

		FOR OFF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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 Facility ID Number:** 0003020

**Facility Name:** MENARD CONVALESCENT CENTER

**Address:** 120 WEST ANTLE STREET PETERSBURG 62675  
 Number City Zip Code

**County:** MENARD

**Telephone Number:** (217) 632-2249 **Fax #** (217) 632-2314

**IDPA ID Number:** 37-0856151001

**Date of Initial License for Current Owners:** 12/1/66

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/04 to 11/30/05 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JERRY W. JENNINGS</u>	
	(Title) <u>CONTROLLER</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____

**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 MENARD CONVALESCENT CENTER

# 0003020 Report Period Beginning: 12/1/04 Ending: 11/30/05

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	59	Skilled (SNF)	59	21,535	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	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			1,845	1,845	8
9	SNF/PED					9
10	ICF	9,807	5,477		15,284	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,807	5,477	1,845	17,129	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.57%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

YES  NO

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

YES  NO

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

Date started / / 66

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 30 and days of care provided 1,845

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 11/30/05 Fiscal Year: 11/30/05

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/04 Ending: 11/30/05

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	101,094	10,056	5,080	116,230		116,230		116,230		1
2	Food Purchase		67,717		67,717		67,717	(2,824)	64,893		2
3	Housekeeping	35,958	8,817		44,775		44,775		44,775		3
4	Laundry	25,072	9,774		34,846		34,846		34,846		4
5	Heat and Other Utilities			52,618	52,618		52,618		52,618		5
6	Maintenance	32,487	17,550	28,894	78,931		78,931	1,018	79,949		6
7	Other (specify):* <b>Utility Workers</b>	5,731			5,731		5,731		5,731		7
8	<b>TOTAL General Services</b>	<b>200,342</b>	<b>113,914</b>	<b>86,592</b>	<b>400,848</b>		<b>400,848</b>	<b>(1,806)</b>	<b>399,042</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	12,033		14,400	26,433		26,433		26,433		9
10	Nursing and Medical Records	791,263	113,762	69,603	974,628	(81,102)	893,526	5,312	898,838		10
10a	Therapy	28,398	1,358	147,576	177,332	(147,576)	29,756		29,756		10a
11	Activities	36,835	1,563		38,398		38,398		38,398		11
12	Social Services	16,441		4,142	20,583		20,583		20,583		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>884,970</b>	<b>116,683</b>	<b>235,721</b>	<b>1,237,374</b>	<b>(228,678)</b>	<b>1,008,696</b>	<b>5,312</b>	<b>1,014,008</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	53,976		9,906	63,882	2,229	66,111	26,282	92,393		17
18	Directors Fees										18
19	Professional Services			94,329	94,329		94,329	(85,835)	8,494		19
20	Dues, Fees, Subscriptions & Promotions			13,611	13,611		13,611	(9,120)	4,491		20
21	Clerical & General Office Expenses	52,241	17,564	4,152	73,957		73,957	19,451	93,408		21
22	Employee Benefits & Payroll Taxes			205,989	205,989		205,989	12,727	218,716		22
23	Inservice Training & Education			3,824	3,824		3,824	2,123	5,947		23
24	Travel and Seminar			6,463	6,463	(3,808)	2,655	492	3,147		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,771	67,771		67,771	112	67,883		26
27	Other (specify):*			23,164	23,164		23,164	(23,164)			27
28	<b>TOTAL General Administration</b>	<b>106,217</b>	<b>17,564</b>	<b>429,209</b>	<b>552,990</b>	<b>(1,579)</b>	<b>551,411</b>	<b>(56,932)</b>	<b>494,479</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,191,529</b>	<b>248,161</b>	<b>751,522</b>	<b>2,191,212</b>	<b>(230,257)</b>	<b>1,960,955</b>	<b>(53,426)</b>	<b>1,907,529</b>		<b>29</b>

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER #0003020 Report Period Beginning: 12/1/04 Ending: 11/30/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			20,591	20,591		20,591	3,887	24,478			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			43,977	43,977		43,977		43,977			33
34	Rent-Facility & Grounds							3,366	3,366			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			64,568	64,568		64,568	7,253	71,821			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers						230,257		230,257			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			47,085	47,085		230,257		277,342			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,191,529	248,161	863,175	2,302,865		2,302,865	(46,173)	2,256,692			45

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

Facility Name & ID Number MENARD CONVALESCENT CENTER

# 0003020

Report Period Beginning: 12/1/04

Ending: 11/30/05

**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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(595)	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	2,591	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(550)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,393)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,044)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,771)	27		24
25	Fund Raising, Advertising and Promotional	(8,903)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(343)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(2,229)	2		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (34,237)		\$	30

OHF 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)	(11,936)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (11,936)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (46,173)		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	<u>THERAPY</u>	X		147,576	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		4,622	10	42
43	Prescription Drugs	X		61,156	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>Ambulance</u>	X		1,137	10	45
46	Other-Attach Schedule <u>Supp, O2</u>	X		15,766	10	46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 230,257		47

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/1/04

Ending: 11/30/05

Sch. V Line Reference

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020

Report Period Beginning:

12/1/04

Ending:

11/30/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(595)	0	0	0	0	0	0	0	0	0	0	(595)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(595)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(595)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	221	0	0	0	0	0	0	0	0	0	221	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,044)	(84,891)	0	0	0	0	0	0	0	0	0	(85,935)	19
20	Fees, Subscriptions & Promotions	(9,246)	0	0	0	0	0	0	0	0	0	0	(9,246)	20
21	Clerical & General Office Expenses	(550)	0	0	0	0	0	0	0	0	0	0	(550)	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	(221)	0	0	0	0	0	0	0	0	0	(221)	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):*	(23,164)	0	0	0	0	0	0	0	0	0	0	(23,164)	27
28	<b>TOTAL General Administration</b>	<b>(34,004)</b>	<b>(84,891)</b>	<b>0</b>	<b>(118,895)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(34,599)</b>	<b>(84,891)</b>	<b>0</b>	<b>(119,490)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER

# 0003020

Report Period Beginning:

12/1/04

Ending:

11/30/05

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	2,591	0	0	0	0	0	0	0	0	0	0	2,591	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	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>2,591</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,591</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(32,008)</b>	<b>(84,891)</b>	<b>0</b>	<b>(116,899)</b>	<b>45</b>								

Facility Name & ID Number MENARD CONVALESCENT CENTER

# 0003020

Report Period Beginning:

12/1/04

Ending:

11/30/05

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM KLEIN	50.00	HILLTOP NURSING HOME	CHARLESTON	NURS. HOME MNGR	SPRINGFIELD	MANAGEMENT
ROBERT SCHAFER	25.00	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE			
BARRY FREE	25.00	MEADOW MANOR	TAYLORVILLE			
		SUNRISE MANOR OF VIRDEN	VIRDEN			

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	19 MANAGEMENT FEE	\$ 93,285	NURSING HOME MANAGERS		\$	\$ (93,285)	1
2	V	VAR SEE ATTACHED		NURSING HOME MANAGERS		72,955	72,955	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		8,394	8,394	3
4	V	24 TRAVEL	221	TO TRANSFER 31 % OF HOME OFFICE TRAVEL			(221)	4
5	V	17 ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		221	221	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		\$ 93,506			\$ 81,570	\$ * (11,936)	14

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/04 Ending: 11/30/05

## 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	ROBERT SCHAFFER	MED. DIRECTOR	MED. DIRECTOR	25.00		6	12.00		\$ 12,033	9-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,033		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 MENARD CONVALESCENT CENTER

# 0003020

Report Period Beginning: 12/1/04

Ending: 11/30/05

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 NURSING HOME MANAGERS  
 Street Address 2653 W. LAWRENCE, SUITE B  
 City / State / Zip Code SPRINGFIELD, IL 62704  
 Phone Number ( 217 ) 787-8530  
 Fax Number ( 217 ) 787-9840

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	SEE ATTACHED SCHEDULES				\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/04 Ending: 11/30/05

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	<b>SAM KLEIN ESTATE</b>	<b>X</b>	<b>WORKING CAPITAL</b>		<b>5/30/03</b>	<b>25,000</b>	<b>795,000</b>	<b>DEMAND</b>	<b>0.0400</b>	6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					<b>\$ 25,000</b>	<b>\$ 795,000</b>			9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					<b>\$</b>	<b>\$</b>		<b>\$</b>	14										
15	<b>TOTALS (line 9+line14)</b>					<b>\$ 25,000</b>	<b>\$ 795,000</b>		<b>\$</b>	15										

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

\* 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**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 12,756	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.)		\$ 29,600	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 16,844	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 27,133	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 43,977	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	13,705	8
	2001	13,764	9
	2002	13,606	10
	2003	13,917	11
	2004	29,600	12
<b>LINE 4 ACCRUAL 11/12 OF \$29600 = \$27133</b>			
<b>FOR OHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME MENARD CONVALESCENT CENTER COUNTY MENARD

FACILITY IDPH LICENSE NUMBER 0003020

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-14-228-001</u>	<u>MENARD CONV. CENTER</u>	\$ <u>24,724.82</u>	\$ <u>24,724.82</u>
2. <u>11-14-228-002</u>	<u>MENARD CONV. CENTER</u>	\$ <u>492.52</u>	\$ <u>492.52</u>
3. <u>11-14-229-001</u>	<u>MENARD CONV. CENTER</u>	\$ <u>307.06</u>	\$ <u>307.06</u>
4. <u>11-14-227-001</u>	<u>MENARD CONV. CENTER</u>	\$ <u>2,456.02</u>	\$ <u>2,456.02</u>
5. <u>11-14-219-006</u>	<u>MENARD CONV. CENTER</u>	\$ <u>307.06</u>	\$ <u>307.06</u>
6. <u>11-14-219-009</u>	<u>MENARD CONV. CENTER</u>	\$ <u>1,312.64</u>	\$ <u>1,312.64</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>29,600.12</u>	\$ <u>29,600.12</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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number MENARD CONVALESCENT CENTER

# 0003020 Report Period Beginning:

12/1/04 Ending:

11/30/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 19,211 B. General Construction Type: Exterior MASONRY Frame STEEL 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).

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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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>43,436</u>	<u>1963-1964</u>	<u>\$ 9,919</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>43,436</b>		<b>\$ 9,919</b>	<b>3</b>

Facility Name & ID Number **MENARD CONVALESCENT CENTER**# **0003020**

Report Period Beginning:

**12/1/04**

Ending:

**11/30/05****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	54		1966	1966	\$ 172,985	\$ 1,397	30	\$	\$ (1,397)	\$ 172,985	4
5	32		1974	1974	148,705		30			148,705	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		LANDSCAPING	1966		5,308					5,308	9
10		FIRE DOORS	1979		1,433					1,433	10
11		FIRE DOORS	1981		8,340					8,340	11
12		BATHROOM	1984		7,335		30	244	244	5,265	12
13		AIR CONDITIONER	1984		1,100		8			1,100	13
14		ELECTRICAL & PLUMBING	1985		11,117	94	15		(94)	11,117	14
15		PLUMBING	1986		4,921	64	15		(64)	4,921	15
16		SMOKE DETECTORS	1986		10,445	173	25	418	245	8,150	16
17		AIR CONDITIONER	1986		2,235	51	10		(51)	2,235	17
18		PLUMBING	1986		1,145	42	20	57	15	1,113	18
19		ROOF	1987		6,362	234	20	318	84	5,883	19
20		WATER HEATER & WINDOWS	1988		6,530	207	15		(207)	6,530	20
21		NURSE CALL	1988		1,674	53	10		(53)	1,674	21
22		ROOF	1989		30,672	974	20	1,533	559	25,309	22
23		WATER HEATER & PARKING LOT	1989		11,502	365	15		(365)	11,502	23
24		FURNACE & FLOORING	1990		19,165	608	15	635	27	19,165	24
25		AIR CONDITIONER	1991		2,633	84	15	177	93	2,550	25
26		PLUMBING FAUCETS	1992		8,909	283	15	594	311	8,019	26
27		DOOR ALARM	1992		1,572	50	20	79	29	1,182	27
28		WATER HEATER & GARAGE DOOR	1993		4,348	138	15	289	151	3,624	28
29		WATER HEATER & PLUMBING	1994		5,074	130	15	338	208	3,888	29
30		LANDSCAPING	1994		3,900	260	15	260		2,925	30
31		AIR CONDITIONER & ROOF	1995		7,049	181	15	469	288	4,934	31
32		REMODEL BATHROOMS - TILE, CEILING, FIXTURES	1996		19,751	506	15	1,316	810	12,509	32
33		AIR CONDITIONER	1997		1,710	44	15	114	70	969	33
34		FIRE DAMPERS	1998		4,076	105	15	272	167	2,039	34
35		FURNACE	1998		2,200	56	15	147	91	1,101	35
36		GREASE TRAP	1999		2,824	72	15	188	116	1,223	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **MENARD CONVALESCENT CENTER**

# **0003020**

Report Period Beginning:

12/1/04

Ending:

11/30/05

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	CEILING REPAIR	2002	\$ 4,935	\$ 127	15	\$ 329	\$ 202	\$ 1,289	37
38	AIR CONDITIONING	2002	2,102	54	15	141	87	444	38
39	AIR CONDITIONING & VENTILATION	2004	4,935	127	10	494	367	905	39
40	WATER HEATER	2004	1,675	43	15	112	69	121	40
41	DOORS & CONCRETE	2005	33,052	813	20	1,653	840	1,653	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)		\$ 561,719	\$ 7,335		\$ 10,177	\$ 2,842	\$ 490,110	70

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 145,693	\$ 11,106	\$ 11,805	\$ 699	VAR	\$ 94,003	71
72	Current Year Purchases	10,072	2,150	1,200	(950)	VAR	1,200	72
73	Fully Depreciated Assets	152,512					152,512	73
74	ASSETS NO LONGER IN SERVICE	(73,230)					(73,230)	74
75	TOTALS	\$ 235,047	\$ 13,256	\$ 13,005	\$ (251)		\$ 174,485	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 806,685	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,591	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,182	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,591	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 664,595	85

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

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

G. Construction-in-Progress

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

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

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

**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	<b>TOTAL</b>				\$			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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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 \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**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: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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	<b>TOTAL</b>		\$	\$	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	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	39-8	hrs	\$	1,304	\$ 62,483	\$	1,304	\$ 62,483	1
2	Licensed Speech and Language Development Therapist	39-8	hrs		190	12,842		190	12,842	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs		1,482	72,251		1,482	72,251	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				61,156		61,156	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): O2, Amb, Supp, Lab, X	39-8					21,525		21,525	13
14	<b>TOTAL</b>			\$	2,976	\$ 147,576	\$ 82,681	2,976	\$ 230,257	14

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

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020Report Period Beginning: 12/1/04

Ending:

11/30/05**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 11/30/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 8,137	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	213,947		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,247		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 250,331	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	561,719		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	303,823		16
17	Accumulated Depreciation (book methods)	(713,636)		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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 161,825	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 412,156	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 251,842	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	795,000		29
30	Accrued Salaries Payable	94,119		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,575		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,133		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,174,669	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,174,669	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (762,513)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 412,156	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(418,573)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(418,573)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>(343,940)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(343,940)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(762,513)</b>	<b>24</b> *

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

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020Report Period Beginning: 12/1/04Ending: 11/30/05**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,927,972	1
2	Discounts and Allowances for all Levels	(62,267)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,865,705</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,013	6
7	Oxygen	13,917	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 87,930</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	784	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	595	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	1,121	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 2,500</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 11</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending 2229, Admit Fee 450	2,679	28
28a	Jury duty 40, W/A 60	100	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 2,779</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,958,925</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	400,848	31
32	Health Care	1,237,374	32
33	General Administration	552,990	33
<b>B. Capital Expense</b>			
34	Ownership	64,568	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	47,085	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,302,865</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(343,940)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (343,940)</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number MENARD CONVALESCENT CENTER

# 0003020

Report Period Beginning:

12/1/04

Ending:

11/30/05

**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	2,000	2,080	\$ 49,087	\$ 23.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,253	4,606	96,640	20.98	3
4	Licensed Practical Nurses	15,992	16,711	249,268	14.92	4
5	CNAs & Orderlies	41,479	42,671	396,268	9.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,807	2,839	28,398	10.00	8
9	Activity Director	1,308	1,428	11,820	8.28	9
10	Activity Assistants	3,413	3,527	25,015	7.09	10
11	Social Service Workers	1,704	1,874	16,441	8.77	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,187	24,947	11.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,898	10,231	76,147	7.44	15
16	Dishwashers					16
17	Maintenance Workers	3,620	3,869	32,487	8.40	17
18	Housekeepers	4,956	5,078	35,958	7.08	18
19	Laundry	3,489	3,627	25,072	6.91	19
20	Administrator	2,000	2,080	53,976	25.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,191	4,656	52,241	11.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	300	300	12,033	40.11	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Utility Workers</u>	866	881	5,731	6.51	33
34	TOTAL (lines 1 - 33)	104,240	108,645	\$ 1,191,529 *	\$ 10.97	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	144	\$ 5,080	1-3	35
36	Medical Director	100	14,400	9-3	36
37	Medical Records Consultant	18	553	10-3	37
38	Nurse Consultant	608	30,995	10-3	38
39	Pharmacist Consultant	96	2,274	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	69	4,142	12-3	45
46	Other(specify) <u>URC</u>	39	3,850	10-3	46
47	<u>MEDICARE CONSULTANT</u>	192	24,159	10-3	47
48	<u>ADMINISTRATIVE CONS.</u>	300	9,906	17-3	48
49	TOTAL (lines 35 - 48)	1,565	\$ 95,359		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	122	4,199	10-3	51
52	Certified Nurse Assistants/Aides	187	3,573	10-3	52
53	TOTAL (lines 50 - 52)	309	\$ 7,772		53





**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? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 384 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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 47,085  
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? YES 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. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
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. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V - PAGES 3 & 4

PAGE 3 - LINE 27 - COLUMN 3  
OTHER GENERAL ADMINISTRATION

SALES TAX	\$	2,393
BAD DEBT		<u>20,771</u>
	\$	<u><u>23,164</u></u>

COLUMN 5 - RECLASSIFICATIONS

RECLASS FROM:		LINE #
AMBULANCE	\$ (1,137)	10
X - RAYS	(363)	10
LABS	(4,259)	10
MEDICARE DRUGS	(61,156)	10
MEDICARE SUPPLIES	(84)	10
OXYGEN	(15,682)	10
PHYSICAL THERAPY	(72,251)	10A
SPEECH THERAPY	(12,842)	10A
OCCUPATIONAL THERAPY	<u>(62,483)</u>	10A

RECLASS TO:		
ANCILLARY	\$ <u>230,257</u>	39

RECLASS TO:		
NURSE CONSULTANT TRAVEL	\$ 1,579	10
ADMINISTRATIVE CONS. TRAVEL	<u>2,229</u>	17

RECLASS FROM:		
TRAVEL	\$ <u>(3,808)</u>	24

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION	
LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 23,182
NURSING HOME MANAGERS ALLOCATION	<u>1,296</u>

SCHEDULE V - LINE 30 - COLUMN 8	\$ <u><u>24,478</u></u>
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SCHEDULE V - PAGE 3 - LINE 24 - COLUMN 8

DETAIL - TRAVEL

ADMINISTRATOR REIMBURSEMENT	\$ 1,071
ACTIVITY TRAVEL	352
MAINTANANCE TRAVEL	217
PATIENT SCREENING TRAVEL	556
MISCELLANEOUS MILEAGE	459
NURSING HOME MANAGERS ALLOCATION	<u>492</u>
	\$ <u><u>3,147</u></u>

SCHEDULE XVII - PAGE 19

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS  
WORKED BASED UPON TIME CARDS.

RECONCILIATION OF INCOME

LINE 41 - NET INCOME	\$ (343,940)
* ACCRUED MANAGEMENT FEE 11/04	(11,935)
* ACCRUED MANAGEMENT FEE 11/05	8,774
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	<u>(11)</u>
TAXABLE INCOME	<u>\$ (347,112)</u>

SCHEDULE V - PAGE 3 - LINE 23 - COLUMN 8

DETAIL - INSERVICE TRAINING & EDUCATION

DIETARY MEETINGS	\$	366
NURSING SEMINARS		1568
MDS CLASS & TRAINING		227
Q I TRAINING		330
HOME OFFICE INSERVICES		553
CPR TRAINING		495
ALZHEIMER SEMINARS		160
ADMINISTRATOR WORKSHOP		125
NURSING HOME MANAGERS ALLOCATION		<u>2123</u>
	\$	<u>5947</u>

\* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX  
PURPOSES INCLUDED HERE FOR CONSISTANCY WITH PRIOR  
COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING  
METHODS.

SCHEDULE VII - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION  
 MENARD  
 2004

	DEC 04	JAN 05	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2004 TOTAL	LINE #
SALARIES-ADMIN	2,240	2,253	2,213	2,277	2,247	2,156	2,098	1,932	1,859	1,777	1,717	1,778	24,547	17
SALARIES-CLERIC	1,685	1,618	1,589	1,635	1,613	1,548	1,506	1,387	1,459	1,394	1,348	1,396	18,178	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	649	403	396	407	402	386	375	346	508	485	469	486	5,312	10
ACCOUNTING	13	7	7	7	7	7	7	6	10	10	10	10	100	19
WORK COMP INS	17	14	14	15	14	14	13	12	34	33	32	33	246	22
SUPPLIES	74	76	75	77	76	73	71	65	40	38	37	38	742	21
TELEPHONE	94	100	98	101	99	95	93	85	82	79	76	79	1,081	21
EMPL BENEFITS	975	780	766	788	778	746	726	669	733	701	677	701	9,040	22
PAYROLL TAXES	290	322	317	326	322	309	300	276	255	244	236	244	3,441	22
TRAVEL	47	58	57	59	58	56	54	50	71	68	66	68	713	24
IN SERVICE	192	250	245	252	249	239	233	214	65	62	60	62	2,123	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	16	16	16	17	16	16	15	14	23	22	21	22	214	6
OWNERS COMP	140	137	135	138	137	131	128	117	118	112	109	113	1,514	17
INS-PROP,LIAB,WC	25	25	25	25	25	24	23	22	(21)	(20)	(20)	(20)	112	26
DEPRECIATION	118	115	113	117	115	110	107	99	104	100	96	100	1,296	30
RENT	299	308	303	312	308	295	287	264	258	247	238	247	3,366	34
MAINTENANCE	88	64	63	65	64	61	60	55	74	71	69	71	804	6
FEES & PUBLICAT	7	6	6	6	6	6	6	5	20	19	18	19	126	20
ADVERTISING		0	0	0	0	0	0	0	0	0	0	0	0	20
		0	0	0	0	0	0	0	0	0	0	0	0	
<b>TOTAL</b>	<b>6,969</b>	<b>6,555</b>	<b>6,437</b>	<b>6,623</b>	<b>6,536</b>	<b>6,273</b>	<b>6,103</b>	<b>5,619</b>	<b>5,693</b>	<b>5,440</b>	<b>5,259</b>	<b>5,445</b>	<b>72,955</b>	
<b>FIXED ASSETS</b>													<b>72,955</b>	
EQUIP - PRIOR	3,631	9,842	9,665	9,945	9,814	9,418	9,163	8,437	5,764	5,508	5,325	5,513	7,669	
EQUIP - CURR	2,815	0	0	78	77	74	271	249	3,192	3,050	2,949	3,053	1,317	
EQUIP - FULLY DEP	6,496	3,171	3,114	3,204	3,162	3,035	2,953	2,719	2,653	2,535	2,451	2,537	3,169	
BLDG - PRIOR	1,111	0	0	0	0	0	0	0	0	0	0	0	93	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	1,117	1,097	1,129	1,114	1,069	1,040	958	935	893	863	894	926	



ALLOCATION PERCENTAGES  
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OCCUPIED								
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
2004								
JANUARY		2,030	2,537	1,662		1,422	2,071	9,722
FEBRUARY		1,886	2,419	1,579		1,304	1,901	9,089
MARCH		1,904	2,594	1,733		1,438	2,148	9,817
APRIL		1,814	2,437	1,647		1,496	2,206	9,600
MAY		1,838	2,364	1,665		1,591	2,159	9,617
JUNE		1,847	2,285	1,683		1,547	2,088	9,450
JULY		1,881	2,437	1,679		1,617	2,176	9,790
AUGUST		1,861	2,363	1,738		1,763	2,236	9,961
SEPTEMBER		1,815	2,198	1,704		1,775	2,166	9,658
OCTOBER		1,897	2,315	1,756		1,789	2,317	10,074
NOVEMBER		1,855	2,279	1,667		1,705	2,167	9,673
DECEMBER		2,013	2,430	1,751		1,652	2,154	10,000
TOTAL	0	22,641	28,658	20,264	0	19,099	25,789	116,451
								116,451

OCCUPIED								
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
2005								
JANUARY		2,230	2,499	1,744		1,682	1,970	10,125
FEBRUARY		1,998	2,290	1,533		1,485	1,797	9,103
MARCH		2,199	2,453	1,727		1,679	1,945	10,003
APRIL		2,085	2,215	1,594		1,566	1,994	9,454
MAY		2,095	2,132	1,655		1,500	2,054	9,436
JUNE		1,942	2,069	1,677		1,402	1,975	9,065
JULY		2,118	2,026	1,781		1,315	1,994	9,234
AUGUST		2,091	2,047	1,833		1,280	1,960	9,211
SEPTEMBER		2,059	1,881	1,778		1,163	1,877	8,758
OCTOBER		2,210	1,902	1,854		1,173	1,999	9,138
NOVEMBER		2,175	1,844	1,936		1,216	1,978	9,149
DECEMBER		2,329	2,001	2,007		1,332	2,030	9,699
TOTAL	0	25,531	25,359	21,119	0	16,793	23,573	112,375
								112,375

ALLOCATION PERCENTAGE							
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
2004							
JANUARY	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
FEBRUARY	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
MARCH	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
APRIL	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
MAY	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
JUNE	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
JULY	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%
AUGUST	0.00%	18.68%	23.72%	17.45%	17.70%	22.45%	100.00%
SEPTEMBER	0.00%	18.79%	22.76%	17.64%	18.38%	22.43%	100.00%
OCTOBER	0.00%	18.83%	22.98%	17.43%	17.76%	23.00%	100.00%
NOVEMBER	0.00%	19.18%	23.56%	17.23%	17.63%	22.40%	100.00%
DECEMBER	0.00%	20.13%	24.30%	17.51%	16.52%	21.54%	100.00%

ALLOCATION PERCENTAGE							
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
2005							
JANUARY	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
FEBRUARY	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
MARCH	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
APRIL	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
MAY	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
JUNE	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%
JULY	0.00%	22.94%	21.94%	19.29%	14.24%	21.59%	100.00%
AUGUST	0.00%	22.70%	22.22%	19.90%	13.90%	21.28%	100.00%
SEPTEMBER	0.00%	23.51%	21.48%	20.30%	13.28%	21.43%	100.00%
OCTOBER	0.00%	24.18%	20.81%	20.29%	12.84%	21.88%	100.00%
NOVEMBER	0.00%	23.77%	20.16%	21.16%	13.29%	21.62%	100.00%
DECEMBER	0.00%	24.01%	20.63%	20.69%	13.73%	20.93%	100.00%