

Facility Name & ID Number Lee Manor

0024356 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 N/A

	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	262	Skilled (SNF)	262	95,630	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	262	TOTALS	262	95,630	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			7,577	7,577	8
9	SNF/PED					9
10	ICF	48,724	12,193	3,748	64,665	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,724	12,193	11,325	72,242	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.54%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7.

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 06/29/79

J. Was the facility purchased or leased after January 1, 1978?
YES Date N/A NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 262 and days of care provided 7,577

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Lee Manor

0024356

Report Period Beginning:

1/1/06

Ending:

12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	353,633	60,106	12,830	426,569		426,569		426,569		1
2	Food Purchase		355,190		355,190		355,190	(7,915)	347,275		2
3	Housekeeping	324,798	47,787		372,585		372,585		372,585		3
4	Laundry	61,300	24,393		85,693		85,693	(11,258)	74,435		4
5	Heat and Other Utilities			222,331	222,331		222,331		222,331		5
6	Maintenance	59,290	13,299	103,956	176,545		176,545		176,545		6
7	Other (specify):*										7
8	TOTAL General Services	799,021	500,775	339,117	1,638,913		1,638,913	(19,173)	1,619,740		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	4,005,754	353,006	57,966	4,416,726		4,416,726		4,416,726		10
10a	Therapy	236,541	66,676	66,676	303,217		303,217		303,217		10a
11	Activities	145,221	27,261	2,403	174,885		174,885		174,885		11
12	Social Services	83,067		2,850	85,917		85,917		85,917		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,470,583	380,267	153,895	5,004,745		5,004,745		5,004,745		16
	C. General Administration										
17	Administrative	83,165		103,333	186,498		186,498		186,498		17
18	Directors Fees										18
19	Professional Services			117,178	117,178		117,178	(2,867)	114,311		19
20	Dues, Fees, Subscriptions & Promotion			46,600	46,600		46,600	(597)	46,003		20
21	Clerical & General Office Expense	443,758	34,491	90,679	568,928		568,928	527	569,455		21
22	Employee Benefits & Payroll Tax			834,908	834,908		834,908	6,899	841,807		22
23	Inservice Training & Education			1,883	1,883		1,883		1,883		23
24	Travel and Seminars			6,624	6,624		6,624		6,624		24
25	Other Admin. Staff Transportation			6,274	6,274		6,274		6,274		25
26	Insurance-Prop.Liab.Malpractice			224,985	224,985		224,985		224,985		26
27	Other (specify):*										27
28	TOTAL General Administration	526,923	34,491	1,432,464	1,993,878		1,993,878	3,962	1,997,840		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,796,527	915,533	1,925,476	8,637,536		8,637,536	(15,211)	8,622,325		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lee Manor

#0024356

Report Period Beginning:

1/1/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			104,897	104,897		104,897	273,171	378,068			30
31	Amortization of Pre-Op. & Org											31
32	Interest			111,149	111,149		111,149	355,730	466,879			32
33	Real Estate Taxes							529,186	529,186			33
34	Rent-Facility & Grounds			1,343,880	1,343,880		1,343,880	(1,343,880)				34
35	Rent-Equipment & Vehicle:			36,720	36,720		36,720		36,720			35
36	Other (specify): ³											36
37	TOTAL Ownership			1,596,646	1,596,646		1,596,646	(185,793)	1,410,853			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		251,149	64,500	315,649		315,649		315,649			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			143,445	143,445		143,445		143,445			42
43	Other (specify): ³ Nonallowable Cost			142,621	142,621		142,621	(142,621)				43
44	TOTAL Special Cost Centers		251,149	350,566	601,715		601,715	(142,621)	459,094			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,796,527	1,166,682	3,872,688	10,835,897		10,835,897	(343,625)	10,492,272			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning: 1/1/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(1,016)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients	(11,258)	4		8
9	Non-Straightline Depreciator	149,871	30		9
10	Interest and Other Investment Incom	(3)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax	(1,170)	43		13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(220)	43		18
19	Entertainment	(5,510)	43		19
20	Contributions	(3,215)	43		20
21	Owner or Key-Man Insuranc				21
22	Special Legal Fees & Legal Retainer	(2,867)	19		22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(60,000)	43		24
25	Fund Raising, Advertising and Promotiona	(56,127)	43		25
26	Income Taxes and Illinois Persona Property Replacement Tax	(1,462)	43		26
27	CNA Training for Non-Employee:				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5a	(17,151)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,128)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(333,497)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (333,497)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (343,625)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Lee Manor

Provider #: 0024356

1/1/2006 to #####

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
X-Ray	(9,945)	43
Lab	(515)	43
Patient Transportation	(3,321)	43
Resident Personal Items	(1,692)	43
Non-allowable interest on shareholder loan	(1,081)	32
Chamber of Commerce	(597)	20
Total	<u>(17,151)</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

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
Gamma Trusts (7)	45	See Schedule 6A		Seneca Building	Des Plaines	Lessor
Dorothy Vangel QSS Trust	33.75			Limited Partnership		
Descendants' GST Trusts (5)	11.25					
Chester Plodzien	10					

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	33 Professional Services	\$	Seneca Building Limited Partnership	100.00%	\$ 11,492	\$ 11,492	1
2	V	21 Bank Charges		Seneca Building Limited Partnership	100.00%	527	527	2
3	V	30 Depreciation		Seneca Building Limited Partnership	100.00%	123,300	123,300	3
4	V	32 Interest		Seneca Building Limited Partnership	100.00%	356,814	356,814	4
5	V	33 Real estate taxes		Seneca Building Limited Partnership	100.00%	517,694	517,694	5
6	V	34 Rent - Facility & Grounds	1,343,880	Seneca Building Limited Partnership	100.00%		(1,343,880)	6
7	V	43 Replacement Tax		Seneca Building Limited Partnership	100.00%	556	556	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,343,880			\$ 1,010,383	\$ * (333,497)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence

Provider #0024356

12/31/2006

Schedule 6A

Page 6, Schedule VII, Part A: Related Nursing Home

<u>Name</u>	<u>City</u>
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park
Butterfield Health Care II, Inc. - Meadowbrook Manor	Naperville
Butterfield Health Care, Inc. - Meadowbrook Manor	Bolingbrook

See Accountants' Compilation Report

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	Chester Plodzien	Owner/Officer	Administrative	10.00	None	40	100.00	Mgmt. Fee	\$ 10,333	L17,C3	1
2	Dorothy Vangel	Administrative	Administrative	25.00***	None	8	20.00	Mgmt. Fee	46,500	L17,C3	2
3	Jason Samatas	Administrative	Administrative	6.4285**	166,855	4	8.00	Mgmt. Fee	46,500	L17,C3	3
4	Sean Dimas	Administrative	Administrative	6.67*	None	40	100.00	Salary	42,591	L21,C1	4
5	Emy Plodzien	DON	Administrative	0.00	None	40	100.00	Salary	82,716	L10,C1	5
6					See Schedule 7A						6
7											7
8					*Ownership of Lee Manor held by Decendants S Corp Trust F/B/O Sean William Dimas						8
9					**Ownership of Lee Manor held by George Samatas 1998 Gamma Trust for Jason U/A/D 11/25/98						9
10					***Ownership through attribution						10
11											11
12											12
13								TOTAL	\$ 228,640		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence
Provider #0024356
12/31/2006

Schedule 7A

Compensation Received From Other Nursing Homes

<u>Name of Facility</u>	<u>Jason Samatas</u>
Lexington Health Care Center of Bloomingdale, Inc.	14,061
Lexington Health Care Center of Chicago Ridge, Inc.	18,312
Lexington Health Care Center of Elmhurst, Inc.	12,263
Lexington Health Care Center of LaGrange, Inc.	9,728
Lexington Health Care Center of Lake Zurich, Inc.	17,413
Lexington Health Care Center of Lombard, Inc.	18,312
Lexington Health Care Center of Orland Park, Inc.	22,074
Lexington Health Care Center of Schaumburg, Inc.	18,312
Lexington Health Care Center of Streamwood, Inc.	18,312
Lexington Health Care Center of Wheeling, Inc.	18,068
	<u>166,855</u>

See Accountants' Compilation Report

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11				N/A					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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/06 Ending: 12/31/06

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		8	9	10			
						Original	Balance						
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											
A. Directly Facility Related													
Long-Term													
1	JP Morgan Chase		X	Mortgage	\$40,806.00	8/15/03	\$ 6,500,000	\$ 6,040,536	8/15/10	Variable	\$ 352,674	1	
2												2	
3										Amortization of mortgage costs		6,876	3
4												4	
5												5	
Working Capital													
6	JP Morgan Chase		x	Line of Credit	Interest only	8/15/04	2,000,000	1,020,671	5/31/07	Variable		72,910	6
7	JP Morgan Chase		x	Working Capital	\$4,119.00	1/25/06	600,000	592,012	2/1/13	0.0668		36,498	7
8	Shareholder loans	x			Interest only		307,000		Demand	0.0400		1,081	8
9	TOTAL Facility Related				\$44,925.00		\$ 9,407,000	\$ 7,653,219				\$ 470,039	9
B. Non-Facility Related*													
10										Amortization of loan costs		660	10
11										Interest Income offset		(2,739)	11
12										Non-related interest		(1,081)	12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$ (3,160)	14
15	TOTALS (line 9+line14)						\$ 9,407,000	\$ 7,653,219				\$ 466,879	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lee Manor COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0024356

CONTACT PERSON REGARDING THIS REPORT Tim Adams

TELEPHONE (847) 635-4000 FAX #: (847) 827-5796

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-20-400-033-0000</u>	<u>Seneca Nursing Home</u>	<u>\$ 448,662.00</u>	<u>\$ 448,662.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 448,662.00	\$ 448,662.00

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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

Facility Name & ID Number Lee Manor

0024356 Report Period Beginning:

1/1/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 106,300 B. General Construction Type: Exterior Brick, Dryvit Frame Fire-proof brick Number of Stories 5

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

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

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

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	Land	110,000	1977	\$ 273,400	1
2					2
3	TOTALS	110,000		\$ 273,400	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	252	1979	1979	\$ 4,087,968	\$	40	\$ 102,999	\$ 102,999	\$ 2,726,395
5		1979	1979	337,653		40	8,441	8,441	231,590
6	10	1985	1985	226,649	3,512	40	6,475	2,963	139,213
7									
8									
Improvement Type**									
9	Improvements	1979	1979	6,000		N/A			
10	Improvements	1981	1981	42,962		20			42,962
11	Audit Adjustment	1979	1979	2,779		40	69	69	1,904
12	Audit Adjustment	1981	1981	90,599		40	2,265	2,265	19,497
13	Improvements	1983	1983	46,881		20			46,881
14	Audit Adjustment	1984	1984	25,000		20			25,000
15	Improvements	1986	1986	36,400	1,893	20	910	(983)	36,400
16	Improvements	1988	1988	8,536	271	31.5	271		4,901
17	Improvements	1989	1989	7,785		31.5	311	311	5,546
18	Improvements	1989	1989	9,621		15			9,621
19	Improvements	1991	1991	18,843		15	718	718	18,843
20	Improvements	1992	1992	61,618	1,956	20	3,081	1,125	45,445
21	Improvements	1993	1993	4,548	117	20	227	110	3,065
22	Improvements	1993	1993	36,719		40	917	917	11,921
23	Improvements	1994	1994	16,738		40	418	418	5,225
24	Improvements	1994	1994	8,299	213	40		(213)	8,299
25	Improvements	1995	1995	8,287	155	40	415	260	4,772
26	Improvements	1995	1995	87,711	2,318	40	2,156	(162)	24,812
27	Brick work	1996	1996	3,040	78	20	152	74	1,596
28	Roof Replacement	1996	1996	1,465	38	20	73	35	767
29	Facia, Overhang renovation	1996	1996	75,200		39	1,902	1,902	19,984
30	Hot Water heater	1996	1996	16,084		39	417	417	4,376
31	Insulation	1997	1997	38,770	892	39	994	102	9,443
32	Roofing	1997	1997	5,875		39	150	150	1,425
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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	Refurbishing of hallways and patient room	1997	\$ 59,595	\$	20	\$ 2,980	\$ 2,980	\$ 28,539	37
38	Tile	1997	20,696		20	1,035	1,035	9,912	38
39	Electrical improvement:	1997	4,112		20	206	206	1,973	39
40	Plumbing Improvements:	1997	3,773		20	188	188	1,801	40
41	Basement remodeling	1998	13,578	348	20	679	331	5,771	41
42	smoke dampers	1998	2,235	57	20	112	55	952	42
43	Circulating pump	1998	2,630	67	20	132	65	1,122	43
44	Fire alarm system	1998	4,715	121	20	236	115	2,006	44
45	Compressor	1998	7,653	196	20	382	186	3,247	45
46	Boiler Valve	1998	3,233	83	20	162	79	1,377	46
47	Window Glazing	1998	2,566	66	20	128	62	1,088	47
48	Landscaping	1998	977	25	20	48	23	408	48
49	Patio Brick	1998	2,590	66	20	130	64	1,105	49
50	Ceiling Tiles	1998	2,233		20	112	112	1,797	50
51	Window Treatments:	1998	2,470	131	20	124	(7)	1,054	51
52	Sliding Doors	1999	854		20	43	43	322	52
53	Air Conditioning improvement:	1999	685		20	34	34	255	53
54	Code Alert Wandering Svsten	1999	511		20	26	26	195	54
55	Elevator upgrad	1999	50,000	1,295	20	2,500	1,205	18,750	55
56	Roof Improvements	1999	3,567		20	178	178	1,335	56
57	Hallway renovation-ceiling tile,wiring,painting , doors & til	2000	40,411	1,036	39	1,036		6,853	57
58	Elevators	2000	20,000	513	39	513		3,485	58
59	hallway renovation-Labo	2000	9,048	232	39	232		1,537	59
60	Hallway Renovation- materials. Painting and labo	2000	7,303	187	39	187		1,225	60
61	Painting- labor	2000	2,859	73	39	73		478	61
62	Compressor	2000	20,674	530	39	530		3,247	62
63	windows	2000	91,557	2,348	39	2,348		14,382	63
64	Automatic Doors	2000	1,985	51	39	51		346	64
65	Painting - Labor	2000	11,630	298	39	298		1,900	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,706,170	\$ 19,166		\$ 148,064	\$ 128,898	\$ 3,566,345	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 5,706,170	\$ 19,166		\$ 148,064	\$ 128,898	\$ 3,566,345		1
2	Furnace Room Improvement	3,259	84	39	84		486		2
3	Third floor remodeling	72,480	1,858	39	1,858		9,750		3
4	fourth floor remodeling	64,481	1,653	39	1,653		8,333		4
5	water heater, wallpaper & tile remodeling	19,553	501	39	501		2,944		5
6	remodeling	5,768	148	39	148		833		6
7	Window Systems	8,059	207	39	207		1,233		7
8	Renovation Floor 2 & 5, balance of floor 3&4	340,426		39	8,729	8,729	39,651		8
9	Renovation floor 1, residual of floor 2 & 5	181,976		39	4,666	4,666	18,859		9
10	Building Signs	1,449		39	37	37	159		10
11	Beauty Parlor	681		39	17	17	70		11
12	Alarm	893		39	23	23	104		12
13	Door Enunciator	1,944		39	50	50	227		13
14	2nd Floor Renovation	87,417		39	2,241	2,241	6,914		14
15	Exterior Rehab - Drivv	23,197		39	595	595	1,836		15
16	Exterior Rehab - Drvvi	36,728		39	942	942	2,906		16
17	Fuel Tank	16,616		39	426	426	1,314		17
18	Alarm System	35,000		39	897	897	2,768		18
19	Kitchen Repairs	2,005		39	51	51	158		19
20	Parking lot repair	2,155		39	55	55	170		20
21	Door Hardware	1,354		39	35	35	108		21
22	Carpet for offices	1,468		39	38	38	116		22
23	Landscaping	6,386		39	164	164	506		23
24	Rebuild Kitchen Stairwell	1,580		39	41	41	126		24
25	Grab bars	1,102		39	28	28	86		25
26	water Heater & Storage Tank	13,634		39	350	350	1,080		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,635,781	\$ 23,617		\$ 171,900	\$ 148,283	\$ 3,667,082		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,635,781	\$ 23,617		\$ 171,900	\$ 148,283	\$ 3,667,082	1
2	Landscaping	2004	11,953		15	797	797	1,815	2
3	Dialysis room	2004	3,188		27.5	116	116	289	3
4	Air handler	2004	8,529		27.5	310	310	775	4
5	Back entrance renovation	2004	4,104		27.5	149	149	373	5
6	Building face resurfacing	2004	47,218		27.5	1,717	1,717	4,293	6
7	Chimney inducer	2004	32,366		27.5	1,177	1,177	2,942	7
8	Dialysis room	2004	13,645		27.5	496	496	1,240	8
9	Floor renovation	2004	78,376		27.5	2,850	2,850	7,125	9
10	Tunner cleaning	2004	1,260		27.5	46	46	115	10
11	Refuse disposal	2004	5,012		27.5	182	182	455	11
12	Roofing	2004	14,500		27.5	527	527	1,318	12
13	Security System	2004	59,500		27.5	2,164	2,164	5,410	13
14	Water heater & storage tank	2004	20,208		27.5	735	735	1,837	14
15	Painting	2004	3,510		27.5	128	128	320	15
16	Pump	2004	4,922		27.5	179	179	447	16
17	Remodeling 2nd floor Transitional Care Uni	2005	37,276		27.5	1,355	1,355	2,033	17
18	Remodeling 2nd floor Transitional Care Uni	2006	80,728	1,808	27.5	1,468	(340)	1,468	18
19	Compressor	2006	13,495	225	27.5	245	20	245	19
20	Parking lot and sidewalk renovatio	2006	16,730	837	27.5	304	(533)	304	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)		\$ 7,092,301	\$ 26,487		\$ 186,846	\$ 160,359	\$ 3,699,886	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 478,543	\$ 179,225	\$ 179,980	\$ 755	Various	\$ 347,381	71
72	Current Year Purchases	112,423	22,485	11,242	(11,243)	5	11,242	72
73	Fully Depreciated Assets	765,618					765,618	73
74								74
75	TOTALS	\$ 1,356,584	\$ 201,710	\$ 191,222	\$ (10,488)		\$ 1,124,241	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	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)	\$ 8,722,285	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 228,197	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 378,068	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 149,871	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,824,127	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93	N/A		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 1

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 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

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. _____ /2007 \$ _____
 13. _____ /2008 \$ _____
 14. _____ /2009 \$ _____

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: \$ 36,720 Description: Medical equip - 28,394, Copy machine - 6,879, Security equip - 585, Postage machine - 862
 (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

* 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>It is the policy of this facility to only hire certified nurses aides 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payment:				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (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

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	

- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	L10a, C1	1296	hrs	\$ 50,051			1,296	\$ 50,051	1	
2	Licensed Speech and Language Development Therapist	L10a, C3		hrs		541	27,055	541	27,055	2	
3	Licensed Recreational Therapist			hrs						3	
4	Licensed Physical Therapist	L10a, C1	5149	hrs	186,490			5,149	186,490	4	
5	Physician Care			visits						5	
6	Dental Care			visits						6	
7	Work Related Program			hrs						7	
8	Habilitation			hrs						8	
9	Pharmacy	L39, C2		# of prescripts			251,149		251,149	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10	
11	Academic Education			hrs						11	
12	Exceptional Care Program									12	
13	Other (specify): <u>Dialysis</u>	L39, C3					64,500		64,500	13	
14	TOTAL				\$ 236,541	541	\$ 91,555	\$ 251,149	6,986	\$ 579,245	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning: 1/1/06

Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 42,132	\$ 74,500	1
2	Cash-Patient Deposits	70,029	70,029	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 359,717)	2,174,152	2,174,152	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,291	66,291	6
7	Other Prepaid Expenses	9,049	9,049	7
8	Accounts Receivable (owners or related parties)	(1,320,204)		8
9	Other(specify): <u>Mortgage escrow account</u>		153,342	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,041,449	\$ 2,547,363	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,400	13
14	Buildings, at Historical Cost	760,288	5,412,558	14
15	Leasehold Improvements, at Historical Cost	1,112,775	1,679,743	15
16	Equipment, at Historical Cost	1,361,896	1,356,584	16
17	Accumulated Depreciation (book methods)	(1,720,113)	(4,824,127)	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>Mortgage costs, net</u>	4,859	29,784	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,519,705	\$ 3,927,942	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,561,154	\$ 6,475,305	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 567,646	\$ 567,646	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,030	69,030	28
29	Short-Term Notes Payable	1,612,683	1,612,683	29
30	Accrued Salaries Payable	309,863	309,863	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		466,609	32
33	Accrued Interest Payable	10,313	10,313	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17a</u>	43,086	43,086	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,612,621	\$ 3,079,230	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,040,536	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)	\$	\$ 6,040,536	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,612,621	\$ 9,119,766	46
47	TOTAL EQUITY(page 18, line 24)	\$ (51,467)	\$ (2,644,461)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,561,154	\$ 6,475,305	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Seneca Nursing Home Inc., d/b/a Lee Manor Nursing Residence

Provider # 0024356

12/31/2006

Schedule 17A

XV. Balance Sheet

C. Current Liabilities	<u>Operating</u>	<u>After Consolidation</u>
-------------------------------	-------------------------	---------------------------------------

Line 36 - Other Current Liabilities

Accrued Expenses	9,735	9,735
Accrued Sales Tax	216	216
Pension Plan	31,981	31,981
Garnishment	1,154	1,154
<u>Total - Line 36</u>	<u>43,086</u>	<u>43,086</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (379,450)	1
2	Restatements (describe):		2
3			3
4	Prior period adjustment	295	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (379,155)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	327,688	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)	\$ 327,688	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (51,467)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning: 1/1/06

Ending: 12/31/06

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,517,485	1
2	Discounts and Allowances for all Level	(2,660,102)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,857,383	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	834,484	6
7	Oxygen	1,765	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 836,249	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,632	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	191,730	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	18,381	19
20	Radiology and X-Ray	1,760	20
21	Other Medical Services	186,185	21
22	Laundry	11,258	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 411,946	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Therapy acct payable settlement, vending income</u>	58,004	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 58,004	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,163,585	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,638,913	31
32	Health Care	5,004,745	32
33	General Administrator	1,993,878	33
B. Capital Expense			
34	Ownership	1,596,646	34
C. Ancillary Expense			
35	Special Cost Centers	458,270	35
36	Provider Participation Fee	143,445	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,835,897	40
41	Income before Income Taxes (line 30 minus line 40)**	327,688	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 327,688	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning: 1/1/06

Ending:

12/31/06

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	1,848	2,080	\$ 82,716	\$ 39.77	1
2	Assistant Director of Nursing	1,560	1,857	56,798	30.59	2
3	Registered Nurses	41,927	51,425	1,431,933	27.85	3
4	Licensed Practical Nurses	14,584	17,457	417,326	23.91	4
5	CNAs & Orderlies	116,650	132,409	1,454,362	10.98	5
6	CNA Trainees					6
7	Licensed Therapist	6,446	7,069	236,541	33.46	7
8	Rehab/Therapy Aides	9,386	10,483	176,169	16.81	8
9	Activity Director					9
10	Activity Assistants	15,458	16,769	145,221	8.66	10
11	Social Service Worker	6,882	7,533	83,067	11.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,973	41,676	353,633	8.49	15
16	Dishwashers					16
17	Maintenance Worker	4,707	5,220	59,290	11.36	17
18	Housekeepers	40,462	44,098	324,798	7.37	18
19	Laundry	7,573	8,139	61,300	7.53	19
20	Administrator	1,960	2,080	83,165	39.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,031	25,760	443,758	17.23	24
25	Vocational Instructor					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					31
32	Other Health C: See Sch 20A	12,003	14,598	386,450	26.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	343,450	388,653	\$ 5,796,527 *	\$ 14.91	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	267	\$ 12,830	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	26	1,430	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	39,621	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,403	L11, C3	44
45	Social Service Consultant	46	2,275	L12, C3	45
46	Other(specify) See Sch 20		47,975		46
47					47
48					48
49	TOTAL (lines 35 - 48)	387	\$ 130,534		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

SEE ACCOUNTANTS' COMPILATION REPORT

Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence
 Provider # 0024356
 12/31/2006

Schedule 20A

XVIII. A. STAFFING AND SALARY COSTS

Name	Number of Hrs.	# of hours	Reporting period	Average
	Actually Worked	Paid	Total Sal & Wages	Hourly Wage
Nurse Supervisor	2410	3090	89,701	29.03
MDS Coordinator	3388	4342	112,563	25.92
Nursing Administration	6205	7166	184,186	25.70
Total	12,003	14,598	386,450	26.47

B. CONSULTANT SERVICES

	Number of Hrs.	Total Consultant	Schedule V
	Paid & Accrued	Cost for Reporting Period	Line & Column Reference
Religious	Monthly	575	L12, C3
Physiatrist	Monthly	27,500	L10, C3
Orthopedic	Monthly	14,400	L10, C3
Nephrology	Monthly	5,500	L10, C3
		47,975	

See Accountants' Compilation Report

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
William McNiff	Administrator	0	\$ 83,165	Workers' Compensation Insurance	\$ 85,304	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	68,042	Advertising: Employee Recruitment	14,306	
				FICA Taxes	448,807	Health Care Worker Background Check	2,594	
				Employee Health Insurance	181,155	(Indicate # of checks performed 259)		
				Employee Meals	6,899	Patient Background Checks	474	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long-Term Care	12,050	
				401(k) Contributions	31,981	Miscellaneous dues and subscriptions	8,609	
				Other employee benefits	19,619	Miscellaneous licenses and inspections	1,714	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,165	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other						Less: Public Relations Expense ()		
Description			Amount			Non-allowable advertising ()		
Management fees			\$ 103,333			Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 103,333	TOTAL (agree to Schedule V, line 22, col.8)		\$ 46,003		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Foley & Lardner LLP	Legal		\$ 920				Out-of-State Travel	\$
Chicago Legal Clinic	Legal		672					
James Samatas	Legal		360				In-State Travel	
Edgerton & Edgerton	Legal		350	N/A				
Ellen E. Douglass	Legal		832					
Sandra Lynn Thiel	Legal		2,036				Seminar Expense	6,624
Altschuler Melvoin & Glasser	Accounting		20,710					
RSM McGladrey Inc	Accounting		4,000					
Paterek & Howse LLC	Accounting		7,000					
							Entertainment Expense ()	
See Schedule 21 A			80,298				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 117,178	TOTAL		\$	TOTAL	\$ 6,624

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lee Manor
Provider #: 0024356
12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Systematic Management	Billing	18,104
Hamilton Thies Lorch & Hagnell LLP	Legal	229
Scott & Kraus LLC	Legal	854
Rethco, Inc.	Accounting	475
Ramano & Associates	Collection	1,446
Kforce Professional Staffing	Accounting	2,938
ADP	Data Processing	1,000
Ceridian	Data Processing	20,276
Wescom Solutions	Data Processing	21,347
Medifax EDI, LLC	Billing	583
New England Financial	401(k) Service	2,700
Transworld Systems	Collection	700
American Express Tax & Business	Accounting	1,850
Krakau Business Computer	Computer Services	3,182
Personnell Planners	Unemployment Svces	864
Consulting Service	Computer Services	3,150
Gene A Whilhorn	Billing	600
		<u>80,298</u>
Total (agree to Schedule V, line 19, column 3)		117,178
Out-of-period legal		(721)
Non-allowable collection fees		(2,146)
Total (agree to Schedule V, line 19, column 8)		<u>114,311</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					7	8	9	10	11	12	13			
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	
			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4	N/A													
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning:

1/1/06

Ending:

12/31/06

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 ICLTC - \$12,050
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report N/A
- (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? N/A
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 84,541 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 N/A
- (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. 143,445
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 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 if 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. \$ 6,899 Has any meal income been offset against related costs? Yes Indicate the amount \$ 1,016
- (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 program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- 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 \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain N/A
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	353,633	60,106	12,830	426,569	0	426,569	0	426,569
2. Food Purchase	0	355,190	0	355,190	0	355,190	-7,915	347,275
3. Housekeeping	324,798	47,787	0	372,585	0	372,585	0	372,585
4. Laundry	61,300	24,393	0	85,693	0	85,693	-11,258	74,435
5. Heat and Other Utilities	0	0	222,331	222,331	0	222,331	0	222,331
6. Maintenance	59,290	13,299	103,956	176,545	0	176,545	0	176,545
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	799,021	500,775	339,117	1,638,913	0	1,638,913	-19,173	1,619,740
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	4,005,754	353,006	57,966	4,416,726	0	4,416,726	0	4,416,726
10a. Therapy	236,541	0	66,676	303,217	0	303,217	0	303,217
11. Activities	145,221	27,261	2,403	174,885	0	174,885	0	174,885
12. Social Services	83,067	0	2,850	85,917	0	85,917	0	85,917
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,470,583	380,267	153,895	5,004,745	0	5,004,745	0	5,004,745
17. Administrative	83,165	0	103,333	186,498	0	186,498	0	186,498
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	117,178	117,178	0	117,178	-2,867	114,311
20. Fees, Subscriptions & Promotion	0	0	46,600	46,600	0	46,600	-597	46,003
21. Clerical & General Office	443,758	34,491	90,679	568,928	0	568,928	527	569,455
22. Employee Benefits & Payroll	0	0	834,908	834,908	0	834,908	6,899	841,807
23. Inservice Training & Education	0	0	1,883	1,883	0	1,883	0	1,883
24. Travel and Seminar	0	0	6,624	6,624	0	6,624	0	6,624
25. Other Admin. Staff Trans	0	0	6,274	6,274	0	6,274	0	6,274
26. Insurance-Prop.Liab.Malpractice	0	0	224,985	224,985	0	224,985	0	224,985
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	526,923	34,491	1,432,464	1,993,878	0	1,993,878	3,962	1,997,840
29. Total General Administrative	5,796,527	915,533	1,925,476	8,637,536	0	8,637,536	-15,211	8,622,325
30. Depreciation	0	0	104,897	104,897	0	104,897	273,171	378,068
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	111,149	111,149	0	111,149	355,730	466,879
33. Real Estate	0	0	0	0	0	0	529,186	529,186
34. Rent - Facility & Grounds	0	0	1,343,880	1,343,880	0	1,343,880	-1,343,880	0
35. Rent - Equipment & Vehicles	0	0	36,720	36,720	0	36,720	0	36,720
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,596,646	1,596,646	0	1,596,646	-185,793	1,410,853
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	251,149	64,500	315,649	0	315,649	0	315,649
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	143,445	143,445	0	143,445	0	143,445
43. Other (specify):*	0	0	142,621	142,621	0	142,621	-142,621	0
44. Total Special Cost Ce	0	251,149	350,566	601,715	0	601,715	-142,621	459,094
45. Grand Total	5,796,527	1,166,682	3,872,688	10,835,897	0	10,835,897	-343,625	10,492,272

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	42,132	74,500
2. Cash - Patient Deposits	70,029	70,029
3. Accounts & Notes Recievable	2,174,152	2,174,152
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	66,291	66,291
7. Other Prepaid Expenses	9,049	9,049
8. Accounts Receivable-Owner/Related Party	-1,320,204	0
9. Other (specify):	0	153,342
10. Total current assets	1,041,449	2,547,363
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	273,400
14. Buildings, at Historical Cost	760,288	5,412,558
15. Leasehold Improvements, Historical Cost	1,112,775	1,679,743
16. Equipment, at Historical Cost	1,361,896	1,356,584
17. Accumulated Depreciation (book methods)	-1,720,113	-4,824,127
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	4,859	29,784
24. Total Long-Term Assets	1,519,705	3,927,942
25. Total Assets	2,561,154	6,475,305
CURRENT LIABILITIES		
26. Accounts Payable	567,646	567,646
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	69,030	69,030
29. Short-Term Notes Payable	1,612,683	1,612,683
30. Accrued Salaries Payable	309,863	309,863
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	466,609
33. Accrued Interest Payable	10,313	10,313
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	43,086	43,086
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,612,621	3,079,230
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	6,040,536
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	6,040,536
46. Total Liabilities	2,612,621	9,119,766
47. Total Equity	-51,467	-2,644,461
48. Total Liabilities and Equity	2,561,154	

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	12,517,485
2. Discounts and Allowances for all Levels	-2,660,102
Subtotal - Inpatient Care	9,857,383
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	834,484
7. Oxygen	1,765
Subtotal - Ancillary Revenue	836,249
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	2,632
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	191,730
18. Sale of Supplies to Non-Patients	0
19. Laboratory	18,381
20. Radiology and X-Ray	1,760
21. Other Medical Services	186,185
22. Laundry	11,258
Subtotal - Other Operating Revenue	411,946
24. Contributions	0
25. Interest and Other Investments Income	3
Subtotal - Non-Operating Revenue	3
27. Other Revenue (specify):	0
28. Other Revenue (specify):	58,004
Subtotal - Other Revenue	58,004
30. Total Revenue	11,163,585
31. General Services	1,638,913
32. Health Care	5,004,745
33. General Administration	1,993,878
34. Ownership	1,596,646
35. Special Cost Centers	458,270
35. Provider Participation Fee	143,445
37. Other	0
40. Total Expenses	10,835,897
41. Income Before Income Taxes	327,688
42. Income Taxes	0
43. Net Income or Loss for the Year	327,688