

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047704

Facility Name: Leroy Manor

Address: 509 South Buck Road, P.O. Box 149 Leroy 61752
Number City Zip Code

County: McLean

Telephone Number: (309) 962-5000 Fax # (309) 962-6227

HFS ID Number:

Date of Initial License for Current Owners: 12/09/05

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) (3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Ron Wilson Telephone Number: (309) 343-1550
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/11 to 9/30/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)
(Type or Print Name) Cindy Scharp
(Title) Regional Director

Paid Preparer

(Signed) See Preparation Report
(Print Name and Title) McGladrey LLP
117 E. Main St., Suite 210
(Firm Name & Address) P.O. Box 1070
Galesburg, IL 61401
(Telephone) (309) 342-1175 Fax # (309) 342-7816

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Leroy Manor# 0047704 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 bedsN/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>102</u>	Skilled (SNF)	<u>102</u>	<u>37,332</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>102</u>	TOTALS	<u>102</u>	<u>37,332</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,862</u>	<u>7,519</u>	<u>4,658</u>	<u>26,039</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>13,862</u>	<u>7,519</u>	<u>4,658</u>	<u>26,039</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.75%

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?

YesG. 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 12/14/05NO ☐

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 4,086Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 9/30/12Fiscal Year: 9/30/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
	A. General Services										
1	Dietary	199,330	17,707	4,270	221,307		221,307		221,307		1
2	Food Purchase		183,652		183,652		183,652	(24)	183,628		2
3	Housekeeping	105,466	40,792		146,258		146,258		146,258		3
4	Laundry	37,449	15,766		53,215		53,215		53,215		4
5	Heat and Other Utilities			131,579	131,579		131,579		131,579		5
6	Maintenance	53,548	22,398	38,899	114,845		114,845		114,845		6
7	Other (specify):*										7
8	TOTAL General Services	395,793	280,315	174,748	850,856		850,856	(24)	850,832		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	1,622,861	262,187	6,694	1,891,742		1,891,742		1,891,742		10
10a	Therapy			415,524	415,524		415,524		415,524		10a
11	Activities	55,857	2,467		58,324		58,324		58,324		11
12	Social Services	33,716			33,716		33,716		33,716		12
13	CNA Training										13
14	Program Transportation			1,057	1,057	2,212	3,269		3,269		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,712,434	264,654	434,275	2,411,363	2,212	2,413,575		2,413,575		16
	C. General Administration										
17	Administrative	93,561			93,561		93,561		93,561		17
18	Directors Fees							3,057	3,057		18
19	Professional Services			306,170	306,170		306,170	1,429	307,599		19
20	Dues, Fees, Subscriptions & Promotions			47,081	47,081		47,081	(27,031)	20,050		20
21	Clerical & General Office Expenses	61,265	32,865	43,008	137,138		137,138	(13,812)	123,326		21
22	Employee Benefits & Payroll Taxes			358,184	358,184		358,184		358,184		22
23	Inservice Training & Education			7,828	7,828		7,828		7,828		23
24	Travel and Seminar			209	209		209		209		24
25	Other Admin. Staff Transportation			4,423	4,423	(2,212)	2,211		2,211		25
26	Insurance-Prop.Liab.Malpractice			38,031	38,031		38,031	25,705	63,736		26
27	Other (specify):* See Att Sch V	36,781		161,540	198,321		198,321	(198,321)			27
28	TOTAL General Administration	191,607	32,865	966,474	1,190,946	(2,212)	1,188,734	(208,973)	979,761		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,299,834	577,834	1,575,497	4,453,165		4,453,165	(208,997)	4,244,168		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.

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			90,461	90,461		90,461	147,732	238,193			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							192,836	192,836			32
33	Real Estate Taxes			2,218	2,218		2,218	72,000	74,218			33
34	Rent-Facility & Grounds			418,920	418,920		418,920	(418,920)				34
35	Rent-Equipment & Vehicles			11,431	11,431		11,431		11,431			35
36	Other (specify):* See Att Sch IV							6,227	6,227			36
37	TOTAL Ownership			523,030	523,030		523,030	(125)	522,905			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			24,157	24,157		24,157		24,157			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			565	565		565		565			41
42	Provider Participation Fee			247,045	247,045		247,045		247,045			42
43	Other (specify):* Outpatient Care			768	768		768		768			43
44	TOTAL Special Cost Centers			272,535	272,535		272,535		272,535			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,299,834	577,834	2,371,062	5,248,730		5,248,730	(209,122)	5,039,608			45

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

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	(24)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(5,796)	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	(14,300)	V-21		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	(159,828)	V-27		24
25	Fund Raising, Advertising and Promotional	(27,063)	V-20		25
	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 VI	(39,893)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (246,904)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	29,247		34
35	Other- Attach Schedule See Att Sch III	8,535		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 37,782		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (209,122)		37

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

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

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

Leroy Manor

ID#

0047704

Report Period Beginning:

10/1/11

Ending:

9/30/12

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

Summary A

Facility Name & ID Number Leroy Manor # 0047704 Report Period Beginning: 10/1/11 Ending: 9/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Facility Name & ID Number

Leroy Manor

#

0047704

Report Period Beginning:

10/1/11

Ending:

9/30/12

Summary B

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	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	29,247	0	0	0	0	0	0	0	0	0	29,247	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	29,247	0	0	0	0	0	0	0	0	0	29,247	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	29,247	0	0	0	0	0	0	0	0	0	29,247	45

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 Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

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	\$ 418,920	Leroy South Buck, LLC	N/A	\$ 448,167	\$ 29,247	1
2	V								2
3	V				See Att Schedule IV and Preparation Report				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 418,920			\$ 448,167	\$ * 29,247	14

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

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								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

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								\$ 3,057	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	\$ 3,057		13

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

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

Facility Name & ID Number Leroy Manor # 0047704 Report Period Beginning: 10/1/11 Ending: 9/30/12

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						\$	\$			1
2		See Att Sch II & III							8,535	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					\$	\$		8,535	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10				
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense					
		YES	NO				Original	Balance								
	A. Directly Facility Related Long-Term															
1	Cambridge Realty Capital LTD. Of Illinois						\$		\$			\$	1			
2			X	Facility purchase	\$22,608.83	12/1/2005		3,960,000		3,545,471	1/1/2036	5.5500	198,632	2		
3														3		
4														4		
5														5		
	Working Capital															
6	Miscellaneous		X											6		
7	Less Interest Income		X										(5,796)	7		
8														8		
9	TOTAL Facility Related				\$22,608.83			\$	3,960,000	\$	3,545,471			\$	192,836	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	\$	3,545,471			\$	192,836	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 17,893 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.)

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 2011 report.		\$	57,524	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.)		\$	70,737	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	13,213	3
4.	Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,892	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.)		\$	5,666	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 \$ 5,553 For 2009 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(5,553)	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	74,218	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	73,560	8	
		2008	76,850	9	
		2009	72,398	10	
		2010	71,005	11	
		2011	70,737	12	
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained					
Amount accrued includes estimated taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill					
Taxes paid during year represents the entire 2011 bill.					
		FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2011	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

2011 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 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 30-20-481-028	Leroy Estates Sub Sec 1 Outlot B	\$ 70,736.92	\$ 70,736.92
2.	& Bel Vue Sub OL Z	\$	\$
3.	(EX N303.1 ALG E LN)	\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 70,736.92	\$ 70,736.92

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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:

A. Land.

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

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	\$ 109,414	40	\$ 109,414	\$	\$ 747,662
5										
6										
7										
8										
	Improvement Type**									
9	Fiberglass Insulation, Air Conditioner			2007	19,852	1,986	10	1,986		10,096
10	New Roof, Valences, Blinds, Drapery, Bedside Cab., Table, Chairs, Paint			2008	251,219	25,947	5-10 yrs	25,947		103,805
11	Wall Paint			2009	3,900	780	5	780		2,925
12	Paint			2009	2,488	498	5	498		1,867
13	Paint			2009	2,528	506	5	506		1,855
14	Fire Alarm Panel			2009	4,760	476	10	476		1,745
15	Duct Work & Motorized Dampers for Dryer			2009	3,545	177	20	177		634
16	Roof Reconstruction			2009	10,182	1,018	10	1,018		3,478
17	A/C Replacement			2009	2,930	586	5	586		1,953
18	Water Heater			2009	4,085	408	10	408		1,293
19	Water Heater			2009	4,124	412	10	412		1,168
20	Fire Pump			2009	15,482	774	20	774		2,193
21	Physical Therapy Remodel (Contracted Total)			2010	242,142	20,178	12	20,178		52,127
22	Physical Therapy Remodel (Contracted Total)			2011	57,818	4,818	12	4,818		7,227
23	Dining Room Addition (Contracted Total)			2011	164,145	13,679	12	13,679		20,519
24	Nortel Phone System			2011	3,871	323	10	323		323
25	Sprinkler - Replace Pipes/Inspection			2012	8,019	241	25	241		241
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 5,177,633	\$ 182,221		\$ 182,221	\$	\$ 961,111	70

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

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	\$504,948	\$55,329	\$55,329	\$	5-15 yrs	\$283,085	71
72	Current Year Purchases	14,959	643	643		10-15 yrs	643	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$519,907	\$55,972	\$55,972	\$		\$283,728	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	Patient Care	2003 GMC Van	2005	\$29,891	\$	\$	\$	4 yrs	\$29,891	76
77										77
78										78
79										79
80	TOTALS			\$29,891	\$	\$	\$		\$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)	\$5,936,431	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$238,193	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$238,193	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)	\$1,274,730	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.

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:				\$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			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: \$ 11,431 Description: See Attached Schedule XII
- (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. /2013 \$ N/A
13. /2014 \$ N/A
14. /2015 \$ 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	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 prescrpts							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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 110,107	\$ 147,631	1
2	Cash-Patient Deposits	4,602	4,602	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,726)	1,190,595	1,190,595	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,712	75,428	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII		110,803	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,379,006	\$ 1,531,049	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		4,540,688	14
15	Leasehold Improvements, at Historical Cost	636,945	636,945	15
16	Equipment, at Historical Cost	318,798	565,198	16
17	Accumulated Depreciation (book methods)	(353,581)	(1,290,130)	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): See Att Sch VII		326,139	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 602,162	\$ 4,987,840	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,981,168	\$ 6,518,889	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 111,451	\$ 111,451	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,602	4,602	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,598	36,598	30
31	Accrued Taxes Payable (excluding real estate taxes)	79,449	79,449	31
32	Accrued Real Estate Taxes(Sch.IX-B)		60,892	32
33	Accrued Interest Payable		16,398	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	3,868,764	5,125,611	36
37	Current portion of long term payable		76,458	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,100,864	\$ 5,511,459	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,469,013	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	22,005	22,005	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 22,005	\$ 3,491,018	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,122,869	\$ 9,002,477	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,141,701)	\$ (2,483,588)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,981,168	\$ 6,518,889	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,004,048)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,004,048)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(137,653)	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)	\$ (137,653)	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)	\$ (2,141,701)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Leroy Manor# 0047704Report Period Beginning: 10/1/11Ending: 9/30/12

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	\$ 4,905,456	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,905,456	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	188,749	6
7	Oxygen	295	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 189,044	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	622	12
13	Barber and Beauty Care	3,473	13
14	Non-Patient Meals	24	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)	\$ 4,119	23
	D. Non-Operating Revenue		
24	Contributions	2,818	24
25	Interest and Other Investment Income***	5,796	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,614	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schdule X	3,844	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,844	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,111,077	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	850,856	31
32	Health Care	2,411,363	32
33	General Administration	1,190,946	33
	B. Capital Expense		
34	Ownership	523,030	34
	C. Ancillary Expense		
35	Special Cost Centers	25,490	35
36	Provider Participation Fee	247,045	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,248,730	40
41	Income before Income Taxes (line 30 minus line 40)**	(137,653)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (137,653)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,818,149	44
45	Private Pay - Net Inpatient Revenue	1,285,211	45
46	Medicare - Net Inpatient Revenue	1,639,784	46
47	Other-(specify)		47
48	Other-(specify) <u>See Att Sch XI</u>	162,312	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,905,456	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.

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	1,814	1,929	\$ 60,295	\$ 31.26	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,373	5,716	136,679	23.91	3
4	Licensed Practical Nurses	18,969	20,180	420,558	20.84	4
5	CNAs & Orderlies	77,496	82,496	931,606	11.29	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	5,033	5,355	55,857	10.43	10
11	Social Service Workers	2,257	2,401	33,716	14.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,957	19,103	199,330	10.43	15
16	Dishwashers					16
17	Maintenance Workers	3,129	3,329	53,548	16.09	17
18	Housekeepers	10,210	10,862	105,466	9.71	18
19	Laundry	3,991	4,246	37,449	8.82	19
20	Administrator	1,502	1,598	57,634	36.07	20
21	Assistant Administrator	2,111	2,245	35,927	16.00	21
22	Other Administrative	1,798	1,913	36,781	19.23	22
23	Office Manager					23
24	Clerical	5,144	5,472	61,265	11.20	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			0		31
32	Other Health Care(specify)	3,782	4,024	73,723	18.32	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,566	170,869	\$ 2,299,834 *	\$ 13.46	34

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	***	\$ 4,270	1-3	35
36	Medical Director	***	11,000	9-3	36
37	Medical Records Consultant	***	1,840	10-3	37
38	Nurse Consultant	***	265	10-3	38
39	Pharmacist Consultant	***	4,589	10-3	39
40	Physical Therapy Consultant	***	197,985	10a-3	40
41	Occupational Therapy Consultant	***	153,921	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	63,618	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify)	***	0	10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		\$ 437,488		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

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		
Julia Smith	Administrator	None	\$ 9,226	Workers' Compensation Insurance	\$ 83,684	IDPH License Fee	\$		
Mickey Kanosky	Administrator	None	13,558	Unemployment Compensation Insurance	13,169	Advertising: Employee Recruitment	11,608		
Reginald Jordan	Administrator	None	13,461	FICA Taxes	171,109	Health Care Worker Background Check			
Joseph Rasmussen	Administrator	None	21,389	Employee Health Insurance	73,485	(Indicate # of checks performed 92)	2,586		
Heidi Cinkovich	Asst Admin	None	11,520	Employee Meals		Patient Background Checks 91	910		
Andrea Johnson	Asst Admin	None	24,407	Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promotion	27,063		
TOTAL (agree to Schedule V, line 17, col. 1)				401 (k)	7,231	Subscriptions	635		
(List each licensed administrator separately.)			\$ 93,561	Other Employee Benefits	9,506	IHCA Dues	3,770		
B. Administrative - Other						Other Licenses & Fees	509		
Description			Amount			Indirect Costs - See Att Sch III	32		
			\$			Less: Public Relations Expense	()		
						Non-allowable advertising	(27,063)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 358,184	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,050	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type	Amount				\$	Out-of-State Travel	\$	
RFMS, Inc	Administrative Services	\$ 132,000							
McGladrey LLP	Accounting Services	8,000							
LTC Support Services, LLC	Support Services	120,960							
Crain, Miller & Wernsman, LTD	Legal Services	1,120					In-State Travel		
Davis & Campbell L.L.C.	Legal Services	167					Staff use of personal vehicle on facility		
Polsinelli Shughart PC	Legal Services	43,858					business and meals (under \$250 per		
Singleton Law Firm, P.C.	Legal Services	65					travel voucher)	0	
							Seminar Expense	209	
							Less: non-allowable out-of-state travel	0	
							Indirect costs - See Att Sch III	0	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 306,170				TOTAL	\$ 209	

*** Attach copy of IMRF notifications**

****See instructions.**

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

\$ 31,621

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.

\$ 247,045

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.

\$ 24
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

McGladrey LLP
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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.