

Facility Name & ID Number Leroy Manor

0047704 Report Period Beginning: 10/1/08 Ending: 9/30/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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>96</u>	Skilled (SNF)	<u>96</u>	<u>35,040</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>96</u>	TOTALS	<u>96</u>	<u>35,040</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>14,828</u>	<u>9,201</u>	<u>1,816</u>	<u>25,845</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>0</u>			12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,828</u>	<u>9,201</u>	<u>1,816</u>	<u>25,845</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.76%

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 1,816

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: 09/30/09 Fiscal Year: 09/30/09

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	205,320	23,367	4,520	233,207		233,207		233,207		1
2	Food Purchase		216,423		216,423		216,423		216,423		2
3	Housekeeping	84,261	22,685		106,946		106,946		106,946		3
4	Laundry	42,665	15,282	120	58,067		58,067		58,067		4
5	Heat and Other Utilities			142,847	142,847		142,847		142,847		5
6	Maintenance	56,784	37,819	37,440	132,043		132,043		132,043		6
7	Other (specify):*										7
8	TOTAL General Services	389,030	315,576	184,927	889,533		889,533		889,533		8
	B. Health Care and Programs										
9	Medical Director			14,792	14,792		14,792		14,792		9
10	Nursing and Medical Records	1,310,423	102,382	3,373	1,416,178		1,416,178		1,416,178		10
10a	Therapy			166,778	166,778		166,778		166,778		10a
11	Activities	61,629	763		62,392		62,392		62,392		11
12	Social Services	28,395			28,395		28,395		28,395		12
13	CNA Training			2,166	2,166		2,166		2,166		13
14	Program Transportation			219	219	1,445	1,664		1,664		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,400,447	103,145	187,328	1,690,920	1,445	1,692,365		1,692,365		16
	C. General Administration										
17	Administrative	99,491			99,491		99,491		99,491		17
18	Directors Fees							2,418	2,418		18
19	Professional Services			280,023	280,023		280,023	(1,084)	278,939		19
20	Dues, Fees, Subscriptions & Promotions			47,683	47,683		47,683	(21,684)	25,999		20
21	Clerical & General Office Expenses	63,112	22,831	27,166	113,109		113,109	30	113,139		21
22	Employee Benefits & Payroll Taxes			294,781	294,781		294,781		294,781		22
23	Inservice Training & Education			2,944	2,944		2,944		2,944		23
24	Travel and Seminar			1,564	1,564		1,564		1,564		24
25	Other Admin. Staff Transportation			2,889	2,889	(1,445)	1,444		1,444		25
26	Insurance-Prop.Liab.Malpractice			52,875	52,875		52,875	23,771	76,646		26
27	Other (specify):* <u>See Att Sch VI</u>	22,519		76,197	98,716		98,716	(98,716)			27
28	TOTAL General Administration	185,122	22,831	786,122	994,075	(1,445)	992,630	(95,264)	897,366		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,974,599	441,552	1,158,377	3,574,528		3,574,528	(95,264)	3,479,264		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.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			58,250	58,250		58,250	130,905	189,155			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							207,777	207,777			32
33	Real Estate Taxes							76,950	76,950			33
34	Rent-Facility & Grounds			406,906	406,906		406,906	(406,906)				34
35	Rent-Equipment & Vehicles			10,561	10,561		10,561		10,561			35
36	Other (specify):* See Att Sch V							6,573	6,573			36
37	TOTAL Ownership			475,717	475,717		475,717	15,299	491,016			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			9,492	9,492		9,492		9,492			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,955	2,955		2,955		2,955			41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			65,007	65,007		65,007		65,007			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,974,599	441,552	1,699,101	4,115,252		4,115,252	(79,965)	4,035,287			45

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

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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	(1,978)	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	(74,578)	V-27		24
25	Fund Raising, Advertising and Promotional	(21,686)	V20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VII	(30,230)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (128,472)		\$	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)	44,197		34
35	Other- Attach Schedule See Att Sch III	4,310		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 48,507		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (79,965)		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

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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

STATE OF ILLINOIS

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Summary B

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	44,197	0	0	0	0	0	0	0	0	0	44,197	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	44,197	0	44,197	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	44,197	0	0	0	0	0	0	0	0	0	44,197	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
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility Rent	\$ 406,906	Leroy South Buck, LLC	N/A	\$ 451,103	\$ 44,197	1
2	V							2
3	V							3
4	V							4
5	V			See Att Schedule V & Independent Accountant's Report				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		\$ 406,906			\$ 451,103	\$ * 44,197	14

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

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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								\$ 2,418	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	\$ 2,418		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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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							4,310	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				\$	\$		\$	4,310

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	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	3,751,009	1/1/2036	5.5500	209,755	2								
3												3								
4												4								
5												5								
	Working Capital																			
6	Miscellaneous		X									6								
7	Less Interest Income										(1,978)	7								
8												8								
9	TOTAL Facility Related				\$22,608.83		\$ 3,960,000	\$ 3,751,009			\$ 207,777	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 3,960,000	\$ 3,751,009			\$ 207,777	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,895 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.)

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,072 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

1. Total Amount Incurred: 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>7.25 Acres</u>	<u>2005</u>	<u>\$ 209,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 209,000	3

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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	96	2005		\$ 4,376,543	\$ 109,414	40	\$ 109,414	\$	\$ 419,420	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Carpet		2006	3,715	743	5	743		2,415	9
10	Fiberglass Insulation		2007	16,057	1,606	10	1,606		3,346	10
11	Air Conditioner		2007	3,795	380	10	380		792	11
12	New Roof		2008	122,466	12,246	10	12,246		13,267	12
13	Wall Paint		2009	3,900	585	5	585		585	13
14	Valances, Blinds, Drapery, Bedside Cabinet, Table, Chairs		2008	120,500	11,045	10	11,045		11,045	14
15	Paint		2009	2,488	373	5	373		373	15
16	Paint		2009	2,528	337	5	337		337	16
17	Fire Alarm Panel		2009	4,760	317	10	317		317	17
18	Duct Work & Motorized Dampers for Dryer		2009	3,545	103	20	103		103	18
19	Roof Reconstruction		2009	10,182	424	10	424		424	19
20	A/C Replacement		2009	2,930	195	5	195		195	20
21	Paint		2008	8,253	1,651	5	1,651		1,651	21
22	Water Heater		2009	4,085	68	10	68		68	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

Facility Name & ID Number **Leroy Manor**

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10/1/08

Ending:

9/30/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$

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

Facility Name & ID Number Leroy Manor

0047704

Report Period Beginning:

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9/30/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 376,046	\$ 38,110	\$ 38,110	\$	3-15 yrs	\$ 123,662	71
72	Current Year Purchases	56,752	3,385	3,385		10-15 yrs	3,385	72
73	Fully Depreciated Assets							73
74	Indirect Costs		701	701				74
75	TOTALS	\$ 432,798	\$ 42,196	\$ 42,196	\$		\$ 127,047	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	\$ 7,472	\$ 7,472	\$	4 yrs	\$ 29,891	76
77										77
78										78
79										79
80	TOTALS			\$ 29,891	\$ 7,472	\$ 7,472	\$		\$ 29,891	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)	\$ 5,357,436	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 189,155	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 189,155	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)	\$ 611,276	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	\$ 11,229	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 15,400	\$ 3,850	\$ 11,229	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?

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>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

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: \$ 10,561 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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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.

Facility Name & ID Number Leroy Manor# 0047704Report Period Beginning: 10/1/08

Ending:

9/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 12,899	\$ 213,533	1
2	Cash-Patient Deposits	8,704	8,704	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>42,238</u>)	315,668	315,668	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,278	76,661	6
7	Other Prepaid Expenses	33,880	33,880	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VIII</u>		69,012	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 438,429	\$ 717,458	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	309,204	309,204	15
16	Equipment, at Historical Cost	231,689	478,089	16
17	Accumulated Depreciation (book methods)	(108,633)	(622,505)	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>	57,818	300,672	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 490,078	\$ 5,051,003	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 928,507	\$ 5,768,461	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 74,272	\$ 107,990	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,704	8,704	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,312	56,312	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,958	12,958	31
32	Accrued Real Estate Taxes(Sch.IX-B)		57,177	32
33	Accrued Interest Payable		17,348	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>	2,145,279	3,352,721	36
37	<u>Accrued Penalties</u>	14,840	14,840	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,312,365	\$ 3,628,050	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,751,009	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	19,500	19,500	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 19,500	\$ 3,770,509	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,331,865	\$ 7,398,559	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,403,358)	\$ (1,630,098)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 928,507	\$ 5,768,461	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,040,112)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,040,112)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(363,246)	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)	\$ (363,246)	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)	\$ (1,403,358)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Leroy Manor# 0047704Report Period Beginning: 10/1/08Ending: 9/30/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,684,902	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,684,902	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,419	6
7	Oxygen	287	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 52,706	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	3,567	12
13	Barber and Beauty Care	3,521	13
14	Non-Patient Meals	55	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)	\$ 7,143	23
D. Non-Operating Revenue			
24	Contributions	95	24
25	Interest and Other Investment Income***	1,978	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,073	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schedule XII	5,182	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,182	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,752,006	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	889,533	31
32	Health Care	1,690,920	32
33	General Administration	994,075	33
B. Capital Expense			
34	Ownership	475,717	34
C. Ancillary Expense			
35	Special Cost Centers	12,447	35
36	Provider Participation Fee	52,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,115,252	40
41	Income before Income Taxes (line 30 minus line 40)**	(363,246)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (363,246)	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:

10/1/08

Ending:

9/30/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,921	2,043	\$ 60,198	\$ 29.47	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,621	9,171	206,902	22.56	3
4	Licensed Practical Nurses	12,242	13,024	269,355	20.68	4
5	CNAs & Orderlies	60,870	64,755	720,079	11.12	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	6,024	6,409	61,629	9.62	10
11	Social Service Workers	2,022	2,151	28,395	13.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,417	20,656	205,320	9.94	15
16	Dishwashers					16
17	Maintenance Workers	4,245	4,516	56,784	12.57	17
18	Housekeepers	8,563	9,109	84,261	9.25	18
19	Laundry	4,674	4,973	42,665	8.58	19
20	Administrator	1,958	2,083	73,104	35.10	20
21	Assistant Administrator	1,448	1,540	26,387	17.13	21
22	Other Administrative	1,159	1,233	22,519	18.26	22
23	Office Manager					23
24	Clerical	5,194	5,526	63,112	11.42	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	834	888	8,877	10.00	31
32	Other Health Care(specify)	1,800	1,915	45,012	23.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,992	149,992	\$ 1,974,599 *	\$ 13.16	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	***	\$ 4,520	1-3	35
36	Medical Director	***	14,792	9-3	36
37	Medical Records Consultant	***	1,760	10-3	37
38	Nurse Consultant	***	113	10-3	38
39	Pharmacist Consultant	***	1,500	10-3	39
40	Physical Therapy Consultant	***	72,259	10a-3	40
41	Occupational Therapy Consultant	***	80,839	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	13,680	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	0	10-3	46
47					47
48	<u>*** Monthly fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 189,463		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: 10/1/08Ending: 9/30/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political action 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? 12 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,417 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. \$ 52,560
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. \$ 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. N/A
- 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
- (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.