

Facility Name & ID Number Leroy Manor

0047704 Report Period Beginning: 10/01/07 Ending: 9/30/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,136	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	96	TOTALS	96	35,136	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					
		2 Medicaid Recipient		3 Private Pay	4 Other		5 Total
		8	SNF	15,518	10,074		1,807
9	SNF/PED					9	
10	ICF		0			10	
11	ICF/DD					11	
12	SC		0			12	
13	DD 16 OR LESS					13	
14	TOTALS	15,518	10,074	1,807	27,399	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.98%

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

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 12/15/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/14/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 96 and days of care provided 1,807

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/08 Fiscal Year: 09/30/08

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

Facility Name & ID Number Leroy Manor # 0047704 Report Period Beginning: 10/01/07 Ending: 9/30/08

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
	A. General Services										
1	Dietary	214,891	23,927	4,647	243,465		243,465		243,465		1
2	Food Purchase		233,555		233,555		233,555		233,555		2
3	Housekeeping	101,947	31,509	778	134,234		134,234		134,234		3
4	Laundry	47,189	21,720		68,909		68,909		68,909		4
5	Heat and Other Utilities			139,010	139,010		139,010		139,010		5
6	Maintenance	52,114	45,676	51,196	148,986		148,986		148,986		6
7	Other (specify):*										7
8	TOTAL General Services	416,141	356,387	195,631	968,159		968,159		968,159		8
	B. Health Care and Programs										
9	Medical Director			11,800	11,800		11,800		11,800		9
10	Nursing and Medical Records	1,581,208	129,725	2,820	1,713,753		1,713,753		1,713,753		10
10a	Therapy			166,729	166,729		166,729		166,729		10a
11	Activities	70,690	1,658	70	72,418		72,418	(3,206)	69,212		11
12	Social Services	15,103			15,103		15,103		15,103		12
13	CNA Training										13
14	Program Transportation			864	864	3,395	4,259		4,259		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,667,001	131,383	182,283	1,980,667	3,395	1,984,062	(3,206)	1,980,856		16
	C. General Administration										
17	Administrative	105,398			105,398		105,398		105,398		17
18	Directors Fees							2,678	2,678		18
19	Professional Services			279,047	279,047		279,047	2,120	281,167		19
20	Dues, Fees, Subscriptions & Promotions			73,019	73,019		73,019	(38,741)	34,278		20
21	Clerical & General Office Expenses	57,751	22,825	33,077	113,653		113,653		113,653		21
22	Employee Benefits & Payroll Taxes			285,294	285,294		285,294		285,294		22
23	Inservice Training & Education			6,594	6,594		6,594		6,594		23
24	Travel and Seminar			1,591	1,591		1,591	(1,216)	375		24
25	Other Admin. Staff Transportation			6,789	6,789	(3,395)	3,394		3,394		25
26	Insurance-Prop.Liab.Malpractice			52,420	52,420		52,420	26,866	79,286		26
27	Other (specify):* <u>See Att Sch VI</u>	32,938		11,752	44,690		44,690	(44,690)			27
28	TOTAL General Administration	196,087	22,825	749,583	968,495	(3,395)	965,100	(52,983)	912,117		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,279,229	510,595	1,127,497	3,917,321		3,917,321	(56,189)	3,861,132		29

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

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

Facility Name & ID Number

Leroy Manor

#0047704

Report Period Beginning:

10/01/07

Ending:

9/30/08

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	
	D. Ownership											
30	Depreciation			24,507	24,507		24,507	130,968	155,475			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							213,067	213,067			32
33	Real Estate Taxes							76,200	76,200			33
34	Rent-Facility & Grounds			418,920	418,920		418,920	(418,920)				34
35	Rent-Equipment & Vehicles			5,532	5,532		5,532		5,532			35
36	Other (specify):* See Att Sch V							6,676	6,676			36
37	TOTAL Ownership			448,959	448,959		448,959	7,991	456,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			10,356	10,356		10,356		10,356			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,569	2,569		2,569		2,569			41
42	Provider Participation Fee			52,704	52,704		52,704		52,704			42
43	Other (specify):*			30	30		30		30			43
44	TOTAL Special Cost Centers			65,659	65,659		65,659		65,659			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,279,229	510,595	1,642,115	4,431,939		4,431,939	(48,198)	4,383,741			45

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

Facility Name & ID Number Leroy Manor

0047704

Report Period Beginning: 10/01/07

Ending: 9/30/08

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				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				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(4)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,938)	V-27		24
25	Fund Raising, Advertising and Promotional	(38,745)	V-20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule See Att Sch VII	(43,024)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,711)		\$	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)	36,346		34
35	Other- Attach Schedule See Att Sch III	7,167		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 43,513		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (48,198)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Leroy Manor

ID# 0047704

Report Period Beginning: 10/01/07

Ending: 9/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Facility Name & ID Number Leroy Manor

0047704

Report Period Beginning: 10/01/07

Ending: 9/30/08

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
None	N/A	See Attached Schedule I		See Attached Schedule I		

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	34 Facility rent	\$ 418,920	Leroy South Buck, LLC	N/A	\$ 455,266	\$	36,346	1
2	V								2
3	V								3
4	V								4
5	V			See Att Schedule V					5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 418,920			\$ 455,266	\$ *	36,346	14

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

Facility Name & ID Number Leroy Manor # 0047704 Report Period Beginning: 10/01/07 Ending: 9/30/08

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	See Attached Schedule II & III								\$ 2,678	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,678		13

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

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

Facility Name & ID Number Leroy Manor # 0047704 Report Period Beginning: 10/01/07 Ending: 9/30/08

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 Unlimited Development, Inc.
 Street Address 285 S Farnham
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-1550
 Fax Number (309) 343-2857

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Att Schedule II & III							7,167	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	7,167

Facility Name & ID Number Leroy Manor # 0047704 Report Period Beginning: 10/01/07 Ending: 9/30/08

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
						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	Cambridge Realty Capital						\$	\$		\$	1
2	LTD. Of Illinois		X	facility purchase	\$22,608.83	12/1/05	3,960,000	3,812,276	1/1/2036	5.5500	213,071
3											3
4											4
5											5
	Working Capital										
6	Miscellaneous		X								6
7	Less Interest Income										(4)
8											8
9	TOTAL Facility Related				\$22,608.83		\$ 3,960,000	\$ 3,812,276			\$ 213,067
	B. Non-Facility Related*										
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related						\$	\$			\$
15	TOTALS (line 9+line14)						\$ 3,960,000	\$ 3,812,276			\$ 213,067

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,194 Line # 26

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

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

Facility Name & ID Number **Leroy Manor**

0047704 Report Period Beginning: **10/01/07** Ending: **9/30/08**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																															
1. Real Estate Tax accrual used on 2007 report.		\$ 54,436	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.)		\$ 73,560	2																												
3. Under or (over) accrual (line 2 minus line 1).		\$ 19,124	3																												
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 57,076	4																												
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																												
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																												
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 76,200	7																												
Real Estate Tax History:																															
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>N/A</td><td>8</td></tr> <tr><td>2004</td><td>N/A</td><td>9</td></tr> <tr><td>2005</td><td>69,392</td><td>10</td></tr> <tr><td>2006</td><td>73,721</td><td>11</td></tr> <tr><td>2007</td><td>73,560</td><td>12</td></tr> </table>	2003	N/A	8	2004	N/A	9	2005	69,392	10	2006	73,721	11	2007	73,560	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2003	N/A	8																													
2004	N/A	9																													
2005	69,392	10																													
2006	73,721	11																													
2007	73,560	12																													
FOR BHF USE ONLY																															
13	FROM R. E. TAX STATEMENT FOR 2007 \$	13																													
14	PLUS APPEAL COST FROM LINE 5 \$	14																													
15	LESS REFUND FROM LINE 6 \$	15																													
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																													
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained. Amount accrued includes taxes for 9 months based on fiscal year end.																															
Estimate of accrual is based on prior year tax bill.																															

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Leroy Manor COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0047704

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. <u>30-20-481-027</u>	<u>BEL VUE SUB OL Z-</u>	<u>\$ 73,560.28</u>	<u>\$ 73,560.28</u>
2. _____	<u>EX N303.1' AS MEAS ALG LN</u>	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	<u>3.79 ACRES</u>	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
TOTALS		<u>\$ 73,560.28</u>	<u>\$ 73,560.28</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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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 Leroy Manor# 0047704 Report Period Beginning:10/01/07 Ending:9/30/08**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 32,072 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. 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, 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	7.25 Acres	2005	\$ 209,000	1
2					2
3	TOTALS	#VALUE!		\$ 209,000	3

Facility Name & ID Number Leroy Manor

0047704

Report Period Beginning:

10/01/07

Ending:

9/30/08

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	96	2005		\$ 4,376,543	\$ 109,414	40	\$ 109,414		\$ 310,006	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Carpet	2006		3,715	743	5	743		1,672	9
10	Fiberglass Insulation	2007		16,057	1,606	10	1,606		1,740	10
11	Air Conditioner	2007		3,795	380	10	380		412	11
12	New Roof	2008		122,466	1,021	10	1,021		1,021	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

*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

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			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,522,576	\$ 113,164		\$ 113,164	\$	\$ 314,851		70

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

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	\$ 290,269	\$ 30,164	\$ 30,164	\$	5-15 yrs	\$ 81,643	71
72	Current Year Purchases	85,777	3,909	3,909		3-15 yrs	3,909	72
73	Fully Depreciated Assets							73
74	Indirect costs		765	765				74
75	TOTALS	\$ 376,046	\$ 34,838	\$ 34,838	\$		\$ 85,552	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	Patient Care	2003 GMC Van	2005	\$ 29,891	\$ 7,473	\$ 7,473	\$	4 yrs	\$ 22,419	76
77										77
78										78
79										79
80	TOTALS			\$ 29,891	\$ 7,473	\$ 7,473	\$		\$ 22,419	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,137,513	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 155,475	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,475	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 422,822	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	2006 Toyota Corolla - 2006	\$ 15,400	\$ 3,850	\$ 7,379	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 15,400	\$ 3,850	\$ 7,379	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Leroy South Buck, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
If NO, see instructions.

	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:			\$ <u>See Attached</u>			3
4	Additions			<u>Schedule V</u>			4
5				<u>Related Party</u>			5
6				<u>Lease</u>			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.	<u>/2009</u>	\$ <u>N/A</u>
13.	<u>/2010</u>	\$ <u>N/A</u>
14.	<u>/2011</u>	\$ <u>N/A</u>

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 N/A N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 5,532 Description: See Attached Schedule XIII
(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.

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Other (specify):													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Leroy Manor# 0047704Report Period Beginning: 10/01/07

Ending:

9/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/08

(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	\$ 56,195	\$ 133,176	1
2	Cash-Patient Deposits	6,666	6,666	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>42,238</u>)	606,638	606,638	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,249	65,932	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VIII</u>	87,430	154,937	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 813,178	\$ 967,349	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		209,000	13
14	Buildings, at Historical Cost		4,376,543	14
15	Leasehold Improvements, at Historical Cost	146,033	146,033	15
16	Equipment, at Historical Cost	174,937	421,337	16
17	Accumulated Depreciation (book methods)	(50,383)	(430,201)	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>See Att Sch VIII</u>	8,254	350,645	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 278,841	\$ 5,073,357	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,092,019	\$ 6,040,706	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 20,905	\$ 47,586	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,666	6,666	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,342	44,342	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,201	8,201	31
32	Accrued Real Estate Taxes(Sch.IX-B)		57,076	32
33	Accrued Interest Payable		17,632	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>	1,963,057	3,170,499	36
37	<u>Accrued penalties</u>	32,000	32,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,075,171	\$ 3,384,002	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,812,276	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security deposits</u>	56,960	56,960	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 56,960	\$ 3,869,236	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,132,131	\$ 7,253,238	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,040,112)	\$ (1,212,532)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,092,019	\$ 6,040,706	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (327,309)	1
2	Restatements (describe):		2
3	See Att Schedule XI	(71,654)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (398,963)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(641,149)	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)	\$ (641,149)	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)	\$ (1,040,112)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Leroy Manor

0047704

Report Period Beginning: 10/01/07

Ending:

Page 19
9/30/08**VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,772,338	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,772,338	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,977	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,977	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,294	12
13	Barber and Beauty Care	3,109	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,403	23
D. Non-Operating Revenue			
24	Contributions	125	24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 129	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	3,206	28
28a	See Att Schedule XII	737	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,943	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,790,790	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	968,159	31
32	Health Care	1,980,667	32
33	General Administration	968,495	33
B. Capital Expense			
34	Ownership	448,959	34
C. Ancillary Expense			
35	Special Cost Centers	12,955	35
36	Provider Participation Fee	52,704	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,431,939	40
41	Income before Income Taxes (line 30 minus line 40)**	(641,149)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (641,149)	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.

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

Facility Name & ID Number **Leroy Manor**

0047704

Report Period Beginning: **10/01/07**

Ending: **9/30/08**

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	1,956	2,103	\$ 60,904	\$ 28.96	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	8,088	8,696	187,409	21.55	3
4	Licensed Practical Nurses	15,869	17,063	332,902	19.51	4
5	CNAs & Orderlies	77,681	83,528	927,994	11.11	5
6	CNA Trainees					6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director		0			9
10	Activity Assistants	6,942	7,465	70,690	9.47	10
11	Social Service Workers	1,089	1,171	15,103	12.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,283	22,885	214,891	9.39	15
16	Dishwashers					16
17	Maintenance Workers	3,812	4,099	52,114	12.71	17
18	Housekeepers	10,952	11,651	101,947	8.75	18
19	Laundry	5,268	5,665	47,189	8.33	19
20	Administrator	1,934	2,080	72,204	34.71	20
21	Assistant Administrator	1,834	1,972	33,194	16.83	21
22	Other Administrative	1,820	1,957	32,938	16.83	22
23	Office Manager					23
24	Clerical	4,756	5,114	57,751	11.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,560	1,677	18,028	10.75	31
32	Other Health Care(specify)	2,510	2,699	53,971	20.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	167,354	179,825	\$ 2,279,229 *	\$ 12.67	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	***	\$ 4,647	1-3	35
36	Medical Director	***	11,800	9-3	36
37	Medical Records Consultant	***	1,320	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,500	10-3	39
40	Physical Therapy Consultant	***	72,863	10a-3	40
41	Occupational Therapy Consultant	***	79,538	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	14,328	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) <u>Dental Consultants</u>	***	0	10-3	46
47					47
48	*** Monthly fee				48
49	TOTAL (lines 35 - 48)		\$ 185,996		49

C. CONTRACT NURSES

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

Facility Name & ID Number Leroy Manor# 0047704Report Period Beginning: 10/01/07Ending: 9/30/08**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. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political organization? Yes - IHCA dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,110 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. \$ 52,704
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 benefit: on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.