

Facility Name & ID Number Leroy Manor

0047704 Report Period Beginning: 10/1/2017 Ending: 9/30/2018

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	102	Skilled (SNF)	102	37,230	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	102	TOTALS	102	37,230	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	16,595	5,927	2,902	25,424	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,595	5,927	2,902	25,424	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.29%

D. How many bed reserve days during this year were paid by the Department?

0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 102 and days of care provided 1,593

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: 9/30/18 Fiscal Year: 9/30/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Leroy Manor** # **0047704** Report Period Beginning: **10/1/2017** Ending: **9/30/2018**

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	247,793	24,654	8,342	280,789		280,789		280,789		1
2	Food Purchase		230,762		230,762		230,762	(52)	230,710		2
3	Housekeeping	119,148	33,251		152,399		152,399		152,399		3
4	Laundry	43,888	9,497		53,385		53,385		53,385		4
5	Heat and Other Utilities			132,048	132,048		132,048		132,048		5
6	Maintenance	71,020	15,496	40,288	126,804		126,804	2,513	129,317		6
7	Other (specify):*										7
8	TOTAL General Services	481,849	313,660	180,678	976,187		976,187	2,461	978,648		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	2,064,955	153,100	141,195	2,359,250		2,359,250		2,359,250		10
10a	Therapy			2,234	2,234		2,234		2,234		10a
11	Activities	69,232	3,073		72,305		72,305		72,305		11
12	Social Services	52,618			52,618		52,618		52,618		12
13	CNA Training										13
14	Program Transportation			3,497	3,497		3,497		3,497		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,186,805	156,173	156,926	2,499,904		2,499,904		2,499,904		16
	C. General Administration										
17	Administrative	82,882			82,882		82,882		82,882		17
18	Directors Fees							2,209	2,209		18
19	Professional Services			294,597	294,597		294,597	2,810	297,407		19
20	Dues, Fees, Subscriptions & Promotions			27,605	27,605		27,605	(2,584)	25,021		20
21	Clerical & General Office Expenses	121,074	18,701	42,613	182,388		182,388	(492)	181,896		21
22	Employee Benefits & Payroll Taxes			350,449	350,449		350,449	22	350,471		22
23	Inservice Training & Education			10,853	10,853		10,853		10,853		23
24	Travel and Seminar			106	106		106		106		24
25	Other Admin. Staff Transportation			3,499	3,499		3,499		3,499		25
26	Insurance-Prop.Liab.Malpractice			70,910	70,910		70,910	8,386	79,296		26
27	Other (specify):*										27
28	TOTAL General Administration	203,956	18,701	800,632	1,023,289		1,023,289	10,351	1,033,640		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,872,610	488,534	1,138,236	4,499,380		4,499,380	12,812	4,512,192		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Leroy Manor

#0047704

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			79,330	79,330		79,330	130,693	210,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							165,750	165,750			32
33	Real Estate Taxes							77,400	77,400			33
34	Rent-Facility & Grounds			418,920	418,920		418,920	(418,920)				34
35	Rent-Equipment & Vehicles			4,452	4,452		4,452		4,452			35
36	Other (specify):* Mortg Insurance							15,309	15,309			36
37	TOTAL Ownership			502,702	502,702		502,702	(29,768)	472,934			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			9,460	9,460		9,460		9,460			38
39	Ancillary Service Centers		79,899	380,950	460,849		460,849		460,849			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			196,545	196,545		196,545		196,545			42
43	Other (specify):* See Att Sch 4A	20,257		176,603	196,860		196,860	(189,171)	7,689			43
44	TOTAL Special Cost Centers	20,257	79,899	763,558	863,714		863,714	(189,171)	674,543			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,892,867	568,433	2,404,496	5,865,796		5,865,796	(206,127)	5,659,669			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Leroy Manor

Period Beginning 10/1/2017

Period End 9/30/2018

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4						
	Ancillary Expense										
	E. Special Cost Centers										
43	Other (specify):*				0	0		0			
	Laboratory/Expenses			3,872	3,872	3,872		3,872			
	Radiology Expenses			3,817	3,817	3,817		3,817			
	Non-Allowable Expenses	20,257		168,914	189,171	189,171	(189,171)	0			
					0	0		0			
					0	0		0			
	TOTAL Other Special Cost C	20,257	0	176,603	196,860	0	196,860	(189,171)	7,689		

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	(52)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,453)	43		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)	30		9
10	Interest and Other Investment Income	(9,331)	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	(2,670)	20		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	(110,128)	43		24
25	Fund Raising, Advertising and Promotional	(46,333)	43		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 Page 5A	(44,378)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (225,428)		\$	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)	19,301		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 19,301		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (206,127)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Leroy Manor

ID# 0047704

Report Period Beginning: 10/1/2017

Ending: 9/30/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Disallow Marketing Wages	\$ (20,257)	43	1
2	Disallow R/E Entity HUD Audit	(26,060)	19	2
3	Expense Capitalized Repairs under \$2,500	2,495	6	3
4	Miscellaneous Income Offset	(556)	21	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
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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	(44,378)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc (UDI)		See Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

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	6 Maintenance	\$	Unlimited Development, Inc.	100.00%	\$ 18	\$ 18	1
2	V	18 Director Fees		Unlimited Development, Inc.	100.00%	2,209	2,209	2
3	V	19 Professional Fees		Unlimited Development, Inc.	100.00%	2,810	2,810	3
4	V	20 Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	11	11	4
5	V	21 General Admin Expense		Unlimited Development, Inc.	100.00%	64	64	5
6	V	22 Employee Benefits		Unlimited Development, Inc.	100.00%	22	22	6
7	V	26 Property Insurance		Unlimited Development, Inc.	100.00%	42	42	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 5,176	\$ * 5,176	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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)		
15	V	19 Professional Fees	\$	Leroy South Buck, LLC	N/A	\$ 26,060	\$	26,060	15
16	V	20 Dues, Fees, Subs & Prom		Leroy South Buck, LLC	N/A	75		75	16
17	V	26 Property Insurance		Leroy South Buck, LLC	N/A	8,344		8,344	17
18	V	30 Depreciation		Leroy South Buck, LLC	N/A	130,776		130,776	18
19	V	32 Interest Expense	246	Leroy South Buck, LLC	N/A	169,993		169,747	19
20	V	32 Loan Fee Amortization		Leroy South Buck, LLC	N/A	5,334		5,334	20
21	V	33 Property Taxes		Leroy South Buck, LLC	N/A	77,400		77,400	21
22	V	34 Facility Rent	418,920	Leroy South Buck, LLC	N/A			(418,920)	22
23	V	36 Mortgage Insurance		Leroy South Buck, LLC	N/A	15,309		15,309	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 419,166			\$ 433,291	\$ *	14,125	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Leroy Manor

0047704

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vahle Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryville				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%	Leroy Manor	Leroy				18
19	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Car	Carbondale	Retirement living ce	19
20	Unlimited Development, Inc. (UDI)	100%	Care Center of Abingdon	Abingdon				20
21	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				21
22	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	22
23	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gal	Galesburg	Assisted Living Faci	23
24	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				24
25	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	25
26	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				26
27	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				27
28	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	28
29	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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0047704

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McCorn	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			Leroy South Buck, LL	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			Abingdon West Marti	Galesburg	Lessor	13
14	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	14
15	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Leroy Manor

0047704

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

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 7A								\$ 2,209	L18, C7	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	\$ 2,209		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Leroy Manor # 0047704 Report Period Beginning: 10/1/2017 Ending: 1/30/2018

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

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

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

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	6	Maintenance	Weighted Avail Bed Days	505,933	21	\$ 240	\$ 37,230	\$ 18	1
2	18	Director Fees	Weighted Avail Bed Days	505,933	21	\$ 30,020	\$ 37,230	2,209	2
3	19	Professional Fees	Weighted Avail Bed Days	505,933	21	38,188	37,230	2,810	3
4	20	Dues, Licenses and Subs	Weighted Avail Bed Days	505,933	21	144	37,230	11	4
5	21	General Admin Expense	Weighted Avail Bed Days	505,933	21	873	37,230	64	5
6	22	Employee Benefits	Weighted Avail Bed Days	505,933	21	300	37,230	22	6
7	26	Property Insurance	Weighted Avail Bed Days	505,933	21	568	37,230	42	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					\$ 70,333	\$	\$ 5,176	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Leroy Manor

0047704

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

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		7	8	9	10						
		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	\$22,609.00	12/1/2005	3,960,000	3,016,256	1/1/2036	5.5500	169,993	2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$22,609.00		\$ 3,960,000	\$ 3,016,256			\$ 169,993	9						
B. Non-Facility Related*																		
10										Amortization Exp	5,334	10						
11										Int Income Offset	(9,577)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (4,243)	14						
15	TOTALS (line 9+line14)						\$ 3,960,000	\$ 3,016,256			\$ 165,750	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 15,309 Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

** 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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	55,808	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.)	2017	\$	76,465	2
3. Under or (over) accrual (line 2 minus line 1).		\$	20,657	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	56,743	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	77,400	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	69,403	8
	2014	69,819	9
	2015	72,060	10
	2016	74,091	11
	2017	76,465	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.

Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.

Taxes paid during year represents the entire 2017 bill.

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Leroy Manor COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0047704

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>30-20-481-029</u>	<u>Leroy Estates Sub Sec 1 Lots 1&2</u>	\$ <u>76,464.90</u>	\$ <u>76,464.90</u>
2. _____	<u>& OL B & Bel Vue Sub OL Z</u>	\$ _____	\$ _____
3. _____	<u>(EX N303.1' ALG E LN SD LOT)</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>76,464.90</u></u>	\$ <u><u>76,464.90</u></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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Leroy Manor

0047704

Report Period Beginning:

10/1/2017 Ending:

9/30/2018

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Leroy Manor

0047704

Report Period Beginning:

10/1/2017

Ending:

9/30/2018

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	102	2005		\$ 4,376,543	\$	40	\$ 109,411	\$ 109,411	\$ 1,404,141	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Fiberglass Insulation, Air Conditioner		2007	19,852		10			19,852	9
10	New Roof, Valences, Blinds, Drapery, Bedside Cab., Table, Chairs, Paint		2008	251,220	23,275	5-10 yrs	23,275		250,216	10
11	Wall Paint, Paint, Paint, Fire Panel, Duct Wrk & Motorized Dampers		2009	17,221	654	5-20 yrs	654		15,216	11
12	Roof Reconstruction, AC Repl, Water heater, Water heater, Fire pump		2009	36,804	2,614	5-20 yrs	2,614		26,745	12
13	Physical Therapy Remodel (Contracted Total)		2010	242,142	20,177	12	20,177		173,199	13
14	PT Remodel, Dining Room, Nortel Phone System		2011	225,834	5,205	10-12 yrs	18,883	13,678	141,371	14
15	Sprinkler - Replace Pipes/Inspection		2012	8,018	320	25	320		2,165	15
16	Parking Lot		2013	61,500		8	7,687	7,687	38,437	16
17	Sprinkler Pipe Replacement		2014	13,917	695	20	695		3,247	17
18	Wall Sconces		2014	6,106	873	7	873		3,998	18
19	Closets		2014	27,300	2,275	12	2,275		10,048	19
20	Water Heater		2014	3,217	321	10	321		1,421	20
21	Shower Remodel-Drywall/Pain/Tile/Lights/Shower Walls		2015	26,916	2,243	12	2,243		7,664	21
22	Bathroom Remodel-Drywall/Tile/Toilet		2015	4,205	351	12	351		1,022	22
23	Fire Dampers		2016	5,606	374	15	374		779	23
24	Water Heaters		2017	8,092	742	10	742		742	24
25	AC Unit/Coil		2018	5,325	266	10	266		266	25
26	2 Furnaces/2 AC Units - Service Hall and Kitchen		2018	12,341	343	15	343		343	26
27	Heater - 3 Ton Condensor / 4 Ton Coil		2017	4,500	275	15	275		275	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

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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						\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 5,356,659	\$ 61,003		\$ 191,779	\$ 130,776	\$ 2,101,147	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

10/1/2017

Ending:

9/30/2018

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 559,162	\$ 18,244	\$ 18,244	\$	3-15 yrs	\$ 505,390	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 559,162	\$ 18,244	\$ 18,244	\$		\$ 505,390	75

D. Vehicle Costs. (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	Facility	2005 Ford E350	2018	\$ 47,110	\$	\$	\$	4	\$ 47,110	76
77										77
78										78
79										79
80	TOTALS			\$ 47,110	\$	\$	\$		\$ 47,110	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)	\$ 6,171,931	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,247	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 210,023	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 130,776	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,653,647	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	\$	\$ 15,400	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 15,400	\$	\$ 15,400	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 4,452 Description: Medical Equipment

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			
		1	2	3	4
		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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	1,845	\$ 138,772	\$	1,845	\$ 138,772	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,100	86,640		1,100	86,640	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,873	149,017		1,873	149,017	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				79,899		79,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39(3)			589	6,521		589	6,521	12
13	Other (specify):									13
14	TOTAL			\$	5,407	\$ 380,950	\$ 79,899	5,407	\$ 460,849	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/2018**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 4,181	\$ 14,910	1
2	Cash-Patient Deposits	25,872	25,872	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>221,000</u>)	831,166	831,166	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,804	72,856	6
7	Other Prepaid Expenses		5,966	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 929,023	\$ 950,770	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	756,966	5,356,659	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	375,272	606,272	16
17	Accumulated Depreciation (book methods)	(877,566)	(2,653,647)	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 Sch 17A</u>		478,024	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 254,672	\$ 3,996,308	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,183,695	\$ 4,947,078	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 138,787	\$ 150,787	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,872	25,872	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,852	60,852	30
31	Accrued Taxes Payable (excluding real estate taxes)	56,594	56,594	31
32	Accrued Real Estate Taxes(Sch.IX-B)		56,743	32
33	Accrued Interest Payable		13,950	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>	7,632,490	8,785,839	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,914,595	\$ 9,150,637	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,016,256	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposits</u>	19,500	19,500	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 19,500	\$ 3,035,756	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,934,095	\$ 12,186,393	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,750,400)	\$ (7,239,315)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,183,695	\$ 4,947,078	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Leroy Manor

Period Beginning 10/1/2017
Period End 9/30/2018

Schedule 17A

XV. Balance Sheet

Line 23 Other

	<u>Operating</u>	<u>After Consolidation</u>
Replacement Reserve		322,540
Loan Fees, Net		52,776
Real Estate Tax Escrow		48,369
Insurance Escrow		12,942
MIP Escrow		41,397
TOTAL		<u>478,024</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,557,985)	1
2	Restatements (describe):		2
3	Prior Year Post Closing Adjustment	(5,568)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,563,553)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,186,847)	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)	\$ (1,186,847)	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)	\$ (6,750,400)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,558,958	1
2	Discounts and Allowances for all Levels	(31,203)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,527,755	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	134,404	6
7	Oxygen	(169)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 134,235	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		12
13	Barber and Beauty Care	1,388	13
14	Non-Patient Meals	52	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	924	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,364	23
D. Non-Operating Revenue			
24	Contributions	1,128	24
25	Interest and Other Investment Income***	9,178	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,306	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	4,289	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,289	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,678,949	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	976,187	31
32	Health Care	2,499,904	32
33	General Administration	1,023,289	33
B. Capital Expense			
34	Ownership	502,702	34
C. Ancillary Expense			
35	Special Cost Centers	667,169	35
36	Provider Participation Fee	196,545	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,865,796	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,186,847)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,186,847)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,299,849	44
45	Private Pay - Net Inpatient Revenue	1,072,023	45
46	Medicare - Net Inpatient Revenue	776,042	46
47	Other-(specify) <u>Medicare Replacement/Managed Care</u>	290,405	47
48	Other-(specify) <u>Hospice</u>	89,436	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,527,755	49

* 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Leroy Manor
IDPH License ID Number: 0047704
Fiscal Year End: 9/30/2018

Schedule 19A

XVII. Income Statement
Line 28a Other Income

Rental Description	Amount
Late Fees	153
Processing Fee Reversal	(20)
Maintenance Fee Income	3,600
Miscellaneous Income	556
Total - Line 16	<u>4,289</u>

Facility Name & ID Number Leroy Manor

0047704

Report Period Beginning: 10/1/2017

Ending: 9/30/2018

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	1,256	1,336	57,043	\$ 42.70	1
2	Assistant Director of Nursing	0	0			2
3	Registered Nurses	13,615	14,095	473,660	33.61	3
4	Licensed Practical Nurses	12,089	12,649	356,280	28.17	4
5	CNAs & Orderlies	84,306	88,384	1,145,732	12.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,800	6,258	69,232	11.06	10
11	Social Service Workers	2,727	2,811	52,618	18.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,106	22,919	247,793	10.81	15
16	Dishwashers					16
17	Maintenance Workers	4,027	4,291	71,020	16.55	17
18	Housekeepers	10,419	10,764	119,148	11.07	18
19	Laundry	4,498	4,743	43,888	9.25	19
20	Administrator	1,946	1,954	82,882	42.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,976	7,354	121,074	16.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,926	2,118	32,240	15.23	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	800	841	20,257	24.09	33
34	TOTAL (lines 1 - 33)	172,491	180,513	\$ 2,892,867 *	\$ 16.03	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	Monthly	\$ 8,342	L1, C3	35
36	Medical Director	Monthly	10,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,000	L10, C3	37
38	Nurse Consultant	Monthly	56	L10, C3	38
39	Pharmacist Consultant	Monthly	7,172	L10, C3	39
40	Physical Therapy Consultant	Monthly	2,234	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,804		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	850	\$ 40,805	L10, C3	50
51	Licensed Practical Nurses	2,170	91,138	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,020	\$ 131,943		53

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Darla Coit	Administrator	None	\$ 42,215	Workers' Compensation Insurance	\$ 19,602	IDPH License Fee	\$ 1,992	
Bekime Feezor Branch	Administrator	None	40,667	Unemployment Compensation Insurance	9,226	Advertising: Employee Recruitment	13,931	
				FICA Taxes	212,174	Health Care Worker Background Check (Indicate # of checks performed <u>118</u>)	2,957	
				Employee Health Insurance	100,461	Patient Background Checks		
				Employee Meals		Subscriptions	1,957	
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	6,732	
				401k	6,287	Other Licenses & Fees	36	
				Other Employee Benefits	2,699	Indirect costs	86	
						Less: Public Relations Expense	(2,670)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,882					
				Indirect costs	22			
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,021	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 350,471			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
N/A			\$	N/A			Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	106
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
LTC Support Services, LLC	Support Services		\$ 139,080				TOTAL	\$ 106
RFMS, Inc.	Administrative Services		132,000					
Templin Healthcare Accounting	Accounting Services		3,226					
RSM US LLP	Accounting Services		19,903					
Davis & Campbell, LLC	Legal Services		388					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 294,597	TOTAL		\$		

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

