

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0049437 Facility Name: Manorcare of Homewood Address: 940 Maple Avenue 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 501(c)(3) ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:
Name: A. Dean Shipman Telephone Number: (419) 254-7841
Email Address:

Facility Name & ID Number

Manorcare of Homewood

#

0049437

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

III. STATISTICAL DATA

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

1	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	132	Skilled (SNF)	132	48,312
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	132	TOTALS	132	48,312

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	16,564	1,079	14,669	32,312
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	16,564	1,079	14,669	32,312

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

66.88%

D. How many bed reserve days during this year were paid by the Department?

0

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

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

Date started

06/18/90

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

YES

X

Date

07/25/2018

NO

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

YES

X

NO

If YES, enter number of beds certified

132

and days of care provided

4,779

Medicare Intermediary

CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

X

Tax Year:

12/31

Fiscal Year:

12/31

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

Facility Name & ID Number Manorcare of Homewood # 0049437 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	358,447	40,310	1,551	400,308		400,308		400,308			1
2	Food Purchase		238,605		238,605		238,605		238,605			2
3	Housekeeping	216,572	25,030	(722)	240,880		240,880		240,880			3
4	Laundry	64,188	29,984		94,172		94,172		94,172			4
5	Heat and Other Utilities			203,285	203,285	3,766	207,051		207,051			5
6	Maintenance	72,182	29,147	159,924	261,253		261,253		261,253			6
7	Other (specify):* Security & Waste			13,205	13,205		13,205		13,205			7
8	TOTAL General Services	711,389	363,076	377,243	1,451,708	3,766	1,455,474		1,455,474			8
	B. Health Care and Programs											
9	Medical Director			21,072	21,072		21,072		21,072			9
10	Nursing and Medical Records	3,431,916	320,065	577,685	4,329,666	174	4,329,840		4,329,840			10
10a	Therapy	1,298,923	15,656	25,177	1,339,756		1,339,756		1,339,756			10a
11	Activities	64,302	2,540	378	67,220		67,220		67,220			11
12	Social Services	194,080	800		194,880		194,880		194,880			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* FIT TESTS			18,011	18,011		18,011		18,011			15
16	TOTAL Health Care and Programs	4,989,221	339,061	642,323	5,970,605	174	5,970,779		5,970,779			16
	C. General Administration											
17	Administrative	170,625		512,625	683,250	(91,621)	591,629		591,629			17
18	Directors Fees											18
19	Professional Services			86,180	86,180		86,180	(86,180)				19
20	Dues, Fees, Subscriptions & Promotions			89,947	89,947		89,947	(16,967)	72,980			20
21	Clerical & General Office Expenses	436,983	50,226	1,137,917	1,625,126		1,625,126	(995,384)	629,742			21
22	Employee Benefits & Payroll Taxes			979,258	979,258	65,131	1,044,389		1,044,389			22
23	Inservice Training & Education			2,494	2,494		2,494		2,494			23
24	Travel and Seminar			4,434	4,434		4,434		4,434			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			2,142,794	2,142,794		2,142,794		2,142,794			26
27	Other (specify):*											27
28	TOTAL General Administration	607,608	50,226	4,955,649	5,613,483	(26,490)	5,586,993	(1,098,531)	4,488,462			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,308,218	752,363	5,975,215	13,035,796	(22,550)	13,013,246	(1,098,531)	11,914,715			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			313,736	313,736	26,765	340,501		340,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(3,444)	(3,444)	(4,215)	(7,659)		(7,659)			32
33	Real Estate Taxes			859,350	859,350		859,350		859,350			33
34	Rent-Facility & Grounds			836,869	836,869		836,869	(836,869)				34
35	Rent-Equipment & Vehicles			39,328	39,328		39,328		39,328			35
36	Other (specify):*											36
37	TOTAL Ownership			2,045,839	2,045,839	22,550	2,068,389	(836,869)	1,231,520			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		364,031		364,031		364,031		364,031			39
40	Barber and Beauty Shops			1,280	1,280		1,280		1,280			40
41	Coffee and Gift Shops	2,728			2,728		2,728		2,728			41
42	Provider Participation Fee			227,920	227,920		227,920		227,920			42
43	Other (specify):* IV X-Ray & Lab		100,270	227,769	328,039		328,039		328,039			43
44	TOTAL Special Cost Centers	2,728	464,301	456,969	923,998		923,998		923,998			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,310,946	1,216,664	8,478,023	16,005,633		16,005,633	(1,935,400)	14,070,233			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms		21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	3,041	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(66,839)	19		22
23	Malpractice Insurance for Individuals		25		23
24	Bad Debt	(998,177)	21		24
25	Fund Raising, Advertising and Promotional	(16,967)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Pg 5a	(856,419)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,935,400)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,935,400)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activity Income	\$	11	1
2	Misc. Income		21	2
3	Vending Income	(209)	21	3
4	Donations Revenue		21	4
5	Accounting/Collection Fees	(19,341)	19	5
6	Collection Agency		19	6
7	Loss on Disposal of Fixed Asset		36	7
8	HCP Lease Interest		32	8
9	WT Rent Expense	(836,869)	34	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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32				32
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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	(856,419)		49

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ 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	\$ 512,625	HCR Manor Care Services, LLC	0.00%	\$ 512,625	\$	1
2	V	Page 8							2
3	V								3
4	V	1-44	Personnel	6,310,947	Heartland Employment Services, LLC	0.00%	6,310,947		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 6,823,572			\$ 6,823,572	\$ *	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:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Manorcare of Homewood # 0049437 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Homewood# 0049437

Report Period Beginning:

01/01/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	5	Utilities - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	\$ 709,073	\$ 0	14,002,955	\$ 3,766	1
2	5	Utilities - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs		0	14,002,955	0	2
3	5	Utilities - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	14,002,955	0	3
4										4
5	10	Nursing - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	32,137	0	14,002,955	171	5
6	10	Nursing - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	454	0	14,002,955	3	6
7	10	Nursing - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	14,002,955	0	7
8										8
9	17	Gen/Admin-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	57,708,481	23,053	14,002,955	306,473	9
10	17	Gen/Admin-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	7,841,321	0	14,002,955	51,990	10
11	17	Gen/Admin-Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs	2,818,405	0	14,002,955	62,541	11
12										12
13	22	Empl Bnfts-Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	5,631,859	35,913,957	14,002,955	29,909	13
14	22	Empl Bnfts-Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	5,312,192	1,179,502	14,002,955	35,222	14
15	22	Empl Bnfts-Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	14,002,955	0	15
16										16
17	30	Depreciation - Pooled	Accumulated Cost	2,636,740,077	485 NFs, HHs, & Re	4,013,110	0	14,002,955	21,312	17
18	30	Depreciation - Direct to all SNFs	Accumulated Cost	2,111,959,745	305 NFs	822,456	0	14,002,955	5,453	18
19	30	Depr - Direct to West Div SNFs	Accumulated Cost	631,044,941	54 NFs		0	14,002,955	0	19
20										20
21										21
22	32	Pooled Interest	Accumulated Cost	2,636,740,077		(782,905)		14,002,955	(4,158)	22
23	32	Directly Assigned Interest	Not Allocated			(8,038)			(57)	23
24		H/O Costs Allocated to Non-SNFs and Other Divisions				34,182,124				24
25	TOTALS					\$ 118,280,668	\$ 37,116,512		\$ 512,625	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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Home Office Pooled Interest Expense											(4,215)	6
7	Interest Income / Interest Expense											(3,444)	7
8													8
9	TOTAL Facility Related						\$		\$			\$ (7,659)	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$ (7,659)	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 2019 report.			\$	798,321	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.)			\$	824,772	2
3. Under or (over) accrual (line 2 minus line 1).			\$	26,451	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	824,772	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.)			\$	8,449	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 \$ <u>(322)</u> For <u>###</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(322)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	859,350	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	<u>604,665</u>	8	
		2016	<u>610,410</u>	9	
		2017	<u>799,192</u>	10	
		2018	<u>798,321</u>	11	
		2019	<u>824,772</u>	12	
Lines 2 & 4: \$0 = \$0 for 1st half 2019 + \$0 for 2nd half 2019					
Line 5: \$8,448.63 = Newman Knight Frank-\$8,000; Worsek & Vihon 2018 Specific Obj Filing Fee-\$368.25 & 2007 RE Tax Fee-\$80.38					
Line 6: (\$322) =Worsek & Vihon 2007 RE Tax Refund					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Homewood COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0049437
CONTACT PERSON REGARDING THIS REPORT A. Dean Shipman
TELEPHONE (419) 254-7841 FAX #: (800) 422-2089

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>29-32-200-046-0000</u>	<u>See Attached</u>	\$ <u>824,771.81</u>	\$ <u>824,771.81</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>824,771.81</u></u>	\$ <u><u>824,771.81</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet: 42,369

B. General Construction Type: ExteriorMasonryFrameSteelNumber of Stories1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
NONE

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	261,447		\$ 383,373	1
2					2
3	TOTALS	261,447		\$ 383,373	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	120			1990	\$ 2,845,251	\$ 142,182		\$ 142,182	\$	\$ 3,055,081
5	12			2012	1,613,046					
6				2019						
7										
8										
	Improvement Type**									
9	Current Year Depreciation					90,378		90,378		2,884,001
10	Bldg./ Land Improvement			1990	494,914					
11	Bldg./ Land Improvement			1991	6,204					
12	Bldg./ Land Improvement			1992	1,968					
13	Bldg./ Land Improvement			1993	141,723					
14	Bldg./ Land Improvement			1994	82,038					
15	Bldg./ Land Improvement			1995	426,069					
16	Bldg./ Land Improvement			1996	527,117					
17	Bldg./ Land Improvement			1997	78,443					
18	Bldg./ Land Improvement			1998	101,471					
19	Bldg./ Land Improvement			1999	31,240					
20	Bldg./ Land Improvement			2000	45,317					
21	Bldg./ Land Improvement			2003	199,751					
22	Bldg./ Land Improvement			2004	49,115					
23	Bldg./ Land Improvement			2005	60,044					
24	Bldg./ Land Improvement			2006	10,698					
25	Bldg./ Land Improvement			2007	48,224					
26	General Overhead & Interest			2007	5,717					
27	07/01/2019 audit adjustment -Ovhd & Int non allowable			2007	(5,717)					
28	Bldg./ Land Improvement			2008	128,199					
29	Bldg./ Land Improvement			2009	37,556					
30	Bldg./ Land Improvement			2010	5,325					
31				2011	23,003					
32										
33										
34										
35										
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:

01/01/2020 Ending: 12/31/2020

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	Bed addition & therapy area renovation:		\$	\$		\$	\$	\$	37
38	40519a Carpentry, doors, windows, countertops	2012	324,705						38
39	40519b Painting, flooring, wall cover, cornder guards	2012	234,532						39
40	40519c Roof coering, ceiling tile, fire protection	2012	41,648						40
41	40519d Drywall/studs, flooring, cubicle track	2012	623,789						41
42	40519e Fire sprinkler system	2012	27,576						42
43	40519f bldg demo, concrete, brick & masonry	2012	118,053						43
44	40520a Paving/parking	2012	45,652						44
45	40520b Concrete testing	2012	4,570						45
46	40521 Landscaping	2012	20,199						46
47	40522 Water/Sewer/Utilities	2012	103,071						47
48	40535 ADJ ASSET -mllwork,carpet, pads wallcvrng	2012	69,251						48
49	07/01/2019 audit adjustment -reclass lines 37-48 to pg 12, Line 5		(1,613,046)						49
50									50
51	40527 Wall Coverings Bathrooms	2012	10,822						51
52	40528 Fire Protection	2012	21,600						52
53	40530 HOLLOW METAL DOOR Main Entrance	2012	7,182						53
54	40531 CONCRETE	2012	3,755						54
55	40533 SEALCOAT PARKING LOT	2012	10,438						55
56	40534 FUSIBLE LINKS	2012	10,152						56
57	40536 SIDEWALKS	2012	5,161						57
58	40543 CARPETING IN HALLWAYS	2012	9,429						58
59	40544 FENCING-west & north side of bldg	2012	7,920						59
60	40545 Landscaping changes	2012	756						60
61	07/01/2019 audit adjustment -cost less than minimum for capitalization		(756)						61
62	40548 FENCING-west & north side of bldg	2013	3,600						62
63	40549 Vinyl wallcovering for activity rm	2013	2,811						63
64	40551 INSTALL NEW ALUM EXTERIOR TRIM	2013	13,943						64
65	40552 INSTALL NEW SERV DOOR - EMP ENT	2013	7,922						65
66	40554 Vinyl wallcovering for activity rm	2013	1,335						66
67	40555 PAINTING-ACTIVITIES &ADON OFF	2013	4,905						67
68	40556 HOT WATER HEATER	2013	11,153						68
69	40562 REPLACE BATH FLOOR IN 15 RES RMS	2013	15,188						69
70	TOTAL (lines 4 thru 69)		\$ 7,104,032	\$ 232,560		\$ 232,560	\$	\$ 5,939,082	70

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

Facility Name & ID Number Manorcare of Homewood

0049437

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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		\$ 7,104,032	\$ 232,560		\$ 232,560	\$	\$ 5,939,082	1
2	40574 EM Wiring to Med rms(2), kiosks(2), Nrs station, DON, Ad	2014	8,359						2
3	40582 Fencing, Cedar, 3 rail, 800 LF	2014	16,065						3
4	40605 Water Main emergency repair 8"x30" clamp	2014	9,833						4
5	40606 Wiring to 3 lights in east parking lot	2014	6,112						5
6	40620 Vinyl Flooring & Base in Bathrooms 300-302	2015	1,714						6
7	07/01/2019 audit adjustment -cost less than minimum for capitalization		(1,714)						7
8	40622 Metal Door & Frame - New Service Door	2015	15,404						8
9	40625 Electric Panel - Dry Storage Room of Kitchen	2015	12,813						9
10	40626 HVAC - Laundry Room Lennox 90K BTU & 2.5 Ton AC	2015	4,338						10
11	40630 Concrete & Repair Doors at Front Entrance	2015	3,590						11
12	40631 Repair Around Parking Lot Drains & Patch Pot Holes	2015	1,980						12
13	07/01/2019 audit adjustment -cost less than minimum for capitalization		(1,980)						13
14	40640 Dry Fire Sprinler System Repair	2015	1,535						14
15	07/01/2019 audit adjustment -cost less than minimum for capitalization		(1,535)						15
16	40641 Firestop systems for wall penetrations(5) Mech rm, Ceiling,	2015	11,990						16
17									17
18	Phone System	2014	54,045						18
19	Dry Fire System Repair to System 1 in Rosewood E. Hall	2015	3,955						19
20	Roof Repair to main roof & garage & new gutters on garage	2015	4,200						20
21	Wet Fire System Repair, multiple leaks in the attic	2015	11,290						21
22	Wiring to 3 PTAC Units in Communication Rm & Business Office	2016	2,792						22
23	Dry Valve Fire Sprinkle Repair by room 603 in Regency Hall	2016	5,767						23
24	Drywall Repair, fire sprinkler leaked, in 601, 603 & Nourishment	2016	16,352						24
25	Dry Fire Sprinkler Heads(7) canpoy areas & laundry room	2016	3,580						25
26	Roof Repair, Install animal resistant vents & shingles	2016	5,500						26
27	Fire System repairs upper roof area, and Dry Sytsem #3.	2016	5,621						27
28	Dry Fire System repairs by employee break room, upper roof area	2016	13,333						28
29	Air Handler blower motor, housing, fan, control board for PT	2016	3,280						29
30	Trees(8), Remove & Replace, E side (4), front E courtyard (2),								30
31	E entrance (1), and N side of bldg (1)	2016	9,885						31
32	Mixing Valve Rebuilt on A Wing	2016	4,701						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,336,837	\$ 232,560		\$ 232,560	\$	\$ 5,939,082	34

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

Facility Name & ID Number Manorcare of Homewood

0049437

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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		\$ 7,336,837	\$ 232,560		\$ 232,560	\$	\$ 5,939,082	1
2	Dry Fire Sprinkler System Repair in System 3 near Central								2
3	Supply & Break Room in Regency Hall	2016	3,111						3
4	Dry Fire Sprinkler System Repair above nourishment rm, Regency	2016	4,449						4
5	Air Compressor for Dry Fire Sprinkle Systems	2016	3,900						5
6	Doors & Frames for Main Dining Room Exterior Doorways(2)	2016	10,600						6
7									7
8	Concrete Sidewalk @ svc entrance & W side courtyard	2017	13,362						8
9	Asphalt -1,824 sq ft - 10 areas around bldg	2017	5,399						9
10	Mixing Valve DVR40 w/recirculation manifold	2016	13,676						10
11	Dry Fire Sprinkler Repair, 4" black pipe, fittings on System #3 (er	2016	7,184						11
12	Fire Alarm System Repair, Water shut off control valve (2)	2016	4,675						12
13	Dry Fire Sprinkler Repair, 3" black pipe, fittings on System #3 (er	2016	4,563						13
14	Water Heater in Mech rm	2017	14,342						14
15	Gas line repair, 5" line	2017	11,910						15
16	Fire Sprinkler repair, Drip drum Assy w ball valve, 1.25" pipe	2017	4,491						16
17	Fire System, Range Guard - Kitchen	2017	3,200						17
18	Electrical - Underground feed to AC Unit by Mech Room	2017	6,158						18
19	Evaporator Coils- PT 5T air handler (2)	2017	6,790						19
20	Eyewash station in kitchen	2016	3,247						20
21	Roofing Repair	2017	3,748						21
22	Evaporator for walk-in cooler	2017	8,500						22
23	Dry Fire Sprinkler repair, 4" black pipe, fittings	2017	13,238						23
24	Fire Sprinkler repair, 1" pipe, sprinkler head pendants (6)	2017	1,798						24
25	Door- Exterior @ Activities	2017	5,445						25
26	Fire Alarm Power Supply, Firelite Module(2), wire, battery (Mech	2017	3,301						26
27	Door Operator and Switch for Inner Main Entrance	2017	2,901						27
28	Dry Fire Sprinkler Repair, 3" black pipe, fittings (attic near main	2017	2,317						28
29	Dry Fire Sprinkler Repair, 4" black pipe, fittings (attic, Rosewood	2017	1,268						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,500,410	\$ 232,560		\$ 232,560	\$	\$ 5,939,082	34

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

Facility Name & ID Number Manorcare of Homewood

0049437

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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 12C, Carried Forward		\$ 7,500,410	\$ 232,560		\$ 232,560	\$	\$ 5,939,082	1
2	<u>flood lights for road signs (2)</u>	2017	6,540						2
3	<u>Piping for #3 Sprinkler system -4" pipe</u>	2017	4,484						3
4	<u>Painting - Breakroom</u>	2017	7,750						4
5	<u>Piping for #3 Sprinkler system -4" pipe</u>	2017	2,838						5
6	<u>Vinyl Tile floor for Breakroom</u>	2018	2,522						6
7	<u>Dry Heads for Sprinkler System (4)</u>	2017	1,760						7
8									8
9	<u>Drywall and Painting -rms 201 & 204</u>	2018	11,302						9
10	<u>Drywall and Painting -rms 407 & 409</u>	2018	3,630						10
11	<u>Drywall & stainless wall panels -Kitchen</u>	2018	4,468						11
12	<u>Dry Heads for Sprinkler System (22)</u>	2018	21,175						12
13	<u>Water Heater -Regency Wing</u>	2018	14,304						13
14	<u>Vinyl Tile floor-Back Hall</u>	2018	6,750						14
15	<u>Water Heater -boiler room #1 -maint ofc</u>	2018	11,633						15
16									16
17	<u>Landscaping-remove dead trees +dirt to fill holes.</u>	2019	3,200						17
18	<u>Parking lot (entire) sealing/stripping</u>	2019	21,997						18
19	<u>Electrical Feed to Pole light-SE corner of bldg.</u>	2019	5,850						19
20	<u>Cabinets-Post Acute Network (PAN) office</u>	2019	7,730						20
21	<u>Dampers-Fire Sprinkler system (210) thruout bldg</u>	2019	5,250						21
22	<u>pipng/dampers -sprinkler sys-above Administrative offices</u>	2019	12,436						22
23	<u>Backflow device-water main in Mech Rm</u>	2019	7,723						23
24	<u>Arch Drawings for Dialysis room (reno current Activity room)</u>	2019	21,196						24
25	<u>07/01/2019 audit adjustment -architect fees to be incl w complete</u>	2019	(20,539)						25
26	<u>Paint Ceiling - internet café</u>	2019	5,194						26
27	<u>compressor -Regency condensing unit</u>	2019	5,031						27
28	<u>Paint walls - rooms 114,116,118,120,117,119,121,123</u>	2019	10,836						28
29	<u>Condensing unit, HVAC-3 phase Diakin DX11TA0903 7.5T by Svc</u>	2019	19,770						29
30	<u>Vinyl Flooring -Main Dining</u>	2019	5,644						30
31	<u>Condensing unit, HVAC-3 phase Diakin DXTA1203 10T for Priva</u>	2019	21,925						31
32	<u>water heater-mech rm</u>	2019	15,621						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,748,430	\$ 232,560		\$ 232,560	\$	\$ 5,939,082	34

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

Facility Name & ID Number Manorcare of Homewood

0049437

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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 12D, Carried Forward		\$ 7,748,430	\$ 232,560		\$ 232,560		\$ 5,939,082	1
2	Water Heater -Main Mech Rm by Maint Ofc	2020	13,836						2
3	Doors/Frams/Closers @ doors one thru 5	2020	17,986						3
4	FRP Board (15)/Quarry Tile - Kitchen @ back Hall, Dishroom rea	2020	7,195						4
5	Lighting-LED -Kitchen, Dhiswashing, & Dry storage	2020	3,275						5
6	Isolation Valves/Angle Stops -rm 207	2020	4,768						6
7	Roof -Frt Courtyard SE corner & S side Facility @ dining Rm	2020	3,170						7
8	Vent Hood Pull Stations/Actuator -Kitchen	2020	3,995						8
9	Split System -Main Dining Room	2020	19,440						9
10	Drainage Basins in Parking Lot	2020	3,000						10
11	Landscape Renewal -Dirt/100# seed/Straw -Front of Bldg	2020	3,990						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,829,085	\$ 232,560		\$ 232,560		\$ 5,939,082	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	\$ 3,282,729	\$ 81,176	\$ 81,176	\$		\$ 3,049,801	71
72	Current Year Purchases	34,186						72
73	Fully Depreciated Assets							73
74	Home Office Depreciation			26,765	26,765			74
75	TOTALS	\$ 3,316,915	\$ 81,176	\$ 107,941	\$ 26,765		\$ 3,049,801	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	11,529,373
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	313,736
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	340,501
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	26,765
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	8,988,883

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 372,933
93		
94		
95		\$ 372,933

* 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: \$ 39,328
- Description: 02 Concentrators, Wheelchairs, Geri Chairs, Elec. Beds, Etc.
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending
- Annual Rent
12. /2021 \$
13. /2022 \$
14. /2023 \$

* 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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	6269 hrs	\$ 263,873		\$	\$ 3,745	6,269	\$ 267,618	1
2	Licensed Speech and Language Development Therapist	10a	2771 hrs	116,619			1,065	2,771	117,684	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4505 hrs	189,618	(1)	(29)	10,846	4,504	200,435	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				364,031		364,031	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Inhal Therapy</u>	10a, 3	1330	55,964	10	596		1,340	56,560	12
13	Other (specify): <u>X-Ray & Lab IV</u>	43, 2 & 3				227,769	100,270		328,039	13
14	TOTAL			\$ 626,074	9	\$ 228,336	\$ 479,957	14,884	\$ 1,334,367	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (417,599))	(362,337)		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)	\$ (361,837)	\$	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	7,829,086		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,316,914		16
17	Accumulated Depreciation (book methods)	(8,988,883)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) OMIT	222,063		22
23	Other(specify): CIP	372,933		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,135,486	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,773,649	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 309,571	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	552,805		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,192		31
32	Accrued Real Estate Taxes(Sch.IX-B)	824,772		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accounts Payable	233,953		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,954,293	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,954,293	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 819,356	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,773,649	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,859,719	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,859,719	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,695,828)	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)	\$ (3,695,828)	17
	B. Transfers (Itemize):		
18	Change in Interdivision	1,655,465	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,655,465	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 819,356	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Homewood

0049437

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,126,634	1
2	Discounts and Allowances for all Levels	(6,274,678)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,851,956	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,180,759	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,180,759	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	209	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	783,829	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	222,954	19
20	Radiology and X-Ray	116,373	20
21	Other Medical Services	48,125	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,171,490	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	Purch Discl QI pymts Gov Sub Inc	1,105,600	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,105,600	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,309,805	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,451,708	31
32	Health Care	5,970,605	32
33	General Administration	5,613,483	33
	B. Capital Expense		
34	Ownership	2,045,839	34
	C. Ancillary Expense		
35	Special Cost Centers	696,078	35
36	Provider Participation Fee	227,920	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,005,633	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,695,828)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,695,828)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,136,827	44
45	Private Pay - Net Inpatient Revenue	408,101	45
46	Medicare - Net Inpatient Revenue	1,074,340	46
47	Other-(specify) Hospice	494,228	47
48	Other-(specify) Insurance	738,460	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,851,956	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	1,827	1,967	\$ 100,194	\$ 50.94	1
2	Assistant Director of Nursing	3,873	4,170	168,099	40.31	2
3	Registered Nurses	33,549	36,125	1,335,181	36.96	3
4	Licensed Practical Nurses	22,032	23,724	736,682	31.05	4
5	CNAs & Orderlies	59,943	64,649	1,068,635	16.53	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	18,453	19,852	835,582	42.09	7
8	Rehab/Therapy Aides	14,143	15,216	463,341	30.45	8
9	Activity Director	3,581	3,857	64,302	16.67	9
10	Activity Assistants					10
11	Social Service Workers	7,149	7,686	194,080	25.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,413	20,882	358,447	17.17	15
16	Dishwashers					16
17	Maintenance Workers	2,551	2,719	72,182	26.55	17
18	Housekeepers	14,445	15,566	216,572	13.91	18
19	Laundry	4,288	4,611	64,188	13.92	19
20	Administrator	2,080	2,080	166,967	80.27	20
21	Assistant Administrator	109	109	3,657	33.55	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,276	18,768	436,985	23.28	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	1,263	1,355	23,125	17.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	213	227	2,728	12.02	33
34	TOTAL (lines 1 - 33)	226,188	243,563	\$ 6,310,947 *	\$ 25.91	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	21,072	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)		\$ 21,072		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,514	\$ 153,322	10, 3	50
51	Licensed Practical Nurses	1,293	58,194	10, 3	51
52	Certified Nurse Assistants/Aides	4,360	135,171	10, 3	52
53	TOTAL (lines 50 - 52)	8,167	\$ 346,687		53

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

** See instructions.

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 \$4,749 & AHCA \$1,786
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,670 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? YES
If YES, give effective date of lease. 7/28/18
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 227,920
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. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NO
Attach invoices and a summary of services for all architect and appraisal fees.