HHs, & R	4,579,765	0	12,302,614	14,087	13
14	30	Depreciation - Direct to All SNFs	Accumulated Cost	3,550,656,576	354 NFs	645,474	0	12,302,614	2,236	14
15	30	Depreciation - Direct to Midwest Division	Accumulated Cost	517,936,312	48 NFs		0	12,302,614	0	15
16										16
17										17
18	32	Pooled Interest	Accumulated Cost	3,999,514,966		25,871,304		12,302,614	79,581	18
19	32	Directly Assigned Interest	Not Allocated			18,513,013			77,325	19
20										20
21		H/O Costs Allocated to Non-SNFs and Other Divisions				30,612,518				21
22										22
23										23
24										24
25	TOTALS					\$ 185,493,069	\$ 50,996,411		\$ 545,947	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	Various		X	Facility		4/2004	\$ 1,183,314	\$ 1,183,314		0.0653	\$ 77,325	1		
2												2		
3												3		
4												4		
5												5		
	Working Capital													
6												6		
7	Home Office Pooled Interest										79,581	7		
8	Interest Income Other										(2,989)	8		
9	TOTAL Facility Related						\$ 1,183,314	\$ 1,183,314			\$ 153,917	9		
	B. Non-Facility Related*													
10												10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$	14		
15	TOTALS (line 9+line14)						\$ 1,183,314	\$ 1,183,314			\$ 153,917	15		

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 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 2011 report.			\$	450,745	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.)			\$	519,722	2
3. Under or (over) accrual (line 2 minus line 1).			\$	68,977	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	519,722	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.)			\$	3,500	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 \$ (52) For 2010 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(52)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	592,147	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	377,943	8	
		2008	409,305	9	
		2009	409,305	10	
		2010	450,745	11	
		2011	519,722	12	
Line 5-Byrnes, Houlihan & Walsh LLC-2011 appraisal fee for real estate tax appeal.					
Line 6-First Class Inc-Additional interest, plus judgment interest on the additional interest on a real estate tax refund.					
		FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2011	\$			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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Manorcare of Homewood

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0049437

CONTACT PERSON REGARDING THIS REPORT
Gary Geise

TELEPHONE
419-252-5731

FAX #:
419-254-5495

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	29-32-200-046-0000	See Attached	\$ 519,722.22	\$ 519,722.22
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 519,722.22	\$ 519,722.22

B.
Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	42,369	B. General Construction Type:	Exterior	Masonry	Frame	Wood	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	----------------	--------------	-------------	--------------------------	----------

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).

N/A

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

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ **4. Dates Incurred:** _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1990	\$ 383,373	1
2					2
3	TOTALS			\$ 383,373	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		1990		\$ 2,845,251	\$ 71,046		\$ 71,046	\$	\$ 1,601,555	4
5	12		2012								5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					171,080		171,080		2,329,690	9
10	Land Improvement			1990	429,835						10
11	Building Improvement			1990	65,079						11
12	Land Improvement			1991	1,679						12
13	Building Improvement			1991	4,525						13
14	Land Improvement			1992	565						14
15	Building Improvement			1992	1,403						15
16	Land Improvement			1993	5,108						16
17	Building Improvement			1993	136,058						17
18	Land Improvement			1994	13,285						18
19	Building Improvement			1994	68,753						19
20	Land Improvement			1995	5,027						20
21	Building Improvement			1995	421,042						21
22	Land Improvement			1996	20,361						22
23	Building Improvement			1996	506,756						23
24	Land Improvement			1997	8,235						24
25	Building Improvement			1997	70,208						25
26	Land Improvement			1998	20,770						26
27	Building Improvement			1998	80,701						27
28	Building Improvement			1999	31,240						28
29	Bldg. Improvement: Wallcovering, Paper, Paint, & Corner Guards			2000	34,575						29
30	Bldg. Improvement: Carpet			2000	8,718						30
31	Bldg. Improvement: Signs			2000	639						31
32	Land Improvement: Sign			2000	1,385						32
33	Land Improvement			2001	none						33
34	Building Improvement			2001	none						34
35	Land Improvement			2002	none						35
36				2002	none						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 Homewood

0049437

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Renovation construction Dept. costs & Interest on financing	2003	\$ 5,781	\$		\$	\$	\$	37
38	Audit, Adjust Remove OH & Interest 6/23/2004	2003	(5,781)						38
39	Carpet, Paint, & Wallcovering	2003	147,107						39
40	Wallcovering & Borders	2003	1,895						40
41	Carpet	2003	101						41
42	Paint, Wallcovering, & Borders	2003	8,010						42
43	Electric wiring	2003	2,870						43
44	Parking lot sealing & striping	2003	35,895						44
45	Sidewalk	2003	3,873						45
46	Paint, Wallcovering, & Borders	2004	1,015						46
47	Doors	2004	3,557						47
48	Flooring & Base	2004	24,082						48
49	Carpet	2004	20,461						49
50	Carpet	2005	1,080						50
51	Flooring	2005	58,964						51
52	Plumbing	2006	10,698						52
53	General Overhead & Interest	2007	5,717						53
54	Flooring	2007	15,015						54
55	Wallcovering & Borders	2007	33,209						55
56	Roof Replacement	2008	109,990						56
57	Doors - Front entrance, Handicap Assessable	2008	18,209						57
58	Water Heaters	2009	20,296						58
59	Water Heaters	2009	578						59
60	Drywall	2009	12,174						60
61	sidewalks and flagpole	2009	4,508						61
62									62
63	BI 40480 basic electric upgrade	2010	5,325						63
64									64
65	BI 040485 Kitchen water heater	2011	6,727						65
66	BI 040500 2 EXHAUST FANS, CENTRAL S	2011	4,535						66
67	BI 040506 THEROPANE WINDOW (FRNT LO	2011	4,770						67
68	BI 040508 EXTERIOR HM DOOR & FRAME	2011	6,971						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,348,830	\$ 242,126		\$ 242,126	\$	\$ 3,931,245	70

**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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,348,830	\$ 242,126		\$ 242,126	\$	\$ 3,931,245	1
2	Bed addition & therapy area renovation:								2
3	40519a Carpentry, doors, windows, countertops	2012	324,707						3
4	40519b Painting, flooring, wall cover, cornder guards	2012	234,532						4
5	40519c Roof coering, ceiling tile, fire protection	2012	41,648						5
6	40519d Drywall/studs, flooring, cubicle track	2012	623,789						6
7	40519e Fire sprinkler system	2012	27,576						7
8	40519f bldg demo, concrete, brick & masonary	2012	118,053						8
9	40520a Paving/parking	2012	45,652						9
10	40520b Concrete testing	2012	4,570						10
11	40521 Landscaping	2012	20,199						11
12	40522 Water/Sewer/Utilities	2012	103,071						12
13	000000040535 ADJ ASSET -mllwork,carpet, pads wallcvrng	2012	69,251						13
14									14
15	000000040527 Wall Coverings Bathrooms	2012	10,822						15
16	000000040528 Fire Protection	2012	21,600						16
17	000000040530 HOLLOW METAL DOOR Main Entrance	2012	7,182						17
18	000000040531 CONCRETE	2012	3,755						18
19	000000040533 SEALCOAT PARKING LOT	2012	10,438						19
20	000000040534 FUSIBLE LINKS	2012	10,152						20
21	000000040536 SIDEWALKS	2012	5,161						21
22	000000040543 CARPETING IN HALLWAYS	2012	9,429						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)		\$ 7,040,416	\$ 242,126		\$ 242,126	\$	\$ 3,931,245	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	\$ 2,379,010	\$ 128,706	\$ 128,706	\$		\$ 2,168,839	71
72	Current Year Purchases	365,749						72
73	Fully Depreciated Assets							73
74	Home Office			16,323	16,323			74
75	TOTALS	\$ 2,744,759	\$ 128,706	\$ 145,029	\$ 16,323		\$ 2,168,839	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,168,548	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 370,832	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 387,155	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,323	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,100,084	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:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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: \$ 31,650
- Description: 02 Concentrators, wheelchairs, gerichairs, electric beds
- (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	Patient Transportation		\$	\$ 1,791	17
18					18
19				above figures includes	19
20				gas & maintenance too.	20
21	TOTAL		\$	\$ 1,791	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	3915	hrs	\$ 170,308	732	\$ 46,138	\$ 1,122	4,647	\$ 217,568	1
2	Licensed Speech and Language Development Therapist	10a	3628	hrs	157,858				3,628	157,858	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	7576	hrs	329,585	2,320	146,157	4,649	9,896	480,391	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				359,175		359,175	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): IV Therapy	43, 2						80,334		80,334	12
13	Other (specify): X-ray & Lab	43, 3					80,486			80,486	13
14	TOTAL				\$ 657,751	3,052	\$ 272,781	\$ 445,280	18,171	\$ 1,375,812	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.

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	\$ 5,350	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,032,669)	2,485,628		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,490,978	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	383,373		13
14	Buildings, at Historical Cost	7,040,417		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,744,760		16
17	Accumulated Depreciation (book methods)	(6,100,084)		17
18	Deferred Charges	8,018,552		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,087,018	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,577,996	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 127,862	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	457,050		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	519,722		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payable	128,538		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,233,172	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,183,314		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,183,314	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,416,486	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,161,510	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,577,996	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,645,083	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,645,083	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(846,305)	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)	\$ (846,305)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	9,362,732	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 9,362,732	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 12,161,510	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Homewood# 0049437Report Period Beginning: 01/01/12Ending: 12/31/12

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	2	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,840,700	1
2	Discounts and Allowances for all Levels	(4,233,768)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,606,932	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,347,822	6
7	Oxygen	576	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,348,398	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	671	12
13	Barber and Beauty Care	12,839	13
14	Non-Patient Meals	283	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	395,498	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,971	19
20	Radiology and X-Ray	29,753	20
21	Other Medical Services	97,194	21
22	Laundry	2	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 568,211	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			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,523,541	30

	1	2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,182,750	31
32	Health Care	4,911,146	32
33	General Administration	3,364,869	33
	B. Capital Expense		
34	Ownership	2,049,142	34
	C. Ancillary Expense		
35	Special Cost Centers	533,316	35
36	Provider Participation Fee	328,623	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,369,846	40
41	Income before Income Taxes (line 30 minus line 40)**	(846,305)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (846,305)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,336,302	44
45	Private Pay - Net Inpatient Revenue	517,155	45
46	Medicare - Net Inpatient Revenue	4,090,771	46
47	Other-(specify) <u>Hospice & Vet</u>	333,407	47
48	Other-(specify) <u>Insurance</u>	329,297	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,606,932	49

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

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

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

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

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	3,044	3,291	\$ 122,877	\$ 37.34	1
2	Assistant Director of Nursing	4,308	4,657	153,913	33.05	2
3	Registered Nurses	25,552	27,622	875,513	31.70	3
4	Licensed Practical Nurses	28,530	30,841	761,921	24.70	4
5	CNAs & Orderlies	77,215	83,652	909,292	10.87	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	15,742	17,014	740,195	43.51	7
8	Rehab/Therapy Aides	15,147	16,370	440,405	26.90	8
9	Activity Director	5,062	5,479	70,073	12.79	9
10	Activity Assistants					10
11	Social Service Workers	8,077	8,726	203,312	23.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,133	23,951	294,494	12.30	15
16	Dishwashers					16
17	Maintenance Workers	2,029	2,195	46,323	21.10	17
18	Housekeepers	11,071	11,978	126,375	10.55	18
19	Laundry	3,720	4,023	40,482	10.06	19
20	Administrator	2,080	2,080	87,408	42.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,469	16,768	349,840	20.86	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	1,886	2,042	32,620	15.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,065	260,689	\$ 5,255,043 *	\$ 20.16	34

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	24,839	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,839		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	%	Amount	Description		Amount	Description		Amount	
Patricia Stoudt		Administrator	0	\$ 75,416	Workers' Compensation Insurance		\$ 44,982	IDPH License Fee		\$ 958	
Suan Jones		Administrator	0	11,992	Unemployment Compensation Insurance		93,567	Advertising: Employee Recruitment		4,915	
					FICA Taxes		383,051	Health Care Worker Background Check		9,432	
					Employee Health Insurance		280,313	(Indicate # of checks performed _____)			
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		3,761	
					Tuition Program		(5,188)	Association Dues		13,113	
					Disability Payments			Advertising (Allow)		7,182	
					401K		12,590	Advertising (Non-All)		10,210	
					Appreciation, other benefits, & mkting adj		3,844	Less: Non-allow association dues		(9,163)	
					SMSP Company Match		133	Less: Public Relations Expense		(7,182)	
					Employee Uniforms		3,270	Non-allowable advertising		(10,210)	
					Home Office Allocation		44,448	Yellow page advertising (_____)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 87,408	TOTAL (agree to Schedule V, line 22, col.8)			\$ 861,010	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 23,016
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description				Amount	Description		Line #	Amount	Description		Amount
Home Office Costs				\$ 545,947				\$	Out-of-State Travel		\$
									In-State Travel		1,757
									Seminar Expense		
									Entertainment Expense (_____)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 545,947	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 1,757
C. Professional Services											
Vendor/Payee		Type		Amount							
United Collection Bureau Inc		Collection Fees		\$ 2,739							
Constangy Brooks & Smith LLC		Legal Fees		65							
Foote Meyers Mielke & Flowers LL		Legal Fees		35,578							
MI Peer Review Organization		Utilization Mgmt Fees		780							
(All legal fees are adjusted off via Page 5, Line 22, therefore, no invoices are attached.)											
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 39,162							

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

- (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 \$3950
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes \$9163

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.

\$ 61,812

Line

10, 2
- (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.

\$ 328,623

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.

\$ 283
- (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 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.