



Facility Name & ID Number Lee Manor

# 0024356 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	<u>262</u>	Skilled (SNF)	<u>262</u>	<u>95,630</u>	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	<u>262</u>	TOTALS	<u>262</u>	<u>95,630</u>	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	<u>52,031</u>	<u>9,168</u>	<u>11,872</u>	<u>73,071</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>52,031</u>	<u>9,168</u>	<u>11,872</u>	<u>73,071</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.41%

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 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 7,401

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name &amp; ID Number

Lee Manor

# 0024356

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	418,056	111,285	12,548	541,889		541,889	541,889			1
2	Food Purchase		376,766		376,766		376,766	(491)	376,275		2
3	Housekeeping	369,629	47,859	50,612	468,100		468,100		468,100		3
4	Laundry	89,352	24,576		113,928		113,928		113,928		4
5	Heat and Other Utilities			372,150	372,150		372,150		372,150		5
6	Maintenance	92,055	13,290	115,477	220,822		220,822		220,822		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	969,092	573,776	550,787	2,093,655		2,093,655	(491)	2,093,164		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	4,846,799	405,685	92,500	5,344,984		5,344,984	(1,640)	5,343,344		10
10a	Therapy	430,516	3,234	128,158	561,908		561,908		561,908		10a
11	Activities	205,957	35,312	2,877	244,146		244,146		244,146		11
12	Social Services	112,384		3,719	116,103		116,103		116,103		12
13	CNA Training										13
14	Program Transportation			12,838	12,838		12,838		12,838		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	5,595,656	444,231	264,092	6,303,979		6,303,979	(1,640)	6,302,339		16
	<b>C. General Administration</b>										
17	Administrative	126,634		270,000	396,634		396,634		396,634		17
18	Directors Fees										18
19	Professional Services			166,446	166,446		166,446		166,446		19
20	Dues, Fees, Subscriptions & Promotions			56,120	56,120		56,120		56,120		20
21	Clerical & General Office Expenses	481,164	61,186	70,545	612,895		612,895	(4,813)	608,082		21
22	Employee Benefits & Payroll Taxes			1,053,196	1,053,196		1,053,196		1,053,196		22
23	Inservice Training & Education			8,518	8,518		8,518		8,518		23
24	Travel and Seminar			6,865	6,865		6,865		6,865		24
25	Other Admin. Staff Transportation			13,767	13,767		13,767	(10)	13,757		25
26	Insurance-Prop.Liab.Malpractice			246,140	246,140		246,140		246,140		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	607,798	61,186	1,891,597	2,560,581		2,560,581	(4,823)	2,555,758		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	7,172,546	1,079,193	2,706,476	10,958,215		10,958,215	(6,954)	10,951,261		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 &amp; ID Number

Lee Manor

#0024356

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			103,200	103,200		103,200	210,705	313,905			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,345	111,345		111,345	415,826	527,171			32
33	Real Estate Taxes			21,210	21,210		21,210	450,018	471,228			33
34	Rent-Facility & Grounds			1,343,880	1,343,880		1,343,880	(1,343,880)				34
35	Rent-Equipment & Vehicles			52,187	52,187		52,187		52,187			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,631,822	1,631,822		1,631,822	(267,331)	1,364,491			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		349,408	17,714	367,122		367,122		367,122			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,052	143,052		143,052		143,052			42
43	Other (specify):* <b>Non-allowable cost</b>			567,943	567,943		567,943	(567,943)				43
44	<b>TOTAL Special Cost Centers</b>		349,408	728,709	1,078,117		1,078,117	(567,943)	510,174			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,172,546	1,428,601	5,067,007	13,668,154		13,668,154	(842,228)	12,825,926			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.

Facility Name & ID Number Lee Manor

# 0024356

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	(56)	1		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	83,805	30		9
10	Interest and Other Investment Income	(185)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,200)	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				17
18	Fines and Penalties	(5,500)	43		18
19	Entertainment	(24,815)	43		19
20	Contributions	(7,400)	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	(343,603)	43		24
25	Fund Raising, Advertising and Promotional	(78,195)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,300)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,980)	43		28
29	Other-Attach Schedule See Sch5A	(106,863)	Vari.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (491,292)		\$	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)	(350,936)	Vari.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (350,936)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (842,228)		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						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

Lee Manor

ID# 0024356

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	<b>Total</b>		0	49

Lee Manor  
0024356  
12/31/2009

Schedule 5A

Schedule 5A

VI. ADJUSTMENT DETAIL

NON-ALLOWABLE EXPENSES

LINE 29 - Other

Description	Amount	Schedule V Reference
To disallow ticket cost in auto expense	(10)	25
To disallow X-Ray expense	(8,814)	43
To disallow Lab expense	(3,692)	43
To disallow Resident Personal Items	(7,938)	43
To disallow Lost Items	(2,806)	43
To disallow non-allowable Physicians Services	(76,700)	43
To offset Vending Income against Dietary Supplies	(435)	1
To offset Other Income against Office Expenses	(4,828)	21
To offset nursing supply rebate	(1,640)	10
<b>Total</b>	<b>(106,863)</b>	

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lee Manor# 0024356

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(56)	0	0	0	0	0	0	0	0	0	0	(56)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(56)</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>(56)</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	15	0	0	0	0	0	0	0	0	0	15	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>15</b>	<b>0</b>	<b>15</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(56)</b>	<b>15</b>	<b>0</b>	<b>(41)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Lee Manor# 0024356

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	83,805	126,900	0	0	0	0	0	0	0	0	0	210,705	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(185)	416,011	0	0	0	0	0	0	0	0	0	415,826	32
33	Real Estate Taxes	0	450,018	0	0	0	0	0	0	0	0	0	450,018	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>83,620</b>	<b>(350,951)</b>	<b>0</b>	<b>(267,331)</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):*	(467,993)	0	0	0	0	0	0	0	0	0	0	(467,993)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(467,993)</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>(467,993)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(384,429)	(350,936)	0	0	0	0	0	0	0	0	0	(735,365)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Chester Plodzien</u>	<u>10</u>	<u>See Schedule 6A</u>		<u>Seneca Building</u>	<u>Des Plaines</u>	<u>Lessor</u>
<u>Eva Dimas Family LP</u>	<u>90</u>			<u>Limited Partnership</u>		

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)	
<u>1</u>	<u>V</u>	<u>21 Bank Charges</u>	\$	<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>\$ 15</u>	<u>\$ 15</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>30 Depreciation</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>126,900</u>	<u>126,900</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>32 Loan Amortization</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>55,943</u>	<u>55,943</u>	<u>3</u>
<u>4</u>	<u>V</u>	<u>32 Interest</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>144,920</u>	<u>144,920</u>	<u>4</u>
<u>5</u>	<u>V</u>	<u>32 Interest</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>342,541</u>	<u>342,541</u>	<u>5</u>
<u>6</u>	<u>V</u>	<u>32 Interest</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>117,814</u>	<u>117,814</u>	<u>6</u>
<u>7</u>	<u>V</u>	<u>32 Interest</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>3,895</u>	<u>3,895</u>	<u>7</u>
<u>8</u>	<u>V</u>	<u>32 Interest</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>(237,495)</u>	<u>(237,495)</u>	<u>8</u>
<u>9</u>	<u>V</u>	<u>32 Interest</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>(11,607)</u>	<u>(11,607)</u>	<u>9</u>
<u>10</u>	<u>V</u>	<u>33 Real Estate Taxes</u>		<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>	<u>450,018</u>	<u>450,018</u>	<u>10</u>
<u>11</u>	<u>V</u>	<u>34 Rent Facility &amp; Grounds</u>	<u>1,343,880</u>	<u>Seneca Building Limited Partnership</u>	<u>100.00%</u>		<u>(1,343,880)</u>	<u>11</u>
<u>12</u>	<u>V</u>							<u>12</u>
<u>13</u>	<u>V</u>							<u>13</u>
<u>14</u>	<b>Total</b>		<b>\$ 1,343,880</b>			<b>\$ 992,944</b>	<b>\$ * (350,936)</b>	<u>14</u>

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

Lee Manor  
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12/31/2009

Schedule 6A

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

<u>Name</u>	<u>City</u>
Butterfield Health Care II, Inc. - Meadowbrook Manor	Naperville
Butterfield Health Care, Inc. - Meadowbrook Manor	Bolingbrook
Butterfield Health Care of LanGrange, Inc.	LaGrange

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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	\$ 42,000	17(3)	1
2	Chris Vangel	Administrative	Administrative	0.00	80,965	8	20.00	Mgmt. Fee	72,000	17(3)	2
3	Nick Vangel	Administrative	Administrative	0.00	22,755	8	20.00	Mgmt. Fee	72,000	17(3)	3
4	Dorothy Vangel	Administrative	Administrative	78.00	None	8	20.00	Mgmt. Fee	72,000	17(3)	4
5	Mark Hocuk	Asst. Administrator	Administrative	0.00	None	40	20.00	Mgmt. Fee	12,000	17(3)	5
6	Mark Hocuk	Asst. Administrator	Administrative	0.00	None	40	100.00	Salary	35,000	17(1)	6
7	Emy Plodzien	DON	Nursing	0.00	None	40	100.00	Salary	91,749	10(1)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 396,749		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 Lee Manor

# 0024356 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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	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									2
3		N/A							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				\$	\$		\$	25

Facility Name &amp; ID Number

Lee Manor

# 0024356

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	JP Morgan Chase		X	Mortgage	\$40,806.00	8/15/03	\$ 6,500,000	\$	08/15/2010		\$ 144,920	1				
2	First Merit - First Bank		x	Mortgage	\$70,810.00	6/15/09	10,800,000	10,707,025	6/15/2012	0.6100	342,541	2				
3	First Merit - First Bank		x	Mortgage - Construction			500,000	391,400	6/15/2012	0.6100	3,895	3				
4	JP Morgan Chase						Amortization of mortgage costs				27,570	4				
5	First Merit - First Bank						Amortization of mortgage costs				28,373	5				
<b>Working Capital</b>																
6	First Merit - First Bank		x	Line of Credit	Interest Only	05/15/04	2,000,000	1,168,234	05/31/2008	Variable	72,586	6				
7	West Suburban Bank		x	Working Capital	\$4,119.00	01/25/06	600,000	559,288	02/01/2013	0.0668	37,786	7				
8	Amortization of Loan Cost		x								788	8				
9	TOTAL Facility Related				\$115,735.00		\$ 20,400,000	\$ 12,825,947			\$ 658,459	9				
<b>B. Non-Facility Related*</b>																
10	JP Morgan Chase		x	Samatas Payoff	\$27,000.00	10/17/07	3,500,000		08/31/2010		117,814	10				
11	LM Contracts Equip.		x	Capital Lease (Bus&Chiller)	\$2,590.07	07/31/07	104,864	41,251	07/31/2012	Variable		11				
12	Loan From Shareholder	x		Working Capital	None	01/01/07	4,500	43,500	On Demand	None		12				
13											Real Estate Entity Interest Income	(249,102)	13			
14	TOTAL Non-Facility Related				\$29,590.07		\$ 3,609,364	\$ 84,751			\$ (131,288)	14				
15	TOTALS (line 9+line14)						\$ 24,009,364	\$ 12,910,698			\$ 527,171	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.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

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

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill				
1. Real Estate Tax accrual used on 2008 report.				\$	699,846	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.)	2008			\$	701,379	2
3. Under or (over) accrual (line 2 minus line 1).				\$	1,533	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	478,467	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>				\$	21,210	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 \$ 29,982 For 2006 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	(29,982)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	471,228	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2004	431,738	8			
	2005	448,661	9			
	2006	458,251	10			
	2007	445,140	11			
	2008	455,907	12			
<b>Based on prior years' tax bills.</b>						
<b>Real Estate Tax Payments</b>						
<b>2008 \$455,907</b>						
<b>2007 \$245,472</b>						
				<b>FOR BHF USE ONLY</b>		
				13	FROM R. E. TAX STATEMENT FOR 2008 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

## NOTES:

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



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>455,907.30</u>	\$ <u>455,907.30</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name & ID Number Lee Manor

# 0024356 Report Period Beginning:

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12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 106,300 B. General Construction Type: Exterior Brick/Drywall Frame Fire-proof brick Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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	<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>	3

Facility Name &amp; ID Number Lee Manor

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**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	\$ 3,035,392	4
5		1979	1979	337,653		40	8,441	8,441	256,913	5
6	10	1985	1985	226,649		40	6,475	6,475	158,638	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	2,111	11
12	Audit Adjustment	1981		90,599		40	2,265	2,265	26,292	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		20			36,400	15
16	Improvements	1988		8,536		31.5	271	271	5,714	16
17	Improvements	1989		7,785		31.5	311	311	6,479	17
18	Improvements	1989		9,621		15			9,621	18
19	Improvements	1991		18,843		15			18,843	19
20	Improvements	1992		61,618		20	3,081	3,081	54,688	20
21	Improvements	1993		4,548		20	227	227	3,746	21
22	Improvements	1993		36,719		40	917	917	14,672	22
23	Improvements	1994		16,738		40	418	418	6,479	23
24	Improvements	1994		8,299		40			8,299	24
25	Improvements	1995		8,287		40	415	415	6,017	25
26	Improvements	1995		87,711		40	2,156	2,156	31,280	26
27	Brick work	1996		3,040		20	152	152	2,052	27
28	Roof Replacement	1996		1,465		20	73	73	986	28
29	Facia, Overhang renovation	1996		75,200		39	1,902	1,902	35,690	29
30	Hot Water heater	1996		16,084		39	417	417	5,627	30
31	Insulation	1997		38,770		39	994	994	12,425	31
32	Roofing	1997		5,875		39	150	150	1,875	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

Facility Name &amp; ID Number Lee Manor

# 0024356

Report Period Beginning:

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12/31/2009

## 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	\$ 37,479	37
38	Tile	1997	20,696		20	1,035	1,035	13,017	38
39	Electrical improvements	1997	4,112		20	206	206	2,591	39
40	Plumbing Improvements	1997	3,773		20	188	188	2,365	40
41	Basement remodeling	1998	13,578		20	679	679	7,808	41
42	smoke dampers	1998	2,235		20	112	112	1,288	42
43	Circulating pump	1998	2,630		20	132	132	1,518	43
44	Fire alarm system	1998	4,715		20	236	236	2,714	44
45	Compressor	1998	7,653		20	382	382	4,393	45
46	Boiler Valve	1998	3,233		20	162	162	1,863	46
47	Window Glazing	1998	2,566		20	128	128	1,472	47
48	Landscaping	1998	977		20	48	48	552	48
49	Patio Brick	1998	2,590		20	130	130	1,495	49
50	Ceiling Tiles	1998	2,233		20	112	112	2,133	50
51	Window Treatments	1998	2,470		20	124	124	1,426	51
52	Sliding Doors	1999	854		20	43	43	451	52
53	Air Conditioning improvements	1999	685		20	34	34	357	53
54	Code Alert Wandering System	1999	511		20	26	26	273	54
55	Elevator upgrade	1999	50,000		20	2,500	2,500	26,250	55
56	Roof Improvements	1999	3,567		20	178	178	1,866	56
57	Hallway renovation-ceiling tile,wiring,painting , doors & tile	2000	40,411		39	1,036	1,036	9,961	57
58	Elevators	2000	20,000		39	513	513	5,024	58
59	hallway renovation-Labor	2000	9,048		39	232	232	2,233	59
60	Hallway Renovation- materials. Painting and labor	2000	7,303		39	187	187	1,786	60
61	Painting- labor	2000	2,859		39	73	73	697	61
62	Compressor	2000	20,674		39	530	530	4,837	62
63	windows	2000	91,557		39	2,348	2,348	21,426	63
64	Automatic Doors	2000	1,985		39	51	51	499	64
65	Painting - Labor	2000	11,630		39	298	298	2,794	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,706,170	\$		\$ 146,436	\$ 146,436	\$ 4,015,650	70

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

Facility Name &amp; ID Number Lee Manor

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## 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	10
	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	\$		\$ 146,436	\$ 146,436	\$ 4,015,650	1
2	Furnace Room Improvements	2001	3,259		39	84	84	738	2
3	Third floor remodeling	2001	72,480		39	1,858	1,858	15,324	3
4	fourth floor remodeling	2001	64,481		39	1,653	1,653	13,292	4
5	water heater, wallpaper & tile	2001	19,553		39	501	501	4,447	5
6	remodeling	2001	5,768		39	148	148	1,277	6
7	Window Systems	2001	8,059		39	207	207	1,854	7
8	Renovation Floor 2 & 5, balance of floor 3&4	2002	340,426		39	8,729	8,729	57,315	8
9	Renovation floor 1, residual of floor 2 & 5	2002	181,976		39	4,666	4,666	32,857	9
10	Building Signs	2002	1,449		39	37	37	270	10
11	Beauty Parlor	2002	681		39	17	17	121	11
12	Alarm	2002	893		39	23	23	173	12
13	Door Enunciator	2002	1,944		39	50	50	377	13
14	2nd Floor Renovation	2003	87,417		39	2,241	2,241	13,637	14
15	Exterior Rehab - Dryvit	2003	23,197		39	595	595	3,621	15
16	Exterior Rehab - Dryvit	2003	36,728		39	942	942	5,732	16
17	Fuel Tank	2003	16,616		39	426	426	2,592	17
18	Alarm System	2003	35,000		39	897	897	5,459	18
19	Kitchen Repairs	2003	2,005		39	51	51	536	19
20	Parking lot repairs	2003	2,155		39	55	55	253	20
21	Door Hardware	2003	1,354		39	35	35	224	21
22	Carpet for offices	2003	1,468		39	38	38	230	22
23	Landscaping	2003	6,386		39	164	164	998	23
24	Rebuild Kitchen Stairwell	2003	1,580		39	41	41	249	24
25	Grab bars	2003	1,102		39	28	28	170	25
26	water Heater & Storage Tanks	2003	13,634		39	350	350	2,130	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	\$		\$ 170,272	\$ 170,272	\$ 4,179,526	34

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

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**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 12B, Carried Forward</b>		\$ 6,635,781	\$		\$ 170,272	\$ 170,272	\$ 4,179,526	1
2	Landscaping	2004	11,953		15	797	797	4,206	2
3	Dialysis room	2004	3,188		27.5	116	116	637	3
4	Air handler	2004	8,529		27.5	310	310	1,705	4
5	Back entrance renovation	2004	4,104		27.5	149	149	820	5
6	Building face resurfacing	2004	47,218		27.5	1,717	1,717	9,444	6
7	Chimney inducer	2004	32,366		27.5	1,177	1,177	6,473	7
8	Dialysis room	2004	13,645		27.5	496	496	2,728	8
9	Floor renovation	2004	78,376		27.5	2,850	2,850	15,675	9
10	Tunner cleaning	2004	1,260		27.5	46	46	253	10
11	Refuse disposal	2004	5,012		27.5	182	182	1,001	11
12	Roofing	2004	14,500		27.5	527	527	2,899	12
13	Security System	2004	59,500		27.5	2,164	2,164	11,902	13
14	Water heater & storage tank	2004	20,208		27.5	735	735	4,042	14
15	Painting	2004	3,510		27.5	128	128	704	15
16	Pump	2004	4,922		27.5	179	179	984	16
17	Remodeling 2nd floor Transitional Care Unit	2006	80,728		27.5	2,936	2,936	10,276	17
18	Compressor	2006	13,495		27.5	490	490	1,715	18
19	Parking lot and sidewalk renovation	2006	16,730		27.5	608	608	2,128	19
20	Chiller	2007	99,000		15	6,600	6,600	16,500	20
21	Paving Patched	2008	8,300		20	415	415	623	21
22	First floor remodel-painting,drywall,wiring,carpeting	2008	769,889		27.5	27,996	27,996	41,994	22
23	Landscaping - Patio	2009	26,289		20	657	657	657	23
24	1st&2nd remodel -drywall, wiring, carpeting, plumbing	2009	337,622		27.5	6,139	6,139	6,139	24
25									25
26									26
27	<b>Current Booked Depreciation</b>			<b>103,200</b>			<b>(103,200)</b>		27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,296,125	\$ 103,200		\$ 227,686	\$ 124,486	\$ 4,323,031	34

\*\*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:

01/01/2009

Ending:

12/31/2009

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	\$ 860,782	\$	\$ 76,706	\$ 76,706	5-15	\$ 560,612	71
72	Current Year Purchases	67,760		3,388	3,388	10	3,388	72
73	Fully Depreciated Assets	765,618				5-15	765,618	73
74								74
75	TOTALS	\$ 1,694,160	\$	\$ 80,094	\$ 80,094		\$ 1,329,618	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	\$	\$ 6,125	\$ 6,125	4	\$ 15,312	76
77										77
78										78
79										79
80	TOTALS			\$ 24,501	\$	\$ 6,125	\$ 6,125		\$ 15,312	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)	\$ 10,288,186	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 103,200	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,905	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 210,705	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,667,961	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Lee Manor

# 0024356

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2010                      \$ N/A

13. \_\_\_\_\_ /2011                      \$ N/A

14. \_\_\_\_\_ /2012                      \$ N/A

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

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: \$ 52,187 Description: Water Soft \$432,, Postage Mach \$1,327, Copier \$10,807,Medical equip \$3,689, Beds \$35,932

(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		<u>N/A</u>			18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	L10A,C1	3956	hrs	\$ 141,765	140	\$ 8,408	\$	4,096	\$ 150,173	1
2	Licensed Speech and Language Development Therapist	L10A,C1&3	4060	hrs	93,062	31	1,841		4,091	94,903	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10A,C1&2	5556	hrs	195,689			3,234	5,556	198,923	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	L39,C2		# of prescripts				349,408		349,408	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	L10A , C3					38,443			38,443	12
13	Other (specify): <u>Dialysis</u>	L39,C3					17,714			17,714	13
14	TOTAL				\$ 430,516	171	\$ 66,406	\$ 352,642	13,743	\$ 849,564	14

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

Facility Name & ID Number Lee Manor# 0024356Report Period Beginning: 01/01/2009

Ending:

12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 178,287	\$ 178,287	1
2	Cash-Patient Deposits	98,278	98,278	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>554,541</u> )	2,679,155	2,679,155	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	66,000	66,000	8
9	Other(specify): <u>See SCH17C</u>	37,513	37,513	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,059,233	\$ 3,059,233	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	7,074,980	14
15	Leasehold Improvements, at Historical Cost	1,221,145	1,221,145	15
16	Equipment, at Historical Cost	1,723,973	1,718,661	16
17	Accumulated Depreciation (book methods)	(2,233,234)	(5,667,961)	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 (spec <u>Loan Cost Amort</u> )	1,538	128,916	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,473,710	\$ 4,749,141	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,532,943	\$ 7,808,374	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,187,903	\$ 1,187,903	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	110,097	110,097	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	463,677	463,677	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		478,467	32
33	Accrued Interest Payable	2,689	2,689	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See SCH17C</u>	31,701	31,701	36
37	<u>Due To Related Parties</u>	657,375	657,375	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,453,442	\$ 2,931,909	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,812,273	1,812,273	39
40	Mortgage Payable		11,098,425	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)	\$ 1,812,273	\$ 12,910,698	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,265,715	\$ 15,842,607	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 267,228	\$ (8,034,233)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,532,943	\$ 7,808,374	48

\*(See instructions.)

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12/31/2009

Schedule 17C

XV. Balance Sheet

<u>A. Current Assets</u>	<u>Operating</u>	<u>After Consolidation</u>
Line 9 -Other		
Payroll Advance	2,800	2,800
Other Receivables	2,700	2,700
Refund Clearing	32,013	32,013
	<u>37,513</u>	<u>37,513</u>

<u>C. Current Liabilities</u>	<u>Operating</u>	<u>After Consolidation</u>
Line 36 -Other Current Liabilities		
Accrued Expenses	7,347	7,347
Due to PA Audit Settlement	5,825	5,825
Due to/From BCBS	(20,620)	(20,620)
Accrued 401(K) Matching	38,342	38,342
Sales Tax Pyable	1,032	1,032
State Corp. Income Tax	(225)	(225)
	<u>31,701</u>	<u>31,701</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 527,863	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 527,863	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	509,257	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>	\$ 509,257	17
<b>B. Transfers (Itemize):</b>			
18	Intercompany Transfer	(769,889)	18
19	Rounding	(3)	19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ (769,892)	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 267,228	24 *

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

Facility Name & ID Number Lee Manor# 0024356Report Period Beginning: 01/01/2009Ending: 12/31/2009

**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	\$ 16,071,572		1
2	Discounts and Allowances for all Levels	(3,988,763)		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,082,809		3
<b>B. Ancillary Revenue</b>				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy	1,394,791		6
7	Oxygen	11,770		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,406,561		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	3,523		13
14	Non-Patient Meals	56		14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs	335,211		17
18	Sale of Supplies to Non-Patients			18
19	Laboratory	24,061		19
20	Radiology and X-Ray	4,975		20
21	Other Medical Services	311,555		21
22	Laundry	(1,179)		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 678,202		23
<b>D. Non-Operating Revenue</b>				
24	Contributions			24
25	Interest and Other Investment Income***	185		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 185		26
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>			27
28	<b>Vending Income</b>	435		28
28a	<b>Other Income</b>	9,219		28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,654		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,177,411		30

		2		
Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	2,093,655		31
32	Health Care	6,303,979		32
33	General Administration	2,560,581		33
<b>B. Capital Expense</b>				
34	Ownership	1,631,822		34
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	935,065		35
36	Provider Participation Fee	143,052		36
<b>D. Other Expenses (specify):</b>				
37				37
38				38
39				39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,668,154		40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	509,257		41
42	<b>Income Taxes</b>			42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 509,257		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 Lee Manor

# 0024356

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	1,984	2,200	\$ 91,749	\$ 41.70	1
2	Assistant Director of Nursing	2,062	2,223	73,745	33.17	2
3	Registered Nurses	55,500	59,085	1,724,535	29.19	3
4	Licensed Practical Nurses	17,594	18,623	445,412	23.92	4
5	CNAs & Orderlies	142,182	151,739	1,677,323	11.05	5
6	CNA Trainees					6
7	Licensed Therapist	12,728	13,572	430,516	31.72	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	20,440	21,835	205,957	9.43	10
11	Social Service Workers	6,912	7,325	112,384	15.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,215	42,388	418,056	9.86	15
16	Dishwashers					16
17	Maintenance Workers	6,250	6,712	92,055	13.71	17
18	Housekeepers	38,821	42,276	369,629	8.74	18
19	Laundry	9,773	10,557	89,352	8.46	19
20	Administrator	1,944	2,240	91,634	40.91	20
21	Assistant Administrator	1,920	1,920	35,000	18.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,578	21,522	481,164	22.36	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	4,465	4,960	67,968	13.70	31
32	Other Health C: <u>See Sch20A</u>	28,761	31,527	766,067	24.30	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	410,129	440,704	\$ 7,172,546 *	\$ 16.28	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	299	\$ 12,548	1, 3	35
36	Medical Director	Monthly	24,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	79,466	10a, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,527	11, 3	44
45	Social Service Consultant	62	3,719	12, 2	45
46	Other(specify) <u>Religious</u>	7	350	11, 3	46
47					47
48	<u>MDS CONSULTANT</u>	Monthly	92,500	10, 3	48
49	TOTAL (lines 35 - 48)	418	\$ 215,110		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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Schedule 20 A

XXVIII. A. Staffing and Salary costs

Name	Number of Hrs Worked	Number Hrs Paid	Tot Sal & Wages	Ave. Hourly
Nurse Supv	2,924	3,308	102,138	30.88
MDS Coordinator	6,865	7,361	229,218	31.14
Nursing Admin	8,830	9,674	230,982	23.88
Restorative Aide	8,244	9,034	110,217	12.20
Rehab Director	1,898	2,150	93,512	43.49
Total	28,761	31,527	766,067	24.30

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
William McNiff	Administrator	0	\$ 91,634	Workers' Compensation Insurance	\$ 87,140	IDPH License Fee	\$ 1,990	
Mark Hocuk	Assist. Admin	0	35,000	Unemployment Compensation Insurance	47,278	Advertising: Employee Recruitment	24,721	
				FICA Taxes	539,083	Health Care Worker Background Check		
				Employee Health Insurance	235,919	(Indicate # of checks performed <u>510</u> )	5,100	
				Employee Meals	58,400	Patient Background Checks	90	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Dues	1,723	
				401 K Contributions	45,450	Miscellaneous Subscriptions	2,918	
				Uniforms	193	Il Council Long Term Care	18,768	
				Other Employee Benefits	39,733			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 126,634					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
Management Fees			\$ 270,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 270,000					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Carolyn Magruder	PA Integrity Audit	\$ 10,208	N/A			Out-of-State Travel	\$	
Peterek & Howse, LLP	401 K Audit	8,500						
RSM McGladrey, Inc	Accounting	39,212				In-State Travel		
Susan Chavez	Medicare billing	1,558						
E-Health Solutions	MDS Service	3,540				Seminar Expense		
Automatic Data Processing	Payroll Processing	22,816				See attached Schedule	6,865	
Michael G. Kaplan	Accounting	16,500						
MNJ Technologies	IT Consulting	2,775				Entertainment Expense	( )	
Medifax-EDI, LLC	Medicare System	713				(agree to Sch. V, line 24, col. 8)		
Wescom Solutions	Accounting System	17,833				TOTAL	\$ 6,865	
Anthony's Mobile Fingerprinting	Fingerprinting	1,232						
See Schedule 21A		41,559						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 166,446					

\* Attach copy of IMRF notifications

\*\*See instructions.

Lee Manor  
Provider #: 0024356  
01/01/2009 to 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE  
C. Professional Services

Scott & Kraus - Scott & Kraus	Financing Services	2,238
New england Financial	401(k) Service	2,450
Kamensky Rubenstein Hochman Delott	Guardianship Services	16,280
Personnel Planners	Unemployment	1,346
Hamilton Thies Iorch & Hagnell LLP	Legal	3,999
Polsinelli Shughart PPC	Regulatory	3,974
Polsinelli Shalton Flanigan Suelthaus	Regulatory	7,466
Serpico, Petrosino & DiPiero LTD	Regulatory	194
Bridge Point Technologies	Computer Services	150
Carmen Deato	Computer Services	512
Probity Consulting	Computer Services	1,950
W-T Land Services, Inc.	Land Survey	1,000
Total for Schedule 21A		<u>41,559</u>

Lee Manor  
 Provider #: 0024356  
 01/01/2009 to 12/31/2009

DATE	PAYEE	TOPIC	ATTENDEE	JOB CLASS
12/15/09	Alzheimer's Associations	Challenging Behaviors	Dee, Jaytavia	Therapy
09/16/09	Activity Therapists Association	Alzheimer's Disease	Ana Arizimendi	Activity
09/28/09	Activity Therapists Association	Alzheimer's Disease	Janelly Vazquez	Activity
10/31/09	Illinois Council on LTC	The New OBRA Pioneer	Emilia Plodzien	DON
11/03/09	Cross Country Education	Strength, Training & Exercise	Darryl Jenkins	Therapy
10/23/09	Cynthia Chow & Associates	Annual Continuing Education	Maria Sanchez	Dietary
10/19/09	Cynthia Chow & Associates	NUTRITION/KIT	Sharon Braniamon	Dietary
04/22/09	Cross Country Education	Strength, Training & Exercise	Deepa George	Therapy
09/30/09	Deepa George	Seminar	Deepa George	Therapy
08/28/09	Encompass Consulting & Education Inc	Medicare Made	Jeff, Emelia, Helen	Nursing
09/22/09	IAPA	2009 annual Convention	Bill McNiff	Administrator
02/25/09	Illinois Council on LTC	New OBRA Pain Requirement	Rosatita, Jeff, Emelia, William	Nursing
06/25/09	Illinois Council on LTC	The New OBRA Pioneer	Melissa, Marissa, Laura Janelly, William	Nursing
06/25/09	Illinois Council on LTC	The New OBRA Pioneer	Mark Hocuk	Assistant Administrator
08/18/09	Illinois Council on LTC	Improving Quality of Life	Janelly, Nolwazi, William	Social Services
01/12/09	Illinois Council on LTC	Innovation Grant Applications	Mark Hocuk	Assistant Administrator
08/13/09	Illinois Pioneer Coalition	CNA SEMINAR	Kathy Kavaney	Nursing
10/13/09	Illinois Pioneer Coalition	Culture Change	Emilia, Nolwazi, Chester	Administrative
10/13/09	Illinois Pioneer Coalition	Culture Change	Mark Hocuk	Assistant Administrator

03/27/09	NASMI	Shoulder, Hip and Knee	James Rybicki	Therapy
05/21/09	Lake County Health Department	Bold New Directions for LTC	Janelly Vazquez	Activity
03/25/09	Institute for Natural Resources	Advances in Women's Health	Mary Ann Cruz	Therapy
07/01/09	Mary Ann Cruz	reimb for	Mary Ann Cruz	Therapy
05/22/09	Cross Country Education	May Serminar	Mylinh Hau	Therapy
05/05/09	Pathway Health Service, Inc	Infection Control Program	Melissa, Marissa	Nursing
05/05/09	Pathway Health Service, Inc - Reversed	Medicaid Reimb	Melissa, Marissa	Nursing
07/20/09	The Healthcare Information Network, Inc	MDS CODING	Jeff, Emelia, Helen	Nursing
03/31/09	Illinois Council on LTC	New Labor Law Trends and Requirements	Mark Hocuk	Assistant Administrator
05/26/09	Illinois Council on LTC	Money Down the Drain - Top Ten Ways that Providers Lose Mone	Mark Hocuk	Assistant Administrator
10/28/09	Illinois Council on LTC	The New IDPH Fingerprint Program	Mark Hocuk	Assistant Administrator

TOTAL

LOCATION	FEE
Chicago	90.00
Chicago	65.00
Chicago	65.00
Skokie, IL	95.00
Chicago	189.00
Chicago	110.00
Chicago	120.00
Chicago	189.00
Chicago	260.00
Chicago	450.00
Chicago	430.00
	380.00
Skokie, IL	
	475.00
Skokie, IL	
Skokie, IL	95.00
Skokie, IL	285.00
Skokie, IL	95.00
Skokie, IL	210.00
Skokie, IL	450.00
Skokie, IL	150.00









Facility Name &amp; ID Number Lee Manor

# 0024356

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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 - 18,768
- (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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 77,437 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. \$ 143,052  
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. \$ 58,400 Has any meal income been offset against related costs? Yes Indicate the amount. \$ (56)
- (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? N/A 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? 0
- 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
- (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.