

Facility Name & ID Number Manorcare of Homewood

0049437 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	15,476	3,656	18,978	38,110	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,476	3,656	18,978	38,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.01%

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)

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 06/18/90

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

YES Date 06/18/90 NO

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

YES NO If YES, enter number of beds certified 120 and days of care provided 15,788

Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	283,838	15,666	1,831	301,335	9,303	310,638		310,638		1
2	Food Purchase		230,149		230,149		230,149	(17)	230,132		2
3	Housekeeping	146,336	25,204	3,022	174,562		174,562		174,562		3
4	Laundry	39,500	15,159	580	55,239		55,239		55,239		4
5	Heat and Other Utilities			206,078	206,078	2,589	208,667		208,667		5
6	Maintenance	41,744	16,422	209,120	267,286		267,286		267,286		6
7	Other (specify):* Medical Waste			1,227	1,227		1,227		1,227		7
8	TOTAL General Services	511,418	302,600	421,858	1,235,876	11,892	1,247,768	(17)	1,247,751		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,826,977	297,256	55,239	3,179,472	3,417	3,182,889		3,182,889		10
10a	Therapy	1,150,806	20,613	68,110	1,239,529		1,239,529		1,239,529		10a
11	Activities	69,366	9,660	3,226	82,252		82,252		82,252		11
12	Social Services	127,348			127,348		127,348		127,348		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,174,497	327,529	150,575	4,652,601	3,417	4,656,018		4,656,018		16
	C. General Administration										
17	Administrative	83,315		472,022	555,337	(143,323)	412,014		412,014		17
18	Directors Fees										18
19	Professional Services			44,493	44,493		44,493	(24,298)	20,195		19
20	Dues, Fees, Subscriptions & Promotions			55,635	55,635		55,635	(34,027)	21,608		20
21	Clerical & General Office Expenses	324,926	49,623	476,720	851,269		851,269	(392,710)	458,559		21
22	Employee Benefits & Payroll Taxes			781,157	781,157	77,233	858,390		858,390		22
23	Inservice Training & Education			9,912	9,912		9,912		9,912		23
24	Travel and Seminar			2,538	2,538		2,538		2,538		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			260,400	260,400		260,400		260,400		26
27	Other (specify):*										27
28	TOTAL General Administration	408,241	49,623	2,102,877	2,560,741	(66,090)	2,494,651	(451,035)	2,043,616		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,094,156	679,752	2,675,310	8,449,218	(50,781)	8,398,437	(451,052)	7,947,385		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Manorcare of Homewood

#0049437

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			269,112	269,112	20,650	289,762		289,762			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(6,432)	(6,432)	30,131	23,699		23,699			32
33	Real Estate Taxes			451,682	451,682		451,682		451,682			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			97,802	97,802		97,802		97,802			35
36	Other (specify):*											36
37	TOTAL Ownership			812,164	812,164	50,781	862,945		862,945			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,576	8,576		8,576		8,576			38
39	Ancillary Service Centers		559,908	1,580	561,488		561,488		561,488			39
40	Barber and Beauty Shops			14,978	14,978		14,978		14,978			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):* IV X-Ray & Lab		60,931	123,719	184,650		184,650		184,650			43
44	TOTAL Special Cost Centers		620,839	214,553	835,392		835,392		835,392			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,094,156	1,300,591	3,702,027	10,096,774		10,096,774	(451,052)	9,645,722			45

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

Manorcare of Homewood

ID# 0049437

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (766)	21	1
2	Misc. Income	(3,137)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,903)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare of Homewood# 0049437

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(17)	0	0	0	0	0	0	0	0	0	0	(17)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(17)	0	(17)	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	(24,298)	0	0	0	0	0	0	0	0	0	0	(24,298)	19
20	Fees, Subscriptions & Promotions	(34,027)	0	0	0	0	0	0	0	0	0	0	(34,027)	20
21	Clerical & General Office Expenses	(392,710)	0	0	0	0	0	0	0	0	0	0	(392,710)	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	(451,035)	0	(451,035)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(451,052)	0	(451,052)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare of Homewood# 0049437

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(451,052)	0	0	0	0	0	0	0	0	0	0	(451,052)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See	\$ 472,022	HCR Manor Care, Inc.	100.00%	\$ 472,022	\$	1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a	39,905	Heartland Rehab Services, LLC	100.00%	39,905		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 511,927			\$ 511,927	\$ *	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:

01/01/09

Ending:

12/31/09

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Manorcare of Homewood

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Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

HCR Manor Care, Inc.

Street Address

333 North Summit St.

City / State / Zip Code

Toledo, OH 43604-2617

Phone Number

(419) 252-5500

Fax Number

(419) 254-5495

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	\$ 2,826,629	\$ 1,585,087	9,405,160	\$ 9,303	1
2	1	Dietary - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			9,405,160	0	2
3	1	Dietary - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rehab			9,405,160	0	3
4	5	Utilities - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.			9,405,160	0	4
5	5	Utilities - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			9,405,160	0	5
6	5	Utilities - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	911,333		9,405,160	2,589	6
7	10	Nursing - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	632,689	715,152	9,405,160	2,082	7
8	10	Nursing - Direct to Central Div SN	Accumulated Cost	691,284,298	95 NFs			9,405,160	0	8
9	10	Nursing - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	469,810		9,405,160	1,335	9
10	17	Gen & Admin - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	35,518,981		9,405,160	116,896	10
11	17	Gen & Admin - Direct to Central	Accumulated Cost	691,284,298	95 NFs	1,045,204		9,405,160	14,220	11
12	17	Gen & Admin - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	69,554,530	79,745,671	9,405,160	197,583	12
13	22	Emp Benefits- Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	6,239,311		9,405,160	20,534	13
14	22	Emp Benefits - Direct to Central D	Accumulated Cost	691,284,298	95 NFs	2,434,366		9,405,160	33,120	14
15	22	Emp Benefits - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	8,300,418		9,405,160	23,579	15
16	30	Depreciation - Direct to All SNFs	Accumulated Cost	2,857,768,524	359 Nurs. Fac.	102,714		9,405,160	338	16
17	30	Depreciation - Direct to Central D	Accumulated Cost	691,284,298	95 NFs	43,612		9,405,160	593	17
18	30	Depreciation - Pooled	Accumulated Cost	3,310,877,906	732 NFs, HHs & Rel	6,941,685		9,405,160	19,719	18
19										19
20	32	Interest				21,122,019			30,131	20
21		Non-Nursing Home Allocations				25,797,439				21
22										22
23										23
24										24
25	TOTALS					\$ 181,940,740	\$ 82,045,910		\$ 472,022	25

Facility Name & ID Number

Manorcare of Homewood

0049437

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Conv. Sub Debentures		X	Facility		4/2004	\$ 1,183,314	\$ 1,183,314		2.5800	\$ 30,131	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8	Interest Income Other										(6,432)	8							
9	TOTAL Facility Related						\$ 1,183,314	\$ 1,183,314			\$ 23,699	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			\$ 23,699	15							

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	389,282	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.)		\$	409,304	2
3. Under or (over) accrual (line 2 minus line 1).		\$	20,022	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	409,305	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.)		\$	22,355	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 \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	451,682	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	326,823	8	
	2005	376,923	9	
	2006	372,896	10	
	2007	377,943	11	
	2008	409,305	12	
Line 5: \$22,355 ---				
\$2400 JSO Valuation Group Ltd - for appraisal fees				
\$7129 Worsek & Vihon P.C. - 2005- 2007 Specific Objections -Filing fees				
\$12,725.95 Rock, Fusco & Associates LLC - for appraisal fees				
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Manorcare of Homewood

0049437

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,083 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).

None

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Manorcare of Homewood

0049437

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	1	2	3	4	5	6	7	8	9		
	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		\$ 2,845,250	\$ 71,217		\$ 71,217	\$	\$ 1,388,147	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					102,342		102,342		1,989,685	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	Building Improvement		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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Renovation construction Dept. costs & Interest on financing	2003	\$ 5,781	\$		\$	\$	\$	37
38	Carpet, Paint, & Wallcovering	2003	147,107						38
39	Wallcovering & Borders	2003	1,895						39
40	Carpet	2003	101						40
41	Paint, Wallcovering, & Borders	2003	8,010						41
42	Electric wiring	2003	2,870						42
43	Parking lot sealing & striping	2003	35,895						43
44	Sidewalk	2003	3,873						44
45	Paint, Wallcovering, & Borders	2004	1,015						45
46	Doors	2004	3,557						46
47	Flooring & Base	2004	24,082						47
48	Carpet	2004	20,461						48
49	Carpet	2005	1,080						49
50	Flooring	2005	58,964						50
51	Plumbing	2006	10,698						51
52	General Overhead & Interest	2007	5,717						52
53	Flooring	2007	15,015						53
54	Wallcovering & Borders	2007	33,209						54
55	Roof Replacement	2008	109,990						55
56	Doors - Front entrance, Handicap Assessable	2008	18,209						56
57									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									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,326,282	\$ 173,559		\$ 173,559	\$	\$ 3,377,832	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 5,326,282	\$ 173,559		\$ 173,559	\$	\$ 3,377,832	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 5,326,282	\$ 173,559		\$ 173,559	\$	\$ 3,377,832	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 5,326,282	\$ 173,559		\$ 173,559	\$	\$ 3,377,832	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 5,326,282	\$ 173,559		\$ 173,559	\$	\$ 3,377,832	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,970,132	\$ 95,553	\$ 95,553	\$		\$ 1,803,008	71
72	Current Year Purchases	202,319						72
73	Fully Depreciated Assets							73
74	Home Office Depr			20,650	20,650			74
75	TOTALS	\$ 2,172,451	\$ 95,553	\$ 116,203	\$ 20,650		\$ 1,803,008	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	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)	\$ 7,882,106	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 269,112	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 289,762	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,650	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,180,840	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

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

16. Rental Amount for movable equipment: \$ 96,775 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

YES NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation	Various	\$ 45.00	\$ 1,027	17
18				Above figure includes	18
19				gas & maintenance too.	19
20					20
21	TOTAL		\$ 45.00	\$ 1,027	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a	5314	hrs	\$ 219,894		\$	2,563	5,314	\$ 222,457	1	
2	Licensed Speech and Language Development Therapist	10a	2575	hrs	106,543	214		11,033	141	2,789	117,717	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10a	11431	hrs	473,026	306		15,800	17,909	11,737	506,735	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	39, 2		# of prescripts				4,072	559,908		563,980	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Other (specify): <u>IV Therapy</u>	43, 2							60,931		60,931	12
13	Other (specify): <u>X-Ray & Lab</u>	43, 3						123,719			123,719	13
14	TOTAL				\$ 799,463	520	\$	154,624	\$ 641,452	19,840	\$ 1,595,539	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare of Homewood# 0049437Report Period Beginning: 01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,771	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>706,701</u>)	1,394,295		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)	\$ 1,397,066	\$	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	5,326,284		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,172,451		16
17	Accumulated Depreciation (book methods)	(5,180,840)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CIP</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,701,268	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,098,334	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 155,473	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	357,111		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	409,304		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Payable</u>	27,747		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 949,635	\$	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)	\$ 949,635	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,148,699	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,098,334	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,239,997	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,239,997	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,778,478	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)	\$ 1,778,478	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(1,869,776)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,869,776)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,148,699	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Manorcare of Homewood# 0049437Report Period Beginning: 01/01/09Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,569,463	1
2	Discounts and Allowances for all Levels	(3,691,399)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,878,064	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,024,543	6
7	Oxygen	5,898	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,030,441	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	766	12
13	Barber and Beauty Care	14,517	13
14	Non-Patient Meals	17	14
15	Telephone, Television and Radio	4,337	15
16	Rental of Facility Space	1,800	16
17	Sale of Drugs	636,923	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	224,602	19
20	Radiology and X-Ray	42,502	20
21	Other Medical Services	38,146	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 963,610	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	<u>Misc. Income & Purchase Discounts</u>	3,137	28
28a	<u>Late Charges</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,137	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,875,252	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,235,876	31
32	Health Care	4,652,601	32
33	General Administration	2,560,741	33
B. Capital Expense			
34	Ownership	812,164	34
C. Ancillary Expense			
35	Special Cost Centers	769,692	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,096,774	40
41	Income before Income Taxes (line 30 minus line 40)**	1,778,478	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,778,478	43

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

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

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

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

Facility Name & ID Number **Manorcare of Homewood**

0049437

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,891	2,054	\$ 85,763	\$ 41.75	1
2	Assistant Director of Nursing	4,117	4,471	153,748	34.39	2
3	Registered Nurses	24,930	27,074	840,779	31.05	3
4	Licensed Practical Nurses	33,095	35,941	871,059	24.24	4
5	CNAs & Orderlies	71,936	78,264	844,339	10.79	5
6	CNA Trainees					6
7	Licensed Therapist	19,319	21,115	873,786	41.38	7
8	Rehab/Therapy Aides	11,233	12,277	277,020	22.56	8
9	Activity Director	4,620	5,056	69,366	13.72	9
10	Activity Assistants					10
11	Social Service Workers	6,091	6,607	127,348	19.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,823	22,696	283,838	12.51	15
16	Dishwashers					16
17	Maintenance Workers	2,140	2,313	41,744	18.05	17
18	Housekeepers	13,626	14,852	146,336	9.85	18
19	Laundry	3,707	4,033	39,500	9.79	19
20	Administrator	2,080	2,080	83,315	40.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,676	18,333	324,926	17.72	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	1,906	2,075	31,289	15.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	238,190	259,241	\$ 5,094,156 *	\$ 19.65	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	24,000	9, 3	36
37	Medical Records Consultant	Monthly	1,365	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,072	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,437		49

C. CONTRACT NURSES

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

Facility Name & ID Number Manorcare of Homewood# 0049437Report Period Beginning: 01/01/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$4483
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes \$4994 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. \$ 74,623 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
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. \$ 17
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.