



Facility Name & ID Number Lee Manor

# 0024356 Report Period Beginning: 01/01/07 Ending: 12/31/07

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			8,296	8,296	8
9	SNF/PED					9
10	ICF	47,288	12,767	7,850	67,905	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,288	12,767	16,146	76,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.68%

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  Note: 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 06/29/1979

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 8,296

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 01/01/2007 Fiscal Year: 12/31/07

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

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
	<b>A. General Services</b>										
1	Dietary	382,083	86,895	13,231	482,209		482,209		482,209		1
2	Food Purchase		385,681		385,681		385,681	(9,658)	376,023		2
3	Housekeeping	339,026	46,922		385,948		385,948		385,948		3
4	Laundry	67,158	28,179		95,337		95,337	(9,494)	85,843		4
5	Heat and Other Utilities			322,476	322,476		322,476		322,476		5
6	Maintenance	75,518	10,381	132,881	218,780		218,780		218,780		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	863,785	558,058	468,588	1,890,431		1,890,431	(19,152)	1,871,279		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	4,214,913	304,971	83,295	4,603,179		4,603,179	8,033	4,611,212		10
10a	Therapy	340,835	3,334	66,542	410,711		410,711		410,711		10a
11	Activities	172,368	21,704	2,388	196,460		196,460		196,460		11
12	Social Services	110,413		3,438	113,851		113,851		113,851		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,838,529	330,009	179,663	5,348,201		5,348,201	8,033	5,356,234		16
	<b>C. General Administration</b>										
17	Administrative	89,301		130,000	219,301		219,301		219,301		17
18	Directors Fees										18
19	Professional Services			125,079	125,079		125,079	6,195	131,274		19
20	Dues, Fees, Subscriptions & Promotions			39,692	39,692		39,692		39,692		20
21	Clerical & General Office Expenses	434,466	49,178	78,277	561,921		561,921	30	561,951		21
22	Employee Benefits & Payroll Taxes			888,994	888,994		888,994	7,574	896,568		22
23	Inservice Training & Education			15,425	15,425		15,425	(8,033)	7,392		23
24	Travel and Seminar			6,601	6,601		6,601		6,601		24
25	Other Admin. Staff Transportation			12,557	12,557		12,557		12,557		25
26	Insurance-Prop.Liab.Malpractice			243,903	243,903		243,903		243,903		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	523,767	49,178	1,540,528	2,113,473		2,113,473	5,766	2,119,239		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,226,081	937,245	2,188,779	9,352,105		9,352,105	(5,353)	9,346,752		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.

Facility Name &amp; ID Number Lee Manor

#0024356

Report Period Beginning:

01/01/07

Ending:

12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			117,451	117,451		117,451	133,958	251,409			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			109,874	109,874		109,874	438,872	548,746			32
33	Real Estate Taxes							452,664	452,664			33
34	Rent-Facility & Grounds			1,343,880	1,343,880		1,343,880	(1,343,880)				34
35	Rent-Equipment & Vehicles			18,652	18,652		18,652		18,652			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,589,857	1,589,857		1,589,857	(318,386)	1,271,471			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		309,898	99,112	409,010		409,010		409,010			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,445	143,445		143,445		143,445			42
43	Other (specify):* <b>Non-allowable Cos</b>			812,124	812,124		812,124	(812,124)				43
44	<b>TOTAL Special Cost Centers</b>		309,898	1,054,681	1,364,579		1,364,579	(812,124)	552,455			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,226,081	1,247,143	4,833,317	12,306,541		12,306,541	(1,135,863)	11,170,678			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: 01/01/07

Ending: 12/31/07

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,084)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(9,494)	4		8
9	Non-Straightline Depreciation	3,804	30		9
10	Interest and Other Investment Income	(434)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,000)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,025)	43		17
18	Fines and Penalties	(1,591)	43		18
19	Entertainment	(14,473)	43		19
20	Contributions	(3,682)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(686,908)	43		24
25	Fund Raising, Advertising and Promotional	(77,785)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(26,584)	Var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (821,257)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(314,606)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (314,606)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,135,863)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Lee Manor

ID# 0024356

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow X-RAYS	\$ (12,810)	43	1
2	Disallow Lab	(3,734)	43	2
3	Disallow non-allowable transportation	(4,957)	43	3
4	Disallow resident personal items	(5,083)	43	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	<b>Total</b>	(26,584)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lee Manor

# 0024356

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,084)	0	0	0	0	0	0	0	0	0	0	(2,084)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(9,494)	0	0	0	0	0	0	0	0	0	0	(9,494)	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	<b>TOTAL General Services</b>	<b>(11,578)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,578)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	36	0	0	0	0	0	0	0	0	0	36	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	<b>TOTAL General Administration</b>	<b>0</b>	<b>36</b>	<b>0</b>	<b>36</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(11,578)</b>	<b>36</b>	<b>0</b>	<b>(11,542)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Lee Manor

# 0024356

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	3,804	130,154	0	0	0	0	0	0	0	0	0	133,958	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(434)	439,300	0	0	0	0	0	0	0	0	0	438,866	32
33	Real Estate Taxes	0	459,784	0	0	0	0	0	0	0	0	0	459,784	33
34	Rent-Facility & Grounds	0	(1,343,880)	0	0	0	0	0	0	0	0	0	(1,343,880)	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	<b>TOTAL Ownership</b>	<b>3,370</b>	<b>(314,642)</b>	<b>0</b>	<b>(311,272)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(813,049)	0	0	0	0	0	0	0	0	0	0	(813,049)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(813,049)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(813,049)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(821,257)</b>	<b>(314,606)</b>	<b>0</b>	<b>(1,135,863)</b>	<b>45</b>								

Facility Name & ID Number

Lee Manor

# 0024356

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		
Decendants' GST Trust (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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	33 Professional Services	\$	Seneca Building Limited Partnership	100.00%	\$ 7,120	\$ 7,120	1
2	V	21 Bank Charges		Seneca Building Limited Partnership	100.00%	36	36	2
3	V	30 Depreciation		Seneca Building Limited Partnership	100.00%	130,154	130,154	3
4	V	32 Interest		Seneca Building Limited Partnership	100.00%	439,300	439,300	4
5	V	33 Real Estate Taxes		Seneca Building Limited Partnership	100.00%	452,664	452,664	5
6	V	34 Rent Facility & Grounds	1,343,880	Seneca Building Limited Partnership	100.00%		(1,343,880)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,343,880			\$ 1,029,274	\$ * (314,606)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence  
Provider #0024356  
12/31/2007

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: 01/01/07 Ending: 12/31/07

## 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	\$ 19,000	L17, C3	1	
2	Chris Vangel	Administrative	Administrative	6.67*	Not Available	8	20.00	Mgmt. Fee	54,000	L17, C3	2	
3	Nick Vangel	Administrative	Administrative	0.00	None	8	20.00	Mgmt. Fee	13,500	L17, C3	3	
4	Jason Samatas	Administrative	Administrative	6.4285**	See Schedule 7A	4	10.00	Mgmt. Fee	30,000	L17, C3	4	
5	George Samatas Gamma Trust	Administrative	Administrative	45.00	None	0	0.00	Mgmt. Fee	13,500	L17, C3	5	
6	Sean Dimas	Administrative	Administrative	6.67*	None	40	100.00	Salary	45,907	L21,C1	6	
7	Mey Plodzien	DON	Administrative	0.00	None	40	100.00	Salary	93,937	L10,C1	7	
8											8	
9											9	
10		*Ownership of Lee Manor held by Decendents S Corp Trust F/B/O Sean William Dimas										10
11		** Ownership of Lee Manor held by George Samatas 1998 Gamma Trust for Jason U/A/D 11/25/98										11
12		*** Ownership through attribution										12
13								TOTAL	\$ 269,844		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

Facility Name & ID Number Lee Manor

# 0024356 Report Period Beginning: 01/01/07 Ending: 12/31/07

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				N/A					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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	JP Morgan Chase		X	Mortgage	\$40,806.00	08/15/03	\$ 6,500,000	\$ 5,905,331	08/15/2010	Variable	\$ 379,644	1								
2												2								
3							Amortization of mortgage costs				7,167	3								
4												4								
5												5								
<b>Working Capital</b>																				
6	JP Morgan Chase		X	Line of Credit	Interest Only	05/15/04	2,000,000	675,000	05/31/07	Variable	66,672	6								
7	JP Morgan Chase		X	Working Capital	\$4,119.00	1/25/06	600,000	581,822	02/1/13	0.0668	42,477	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$44,925.00		\$ 9,100,000	\$ 7,162,153			\$ 495,960	9								
<b>B. Non-Facility Related*</b>																				
10	SBP 3.5		X	Samatas payoff	\$27,000.00	10/17/2007	3,500,000	3,480,428	8/31/2010	Libor + 200bp	52,786	10								
11	LM Contracts Equip		X	Capital Lease (Bus&Chiller)	\$2,590.07	07/31/07	104,862	104,862	07/31/2012	Variable		11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>				\$29,590.07		\$ 3,604,862	\$ 3,585,290			\$ 52,786	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 12,704,862	\$ 10,747,443			\$ 548,746	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.)

Facility Name & ID Number Lee Manor# 0024356

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>466,609</b>	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.)		2006	\$	<b>458,251</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(8,358)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>488,972</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		<b>Unreconciled difference</b>	\$	<b>(27,950)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>452,664</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	<u>397,562</u>	<u>8</u>			
2003	<u>408,894</u>	<u>9</u>			
2004	<u>431,738</u>	<u>10</u>			
2005	<u>448,661</u>	<u>11</u>			
2006	<u>458,251</u>	<u>12</u>			
<b>2007 Taxes \$458,251</b>					
<b>1.04% Increase = \$476,581</b>					
<b>Accrued 2007 = \$488,972</b>					
<b>Variance immaterial</b>					
			<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2006	\$			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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

**2006 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 Cos**

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2006

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 09-20-400-033-0000	Seneca Nursing Home	\$ 458,251.00	\$ 458,251.00
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>458,251.00</u>	\$ <u>458,251.00</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2007

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

# 0024356 Report Period Beginning:

01/01/07 Ending:

12/31/07

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

---

---

---

---

---

---

---

---

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

1. Total Amount Incurred: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Land</u>	<u>110,000</u>	<u>1977</u>	<u>\$ 273,400</u>	1
2					2
3	<b>TOTALS</b>	<b>110,000</b>		<b>\$ 273,400</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

# 0024356

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	\$ 2,829,394	4
5			1979	1979	337,653		40	8,441	8,441	240,031	5
6	10		1985	1985	226,649	3,512	40	6,475	2,963	145,688	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Improvements		1979		6,000		N/A				9
10	Improvements		1981		42,962		20			42,962	10
11	Audit Adjustment		1979		2,779		40	69	69	1,973	11
12	Audit Adjustment		1981		90,599		40	2,265	2,265	21,762	12
13	Improvements		1983		46,881		20			46,881	13
14	Audit Adjustment		1984		25,000		20			25,000	14
15	Improvements		1986		36,400	1,893	20	910	(983)	36,400	15
16	Improvements		1988		8,536	271	31.5	271		5,172	16
17	Improvements		1989		7,785		31.5	311	311	5,857	17
18	Improvements		1989		9,621		15			9,621	18
19	Improvements		1991		18,843		15	718	718	18,843	19
20	Improvements		1992		61,618	1,956	20	3,081	1,125	48,526	20
21	Improvements		1993		4,548	117	20	227	110	3,292	21
22	Improvements		1993		36,719		40	917	917	12,838	22
23	Improvements		1994		16,738		40	418	418	5,643	23
24	Improvements		1994		8,299	213	40		(213)	8,299	24
25	Improvements		1995		8,287	155	40	415	260	5,187	25
26	Improvements		1995		87,711	2,318	40	2,156	(162)	26,968	26
27	Brick work		1996		3,040	78	20	152	74	1,748	27
28	Roof Replacement		1996		1,465	38	20	73	35	840	28
29	Facia, Overhang renovation		1996		75,200		39	1,902	1,902	31,886	29
30	Hot Water heater		1996		16,084		39	417	417	4,793	30
31	Insulation		1997		38,770	892	39	994	102	10,437	31
32	Roofing		1997		5,875		39	150	150	1,575	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lee Manor

# 0024356

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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 rooms	1997	\$ 59,595	\$	20	\$ 2,980	\$ 2,980	\$ 31,519	37
38	Tile	1997	20,696		20	1,035	1,035	10,947	38
39	Electrical improvements	1997	4,112		20	206	206	2,179	39
40	Plumbing Improvements	1997	3,773		20	188	188	1,989	40
41	Basement remodeling	1998	13,578	348	20	679	331	6,450	41
42	smoke dampers	1998	2,235	57	20	112	55	1,064	42
43	Circulating pump	1998	2,630	67	20	132	65	1,254	43
44	Fire alarm system	1998	4,715	121	20	236	115	2,242	44
45	Compressor	1998	7,653	196	20	382	186	3,629	45
46	Boiler Valve	1998	3,233	83	20	162	79	1,539	46
47	Window Glazing	1998	2,566	66	20	128	62	1,216	47
48	Landscaping	1998	977	25	20	48	23	456	48
49	Patio Brick	1998	2,590	66	20	130	64	1,235	49
50	Ceiling Tiles	1998	2,233		20	112	112	1,909	50
51	Window Treatments	1998	2,470	131	20	124	(7)	1,178	51
52	Sliding Doors	1999	854		20	43	43	365	52
53	Air Conditioning improvements	1999	685		20	34	34	289	53
54	Code Alert Wandering System	1999	511		20	26	26	221	54
55	Elevator upgrade	1999	50,000	1,295	20	2,500	1,205	21,250	55
56	Roof Improvements	1999	3,567		20	178	178	1,510	56
57	Hallway renovation-ceiling tile,wiring,painting , doors & tile	2000	40,411	1,036	39	1,036		7,889	57
58	Elevators	2000	20,000	513	39	513		3,998	58
59	hallway renovation-Labor	2000	9,048	232	39	232		1,769	59
60	Hallway Renovation- materials, Painting and labor	2000	7,303	187	39	187		1,412	60
61	Painting- labor	2000	2,859	73	39	73		551	61
62	Compressor	2000	20,674	530	39	530		3,777	62
63	windows	2000	91,557	2,348	39	2,348		16,730	63
64	Automatic Doors	2000	1,985	51	39	51		397	64
65	Painting - Labor	2000	11,630	298	39	298		2,198	65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 5,706,170	\$ 19,166		\$ 148,064	\$ 128,898	\$ 3,722,778	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Lee Manor

# 0024356

Report Period Beginning:

01/01/07 Ending:

12/31/07

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,706,170	\$ 19,166		\$ 148,064	\$ 128,898	\$ 3,722,778	1
2	Furnace Room Improvements	2001	3,259	84	39	84		570	2
3	Third floor remodeling	2001	72,480	1,858	39	1,858		11,608	3
4	fourth floor remodeling	2001	64,481	1,653	39	1,653		9,986	4
5	water heater, wallpaper & tile	2001	19,553	501	39	501		3,445	5
6	remodeling	2001	5,768	148	39	148		981	6
7	Window Systems	2001	8,059	207	39	207		1,440	7
8	Renovation Floor 2 & 5, balance of floor 3&4	2002	340,426		39	8,729	8,729	39,857	8
9	Renovation floor 1, residual of floor 2 & 5	2002	181,976		39	4,666	4,666	23,525	9
10	Building Signs	2002	1,449		39	37	37	196	10
11	Beauty Parlor	2002	681		39	17	17	87	11
12	Alarm	2002	893		39	23	23	127	12
13	Door Enunciator	2002	1,944		39	50	50	277	13
14	2nd Floor Renovation	2003	87,417		39	2,241	2,241	9,155	14
15	Exterior Rehab - Dryvit	2003	23,197		39	595	595	2,431	15
16	Exterior Rehab - Dryvit	2003	36,728		39	942	942	3,848	16
17	Fuel Tank	2003	16,616		39	426	426	1,740	17
18	Alarm System	2003	35,000		39	897	897	3,665	18
19	Kitchen Repairs	2003	2,005		39	51	51	434	19
20	Parking lot repairs	2003	2,155		39	55	55	143	20
21	Door Hardware	2003	1,354		39	35	35	154	21
22	Carpet for offices	2003	1,468		39	38	38	154	22
23	Landscaping	2003	6,386		39	164	164	670	23
24	Rebuild Kitchen Stairwell	2003	1,580		39	41	41	167	24
25	Grab bars	2003	1,102		39	28	28	114	25
26	water Heater & Storage Tanks	2003	13,634		39	350	350	1,430	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,635,781	\$ 23,617		\$ 171,900	\$ 148,283	\$ 3,838,982	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

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	\$ 3,838,982	1
2	Landscaping	2004	11,953		15	797	797	2,612	2
3	Dialysis room	2004	3,188		27.5	116	116	405	3
4	Air handler	2004	8,529		27.5	310	310	1,085	4
5	Back entrance renovation	2004	4,104		27.5	149	149	522	5
6	Building face resurfacing	2004	47,218		27.5	1,717	1,717	6,010	6
7	Chimney inducer	2004	32,366		27.5	1,177	1,177	4,119	7
8	Dialysis room	2004	13,645		27.5	496	496	1,736	8
9	Floor renovation	2004	78,376		27.5	2,850	2,850	9,975	9
10	Tunner cleaning	2004	1,260		27.5	46	46	161	10
11	Refuse disposal	2004	5,012		27.5	182	182	637	11
12	Roofing	2004	14,500		27.5	527	527	1,845	12
13	Security System	2004	59,500		27.5	2,164	2,164	7,574	13
14	Water heater & storage tank	2004	20,208		27.5	735	735	2,572	14
15	Painting	2004	3,510		27.5	128	128	448	15
16	Pump	2004	4,922		27.5	179	179	626	16
17	Remodeling 2nd floor Transitional Care Unit	2005	37,276		27.5	1,355	1,355	3,388	17
18	Remodeling 2nd floor Transitional Care Unit	2006	80,728	1,808	27.5	2,936	1,128	4,404	18
19	Compressor	2006	13,495	225	27.5	490	265	735	19
20	Parking lot and sidewalk renovation	2006	16,730	837	27.5	608	(229)	912	20
21									21
22									22
23	Chiller	2007	99,000		15	3,300	3,300	3,300	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)		\$ 7,191,301	\$ 26,487		\$ 192,162	\$ 165,675	\$ 3,892,048	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: 01/01/07 Ending: 12/31/07

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	\$ 590,966	\$ 86,454	\$ 52,885	\$ (33,569)	5-15	\$ 403,900	71
72	Current Year Purchases	98,563	3,285	3,300	15	15	3,300	72
73	Fully Depreciated Assets	765,618					765,618	73
74								74
75	TOTALS	\$ 1,455,147	\$ 89,739	\$ 56,185	\$ (33,554)		\$ 1,172,818	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	Bus	2000 Ford Bus	2007	\$ 24,501	\$ 1,225	\$ 3,062	\$ 1,837	4	\$ 3,062	76
77										77
78										78
79										79
80	TOTALS			\$ 24,501	\$ 1,225	\$ 3,062	\$ 1,837		\$ 3,062	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)	\$ 8,944,349	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,451	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 251,409	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 133,958	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,067,928	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	CIP	\$ 162,112	92
93			93
94			94
95		\$ 162,112	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: 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	<b>TOTAL</b>				\$			7

\*\*

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 18,652 Description: Water Soft \$432, Security Equip \$150, Postage Mach \$804, Copier \$6,921, Medical equip \$10,345

(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	<b>TOTAL</b>		\$	\$	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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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>	<input type="checkbox"/> YES  <input checked="" type="checkbox"/> NO	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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)	
<b>TOTAL TRAINED</b>	

- (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.
- 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(1)	2700	hrs	\$ 87,495		\$	2,700	\$ 87,495	1	
2	Licensed Speech and Language Development Therapist	L 10A(1,3)	2414	hrs	58,884	161	8,036	2,575	66,920	2	
3	Licensed Recreational Therapist			hrs						3	
4	Licensed Physical Therapist	L10A(1,2)	5300	hrs	194,456		3,334	5,300	197,790	4	
5	Physician Care			visits						5	
6	Dental Care			visits						6	
7	Work Related Program			hrs						7	
8	Habilitation			hrs						8	
9	Pharmacy	L39(2)		# of prescripts			309,898		309,898	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10	
11	Academic Education			hrs						11	
12	Exceptional Care Program									12	
13	Other (specify): <b>Dialysis</b>	L39 (3)				99,112			99,112	13	
14	<b>TOTAL</b>				\$ 340,835	161	\$ 107,148	\$ 313,232	10,575	\$ 761,215	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.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Lee Manor

# 0024356

Report Period Beginning: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 46,943	\$ (4,820)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 879,141 )	1,971,418	1,971,418	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,184	107,184	6
7	Other Prepaid Expenses	35,056	35,056	7
8	Accounts Receivable (owners or related parties)	506,368	506,368	8
9	Other(specify): Escrow-taxes		11,471	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,666,969	\$ 2,626,677	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,400	13
14	Buildings, at Historical Cost	760,288	4,652,270	14
15	Leasehold Improvements, at Historical Cost	1,211,774	2,539,031	15
16	Equipment, at Historical Cost	1,484,960	1,479,648	16
17	Accumulated Depreciation (book methods)	(1,837,564)	(5,067,928)	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 (CII/CIP)	162,112	162,112	22
23	Other(specify): Mortgage costs	4,134	46,779	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,785,704	\$ 4,085,312	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,452,673	\$ 6,711,989	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 858,914	\$ 858,914	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,256,822	1,256,822	29
30	Accrued Salaries Payable	377,087	377,087	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		488,972	32
33	Accrued Interest Payable	3,239	58,080	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Schedule 17A	2,383,803	103,645	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 4,879,865	\$ 3,143,520	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	104,862	104,862	39
40	Mortgage Payable		9,385,759	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 104,862	\$ 9,490,621	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,984,727	\$ 12,634,141	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (532,054)	\$ (5,922,152)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,452,673	\$ 6,711,989	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence**  
**Provider # 0024356**  
**12/31/2007**

**Schedule 17 A**

XV. Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 36 -Other Current Liabilities		
Accrued Expenses	8,000	8,000
Accrued Insurance	13974	13974
Due to PA-Audit	42373	42373
Accrued 401K	32799	32799
401K Withholding	4,824	4,824
Garnishment	1,153	1,153
Sales Tax Payable	522	522
Due to Building	2,280,158	-
	<u>2,383,803</u>	<u>103,645</u>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (51,467)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (51,467)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(480,587)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (480,587)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (532,054)</b>	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lee Manor

# 0024356

Report Period Beginning: 01/01/07

Ending:

12/31/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 13,310,807	1
2	Discounts and Allowances for all Levels	(3,143,233)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,167,574	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,092,098	6
7	Oxygen	4,115	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,096,213	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,625	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	292,585	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,826	19
20	Radiology and X-Ray	3,710	20
21	Other Medical Services	232,409	21
22	Laundry	9,494	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 559,649	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	434	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 434	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Meals, Vending &amp; Other Income</u>	2,084	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,084	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,825,954	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,890,431	31
32	Health Care	5,348,201	32
33	General Administration	2,113,473	33
<b>B. Capital Expense</b>			
34	Ownership	1,589,857	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,221,134	35
36	Provider Participation Fee	143,445	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,306,541	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(480,587)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (480,587)	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:

01/01/07

Ending:

12/31/07

**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	2,008	2,240	\$ 93,937	\$ 41.94	1
2	Assistant Director of Nursing	1,070	1,182	37,326	31.58	2
3	Registered Nurses	47,473	51,266	1,529,778	29.84	3
4	Licensed Practical Nurses	16,227	17,409	468,838	26.93	4
5	CNAs & Orderlies	121,665	130,672	1,417,814	10.85	5
6	CNA Trainees					6
7	Licensed Therapist	10,414	11,063	340,835	30.81	7
8	Rehab/Therapy Aides	10,770	11,668	211,768	18.15	8
9	Activity Director					9
10	Activity Assistants	17,211	18,564	172,368	9.29	10
11	Social Service Workers	7,975	8,527	110,413	12.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,962	42,547	382,083	8.98	15
16	Dishwashers					16
17	Maintenance Workers	3,362	6,385	75,518	11.83	17
18	Housekeepers	37,954	43,114	339,026	7.86	18
19	Laundry	7,581	8,357	67,158	8.04	19
20	Administrator	4,346	2,160	89,301	41.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,710	24,907	434,466	17.44	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	3,918	4,297	56,268	13.09	31
32	Other Health CareSee Sch 20A	11,708	12,516	399,184	31.89	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	366,354	396,874	\$ 6,226,081 *	\$ 15.69	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	265	\$ 13,231	L1,C3	35
36	Medical Director	Monthly	24,000	L9,3	36
37	Medical Records Consultant	22	1,108	L10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	58,506	L10A,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,388	L11,3	44
45	Social Service Consultant	48	2,888	L12,3	45
46	Other(specify)See Sch 20A		66,900	L10 (3)	46
47	See Sch 20A		550	L12(3)	47
48					48
49	TOTAL (lines 35 - 48)	375	\$ 169,571		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**  
**12/31/2007**

**Schedule 20 A**

XXVIII. A. Staffing and Salary costs

Name	Number of Hrs Worked	Number Hrs Paid	Tot Sal & Wages	Ave. Hourly
Nurse Supv	2,384	2,576	81,691	31.71
MDS Coordinator	7,662	8,150	262,619	32.22
Nursing Admin	1,662	1,790	54,874	30.66
Total	11,708.0	12,516.0	399,184.0	31.89

B. Consultant Services

Religious	Monthly		550	L12,C3
Physiatrist	Monthly		30,000	L10,C3
Orthopedic	Monthly		14,400	L10,C3
Nephrology	Monthly		6,000	L10,C3
MDS Consultant		275	16,500	L10,C3
			66,900	

Facility Name & ID Number Lee Manor

# 0024356

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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		\$ 89,301	Workers' Compensation Insurance	\$ 107,918	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	87,895	Advertising: Employee Recruitment	15,503	
				FICA Taxes	465,738	Health Care Worker Background Check	1,430	
				Employee Health Insurance	172,697	(Indicate # of checks performed <u>143</u> )		
				Employee Meals	7,574	Patient Background Checks	250 2,500	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,227	
				401 K Contributions	33,311	Miscellaneous Dues & Subscriptions	6,962	
				Uniforms	1,241	Illinois Concil Long Term Care	12,070	
				Other Employee Benefits	20,194			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: COPE Dues	(1,846)	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 37,846	
						G. Schedule of Travel and Seminar**		
Description				Description		Description		
Amount				Line #		Amount		
Management Fees				N/A		Out-of-State Travel		
\$ 130,000						\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL		In-State Travel		
\$ 130,000								
C. Professional Services								
Vendor/Payee								
Type								
Amount								
\$								
K Force Staffing						Seminar Expense		
Staffing						6,601		
6,480								
RSM McGladrey						Entertainment Expense		
Accounting						( )		
30,204								
Peterek & Howse LLP						TOTAL (agree to Sch. V, line 24, col. 8)		
Accounting						\$ 6,601		
4,931								
Michael Kaplan								
Consulting								
8,000								
See Schedule 21A								
75,464								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 125,079								

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Lee Manor  
Provider #: 0024356  
12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE  
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
New England Financial	401(k) Service	1,134
Lorch Hamilton	Accounting	358
W-T Land Survey	Appraisal	1,500
J P Morgan	Appraisal	6,000
Zimmerman & Assoc.	Appraisal	5,000
Dennis Hetler	Appraisal	11,492
Medifax EDI, LLC	Billing	180
Edgerton	Collection	175
Krakau Business Computer	Computer Services	7,176
CNR	Data Processing	2,070
E Health Data	Data Processing	2,309
ADP	Data Processing	15,957
Mutual Omaha	Data Processing	401
Wescom Solutions	Data Processing	17,657
Anthony's Mobile Fingerprinting	Finger Printing	390
Chicago Legal Clinic	Guardianship	1,125
Carmen Deato	IT Support	650
Personnel Planners	unemployment Service	1,140
Richard Sora	Collection	750
		<u>75,464</u>
<b>Total (Agree Schedule V, line 19, column 3)</b>		<u><b>125,079</b></u>
Non-allowable collection fees		(925)
Home Office Legal allocation		7,120
<b>Total (agree to Schedule V, line 19 , column 8)</b>		<u><b>131,274</b></u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6								N/A					
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lee Manor

**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 \$1,846
- (3) Did the nursing home make political contributions or payments to a political action 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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 85,861 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. N/A
- (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 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. \$ 7,574 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 44
- (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. \$ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**