

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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: 0033159

Facility Name: Clinton Manor Living Center

Address: 111 East Illinois Street New Baden 62265
 Number City Zip Code

County: Clinton

Telephone Number: 618-588-4924 Fax # ()

HFS ID Number: 371224393001

Date of Initial License for Current Owners: 01/01/88

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
IRS Exemption Code _____	<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: James G. Hull, C.P.A. **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>James G. Hull, C.P.A.</u> <u>Vice President</u>	
	(Firm Name & Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison, Quincy, IL 62301</u>	
	(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>	

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 Clinton Manor Living Center

0033159 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	<u>33</u>	Skilled (SNF)	<u>33</u>	<u>12,045</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>50</u>	Intermediate/DD	<u>50</u>	<u>18,250</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>83</u>	TOTALS	<u>83</u>	<u>30,295</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>858</u>	<u>858</u>	8
9	SNF/PED					9
10	ICF	<u>7,125</u>	<u>3,339</u>		<u>10,464</u>	10
11	ICF/DD	<u>16,982</u>			<u>16,982</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,107</u>	<u>3,339</u>	<u>858</u>	<u>28,304</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.43%

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)

N/A

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 01/01/88

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 33 and days of care provided 858

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	A. General Services											
1	Dietary	164,013	14,747	4,511	183,271		183,271		183,271			1
2	Food Purchase		135,282		135,282		135,282	(1,383)	133,899			2
3	Housekeeping	94,830	11,979	301	107,110		107,110		107,110			3
4	Laundry	55,262	10,870		66,132		66,132		66,132			4
5	Heat and Other Utilities			65,966	65,966		65,966		65,966			5
6	Maintenance	45,172	6,547	68,801	120,520		120,520	(509)	120,012			6
7	Other (specify):*							(12,000)	(12,000)			7
8	TOTAL General Services	359,277	179,425	139,579	678,281		678,281	(13,892)	664,390			8
	B. Health Care and Programs											
9	Medical Director			10,700	10,700		10,700		10,700			9
10	Nursing and Medical Records	1,463,885	57,742	78,688	1,600,315		1,600,315	(38,302)	1,562,013			10
10a	Therapy			163,361	163,361		163,361		163,361			10a
11	Activities	23,275	17,272		40,547		40,547		40,547			11
12	Social Services	126,050		2,023	128,073		128,073	(27,427)	100,646			12
13	CNA Training											13
14	Program Transportation	49,485	23,327		72,812		72,812		72,812			14
15	Other (specify):*					403	403		403			15
16	TOTAL Health Care and Programs	1,662,695	98,341	254,772	2,015,808	403	2,016,211	(65,729)	1,950,482			16
	C. General Administration											
17	Administrative	120,872		24,000	144,872		144,872	(24,000)	120,872			17
18	Directors Fees											18
19	Professional Services			108,414	108,414		108,414	(72,710)	35,704			19
20	Dues, Fees, Subscriptions & Promotions			50,808	50,808		50,808	(25,590)	25,218			20
21	Clerical & General Office Expenses	110,631	11,803	20,788	143,222		143,222	(22,304)	120,918			21
22	Employee Benefits & Payroll Taxes			353,406	353,406		353,406	(1,480)	351,926			22
23	Inservice Training & Education			4,254	4,254	(227)	4,027		4,027			23
24	Travel and Seminar			10,689	10,689	(176)	10,513	(31)	10,482			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,422	55,422		55,422		55,422			26
27	Other (specify):*			1,157	1,157		1,157		1,157			27
28	TOTAL General Administration	231,503	11,803	628,938	872,244	(403)	871,841	(146,115)	725,726			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,253,475	289,569	1,023,289	3,566,333		3,566,333	(225,736)	3,340,597			29

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

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

Facility Name & ID Number Clinton Manor Living Center #0033159 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	D. Ownership										
30	Depreciation			99,069	99,069		99,069	(1,502)	97,567		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			101,309	101,309		101,309	(341)	100,968		32
33	Real Estate Taxes			20,167	20,167		20,167		20,167		33
34	Rent-Facility & Grounds			1,582	1,582		1,582		1,582		34
35	Rent-Equipment & Vehicles			4,655	4,655		4,655		4,655		35
36	Other (specify):*			6,783	6,783		6,783	(6,784)	(1)		36
37	TOTAL Ownership			233,565	233,565		233,565	(8,627)	224,938		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		54,887	5,658	60,545		60,545		60,545		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops		12,851		12,851		12,851		12,851		41
42	Provider Participation Fee			45,995	45,995		45,995		45,995		42
43	Other (specify):*			22,806	22,806		22,806	(20,944)	1,862		43
44	TOTAL Special Cost Centers		67,738	74,459	142,197		142,197	(20,944)	121,253		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,253,475	357,307	1,331,313	3,942,095		3,942,095	(255,306)	3,686,789		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 Clinton Manor Living Center

0033159

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	(1,373)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(12,000)	7		6
7	Sale of Supplies to Non-Patients	(2,302)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	24	30		9
10	Interest and Other Investment Income	(341)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,323)	36		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	(91)	36		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,944)	43		24
25	Fund Raising, Advertising and Promotional	(25,590)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,810)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See List Attached	(141,546)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (207,306)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (207,306)		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Clinton Manor Living Center

ID# 0033159

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Bank Fees	\$ (2,035)	36	1
2	Amortization of Loan Costs	(1,076)	36	2
3	Political Contributions	(449)	36	3
4	CSS Labor:Admin Progr.	(27,427)	12	4
5	CSS Labor:Admin Asst.	(22,304)	21	5
6	CSS Labor:Nursing	(36,000)	10	6
7	CSS Labor: Maintenance	(509)	6	7
8	Non-care Related Depreciation	(1,526)	30	8
9	Related Party Management Fees	(48,000)	19	9
10	Payroll Tax Reimbursements	(1,480)	22	10
11	2005 Seminar Expense	(31)	24	11
12	Non-care Related Legal Expenses	(710)	19	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	(141,546)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning:

01/01/06

Ending:

12/31/06

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,383)	0	0	0	0	0	0	0	0	0	0	(1,383)	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	(509)	0	0	0	0	0	0	0	0	0	0	(509)	6
7	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	7
8	TOTAL General Services	(13,892)	0	0	0	0	0	0	0	0	0	0	(13,892)	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	(38,302)	0	0	0	0	0	0	0	0	0	0	(38,302)	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	(27,427)	0	0	0	0	0	0	0	0	0	0	(27,427)	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	(65,729)	0	0	0	0	0	0	0	0	0	0	(65,729)	16
	C. General Administration													
17	Administrative	0	(24,000)	0	0	0	0	0	0	0	0	0	(24,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(48,710)	(24,000)	0	0	0	0	0	0	0	0	0	(72,710)	19
20	Fees, Subscriptions & Promotions	(25,590)	0	0	0	0	0	0	0	0	0	0	(25,590)	20
21	Clerical & General Office Expenses	(22,304)	0	0	0	0	0	0	0	0	0	0	(22,304)	21
22	Employee Benefits & Payroll Taxes	(1,480)	0	0	0	0	0	0	0	0	0	0	(1,480)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(31)	0	0	0	0	0	0	0	0	0	0	(31)	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	(98,115)	(48,000)	0	(146,115)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(177,736)	(48,000)	0	(225,736)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning:

01/01/06 Ending:

12/31/06

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	(1,502)	0	0	0	0	0	0	0	0	0	0	(1,502)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(341)	0	0	0	0	0	0	0	0	0	0	(341)	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):*	(6,784)	0	0	0	0	0	0	0	0	0	0	(6,784)	36
37	TOTAL Ownership	(8,627)	0	0	0	0	0	0	0	0	0	0	(8,627)	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):*	(20,944)	0	0	0	0	0	0	0	0	0	0	(20,944)	43
44	TOTAL Special Cost Centers	(20,944)	0	0	0	0	0	0	0	0	0	0	(20,944)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(207,306)	(48,000)	0	(255,306)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Brave	25			Brave Inc.	New Baden	Management
Ann Reis	25	Carlyle Healthcare Center	Carlyle	DAR Mngmt	Quincy	Management
		St. Vincent's Home, Inc.	Quincy	Wdm Computer Servi	Quincy	Data Processing
Blain Richard	25	St. Ann's Healthcare Center, Inc.	Chester	RDR Mngmt	Albers	Management
Michael & Gail Greer	25	St. Ann's Healthcare Center, Inc.	Chester	Greer Mngmt	Trenton	Management
		O'Fallon Healthcare Center, Inc.	O'Fallon			

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	17 Management	\$ 24,000	Brave Management	0.00%	\$	\$ (24,000)	1
2	V	19 Management	24,000	DAR Management	0.00%		(24,000)	2
3	V	19 Data Processing	18,723	WDM Computer Services	0.00%	18,723		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		\$ 66,723			\$ 18,723	\$ * (48,000)	14

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

Facility Name & ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Michael Greer	Vice President	Owner	25.00	0	14	33.00	Wages	\$ 14,400	17-1	1
2	Blain Richard	President	Owner	25.00	0	10	25.00	Wages	14,400	17-1	2
3	Ann Reis	n/a	Owner	25.00	0	0	0.00	n/a	0	17-1	3
4	Dave Reis	Treasurer	Board Member	0.00	0	10	25.00	Wages	14,400	17-1	4
5	Michael Brave	Administrator	Administrator	25.00	0	40	100.00	Wages	77,672	17-1	5
6	RDR Mngmt	Management	Management	0.00	0	5	12.00	Mngt Fees	24,000	19-3	6
7	DAR Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	24,000	19-3	7
8	Greer Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	24,000	19-3	8
9	Brave, Inc.	Management	Management	0.00	0	5	12.00	Mngt Fees	24,000	17-3	9
10	See Attatched List (Pg 28)										10
11											11
12											12
13								TOTAL	\$ 216,872		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 Clinton Manor Living Center

0033159

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

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	First National Bank		X	Mortgage	\$12,930.02	10/3/01	\$ 1,325,000	\$	12/31/06	\$ 37,773	1									
2	First National Bank		X	Refinance	\$924.82	01/03/02	100,000		12/31/06	5,360	2									
3	Ford Credit		X	Auto Loan	\$633.45	04/03/03	38,007	10,135	04/03/08	0.0000	3									
4	First National Bank		X	Construction Loan	\$1,308.32	12/19/03	95,000	73,643	05/19/09	7.2500	5,835	4								
5	See List Attached		X	See List Attached	\$14,299.00	Various	1,312,835	1,311,128	Various	Various	4,539	5								
Working Capital																				
6	First National Bank		X	Liability Insurance	Various	02/11/04	53,500		01/11/06		14	6								
7	First National Bank		X	Cash Flow	Various	10/15/03	225,000		12/31/06	7.2500	23,789	7								
8	Owners	X		Cash Flow	Interest	04/13/97	48,000	400,000	12/31/07	6.0000	24,000	8								
9	TOTAL Facility Related				\$30,095.61		\$ 3,197,342	\$ 1,794,907		\$ 101,309	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$ 3,197,342	\$ 1,794,907		\$ 101,309	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>Important, 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 2005 report.		\$ 20,257	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.)		\$ 20,212	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ (45)	3																																	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 20,212	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 20,167	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>19,607</td><td>8</td></tr> <tr><td>2002</td><td>19,703</td><td>9</td></tr> <tr><td>2003</td><td>20,137</td><td>10</td></tr> <tr><td>2004</td><td>19,209</td><td>11</td></tr> <tr><td>2005</td><td>20,257</td><td>12</td></tr> </table>	2001	19,607	8	2002	19,703	9	2003	20,137	10	2004	19,209	11	2005	20,257	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	19,607	8																																		
2002	19,703	9																																		
2003	20,137	10																																		
2004	19,209	11																																		
2005	20,257	12																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clinton Manor Living Center COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0033159

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Clinton Manor Living Center

0033159 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,794 B. General Construction Type: Exterior Frame Wood, Steel & Concrete Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 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>26,669</u>	<u>1987</u>	<u>\$ 66,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	26,669		\$ 66,000	3

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	69		1987	1969	\$ 594,000	\$ 19,800	30	\$ 19,800		\$ 376,203	4
5	12		1991	1991	511,306	17,096	30	17,044	(52)	259,134	5
6											6
7											7
8											8
	Improvement Type**										
9		SPRINKLER		1990	3,140	158	20	157	(1)	2,550	9
10		LAND IMPROVEMENT		1992	5,410		10			5,410	10
11		BUILDING IMPROVEMENT		1992	37,505	1,629	20,10	1,620	(9)	28,136	11
12		BUILDING IMPROVEMENT		1992	26,098	1,312	20	1,305	(7)	18,336	12
13		CON		1992	3,000		30	100	100	1,500	13
14		BUILDING IMPROVEMENT		1994	12,580	295	20,10	294	(1)	10,460	14
15		PLUMBING		1995	12,200	613	20	610	(3)	7,142	15
16		LANDSCAPING		1997	1,675	167	10	168	1	1,605	16
17		BOILER		1997	8,858		8			8,858	17
18		REMODEL OF DINING ROOM		1997	35,389	1,769	20	1,769		16,073	18
19		HEATING/COOLING SYSTEM		1999	13,826	1,384	10	1,383	(1)	9,905	19
20		FIRE ALARM UPGRADE		2001	2,610	261	10	261		1,327	20
21		FRONT ADDITION		2001	115,835	5,792	20	5,792		29,443	21
22		DINING ROOM REMODEL		2001	84,135	4,207	20	4,207		21,386	22
23		Kitchen Improvements		2004	3,852	197	20	193	(4)	508	23
24		Flooring		2004	2,790	279	10	279		628	24
25		Laundry Building		2004	106,437	5,322	20	5,322		12,861	25
26		Bathroom Flooring		2005	3,650	183	20	183		319	26
27		Concrete		2005	2,367	237	10	237		335	27
28		Flooring		2005	3,032	152	20	152		215	28
29		Bathroom Remodel		2005	3,550	177	20	178	1	222	29
30		Roof Repairs		2005	4,225	211	20	211		282	30
31		Flooring		2006	5,960	298	20	298		298	31
32		New A/C Units		2006	6,141	240	15	240		240	32
33		New Office Building		2006	93,901	516	30	516		516	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$	\$		\$	\$	\$	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)	\$	\$		\$	\$	\$	70
		1,703,472	62,295		62,319	24	813,892	

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

Facility Name & ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 198,046	\$ 23,138	\$ 23,138	\$	5-10	\$ 98,346	71
72	Current Year Purchases	18,749	1,274	1,274		5-8	1,274	72
73	Fully Depreciated Assets	298,455				3-10	298,455	73
74								74
75	TOTALS	\$ 515,250	\$ 24,412	\$ 24,412	\$		\$ 398,075	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	Facility	Station Wagon	2005	\$ 7,943	\$ 1,616	\$ 1,616	\$	5	\$ 1,748	76
77	Facility	03 Ford Van	2003	40,507	8,102	8,102		5	30,381	77
78	Facility	Van	1999	37,719				5	37,719	78
79	Facility	Used Truck	204	5,497	1,118	1,118		5	2,329	79
80	TOTALS			\$ 91,666	\$ 10,836	\$ 10,836	\$		\$ 72,177	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)	\$ 2,376,388	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,543	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,567	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,284,144	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	Office Building	\$ 45,776	\$ 1,526	\$ 14,623	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 45,776	\$ 1,526	\$ 14,623	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning: 01/01/06

Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 4,655 Description: Dishwasher (\$1,389.72) & Generator (\$3,264.81)

(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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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	10-3	visits			3,858			3,858	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	10-3	hrs		207	10,326		207	10,326	10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	207	\$ 14,184	\$	207	\$ 14,184	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 Clinton Manor Living Center# 0033159Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (213,207)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	989,302		3
4	Supply Inventory (priced at <u>FIFO</u>)	18,067		4
5	Short-Term Investments			5
6	Prepaid Insurance	29,324		6
7	Other Prepaid Expenses	52		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Rounding</u>	(1)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 823,537	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,974		12
13	Land	116,387		13
14	Buildings, at Historical Cost	2,290,032		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	629,929		16
17	Accumulated Depreciation (book methods)	(1,499,115)		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 (spe <u>Loan Org. Fee</u>)	5,134		22
23	Other(specify): <u>CIP</u>	15,347		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,560,688	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,384,225	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 63,912	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,946		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,984		32
33	Accrued Interest Payable	6,035		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Wage Garnishment</u>	2,173		36
37	<u>Ins. Withheld</u>	(3,714)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 253,336	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	89,326		39
40	Mortgage Payable	1,509,709		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Notes Payable Owners</u>	400,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,999,035	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,252,371	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 131,854	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,384,225	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 172,685	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 172,685	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	27,837	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	(92,059)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>Income/(Loss) Rental Properties</u>	23,391	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (40,831)	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)	\$ 131,854	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Clinton Manor Living Center# 0033159Report Period Beginning: 01/01/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,684,060	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,684,060	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	89,258	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 89,258	8
C. Other Operating Revenue			
9	Payments for Education	14,763	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	10,340	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,373	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	184	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)	\$ 26,660	23
D. Non-Operating Revenue			
24	Contributions	30	24
25	Interest and Other Investment Income***	341	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 371	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See List Attached</u>	169,583	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 169,583	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,969,932	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	678,281	31
32	Health Care	2,015,808	32
33	General Administration	872,244	33
B. Capital Expense			
34	Ownership	233,565	34
C. Ancillary Expense			
35	Special Cost Centers	45,995	35
36	Provider Participation Fee	96,202	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,942,095	40
41	Income before Income Taxes (line 30 minus line 40)**	27,837	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 27,837	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	2,650	2,936	\$ 74,506	\$ 25.38	1
2	Assistant Director of Nursing	3,180	3,368	74,111	22.00	2
3	Registered Nurses	3,573	3,661	76,122	20.79	3
4	Licensed Practical Nurses	17,518	18,741	328,612	17.53	4
5	CNAs & Orderlies	17,955	19,168	216,513	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,886	1,958	23,275	11.89	9
10	Activity Assistants					10
11	Social Service Workers	4,399	4,817	62,325	12.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,968	2,088	30,891	14.79	14
15	Cook Helpers/Assistants	8,592	9,102	87,090	9.57	15
16	Dishwashers	6,372	6,531	46,032	7.05	16
17	Maintenance Workers	2,888	3,236	45,172	13.96	17
18	Housekeepers	10,535	11,116	94,830	8.53	18
19	Laundry	6,501	7,008	55,262	7.89	19
20	Administrator	1,916	2,088	77,672	37.20	20
21	Assistant Administrator					21
22	Other Administrative			43,200		22
23	Office Manager					23
24	Clerical	6,956	7,683	110,631	14.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,131	7,487	106,646	14.24	28
29	Resident Services Coordinator	1,960	2,088	63,725	30.52	29
30	Habilitation Aides (DD Homes)	55,438	58,247	587,375	10.08	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	3,882	4,351	49,485	11.37	33
34	TOTAL (lines 1 - 33)	165,300	175,674	\$ 2,253,475 *	\$ 12.83	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	96	\$ 4,511	1-3	35
36	Medical Director	Contract	10,700	9-3	36
37	Medical Records Consultant	24	840	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,800	10-3	39
40	Physical Therapy Consultant	Contract	93,017	10a-3	40
41	Occupational Therapy Consultant	Contract	46,552	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Contract	23,793	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	38	2,023	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	158	\$ 183,236		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	40	\$ 1,756	10-3	50
51	Licensed Practical Nurses	385	12,010	10-3	51
52	Certified Nurse Assistants/Aides	2,627	50,640	10-3	52
53	TOTAL (lines 50 - 52)	3,052	\$ 64,406		53

Facility Name & ID Number Clinton Manor Living Center

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Report Period Beginning: 01/01/06

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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	
Michael Brave	Administrator	25	\$ 77,672	Workers' Compensation Insurance	\$ 87,918	IDPH License Fee	\$ 3,250	
Blain Richard	Owner	25	14,400	Unemployment Compensation Insurance	29,341	Advertising: Employee Recruitment	12,612	
Michael Greer	Owner	25	14,400	FICA Taxes	168,239	Health Care Worker Background Check		
Dave Reis	Owner	25	14,400	Employee Health Insurance	64,408	(Indicate # of checks performed <u>63</u>)	250	
				Employee Meals		Patient Background Checks <u>96</u>	960	
				Illinois Municipal Retirement Fund (IMRF)*		Promo/Public Relations	25,590	
				Deffered Compensation	3,500	Employee Drug Tests	2,570	
						See List Attached	5,576	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 120,872					
B. Administrative - Other								
Description			Amount					
Brave Management			\$ 24,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 24,000					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Giffen Winning, Bodewes	Legal		\$ 6,118	N/A			Out-of-State Travel	\$
Hartford	Retirement Plan Admin.		1,530					
Draper	Appraisal Services		750					
RDR Management	Management Svcs		24,000				In-State Travel	
DAR Management	Management Svcs		24,000					
Greer Management	Management Svcs		24,000					
Accumed	Software Support		5,445					
WDM Computer Svcs	Data Processing		18,723				Seminar Expense	
CMS	Medicare Billing		884				See List Attached	10,482
N. Bakker	Data Processing		2,254					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 107,703					\$ 10,482

* Attach copy of IMRF notifications

**See instructions.

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. IHCA 2290.80
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes 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? _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,897 Line 10-2
- (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. \$ 45,995
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,373
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 3,016
- c. What percent of all travel expense relates to transportation of nurses and patients? 75
- 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? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: No 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Clinton Manor Living Center, Inc.
01/01/06 thru 12/31/06
0033159

The following is a breakdown of Schedule V Line 23 Column 3

<u>Vendor</u>	<u>Purpose</u>	<u>Expense</u>
Gordon B	12 hours HR training	\$1,200.00
G. Neil	USSERA Notification Kit	\$61.35
G. Neil	USSERA Guidelines	\$36.21
Sam's Club	DSP Training Supplies	\$166.13
Sam's Club	Training Table	\$24.46
Texas State U.	Training Booklet	\$20.95
Eden Alternative	Training Booklet	\$25.45
MTINN Training	Staff Training Survey-Pioneer Project	\$36.90
MTINN Training	Staff Training Survey-Pioneer Project	\$128.70
New Baden Market	Training Supplies	\$16.43
Area Agency on Aging	AAA Culture Change Collaboration	\$750.00
Credit Card	Training Supplies	\$37.01
Credit Card	Training Supplies	\$37.00
Quill	Annual Training	\$92.60
Quill	Annual Training	\$45.76
CHANN HCP Instrustor	CPR Booklets/Cards	\$94.03
Celebrate Diversity	Annual Training Supplies	\$39.00
Quill	Binders for Staff training	\$273.77
Quill	Binders for Staff training	\$15.69
American Legion	Hall Rental for Annual Training	\$233.00
Heart Saver	CPR Training	\$104.66
Midwest Geriatric	DD Training Manuals	\$40.00
Office Depot	Binders for Staff training	\$54.82
Office Depot	Binders for Staff training	\$59.14
Training Systems	Direct Support Training Materials	\$322.71
MacArthur's Bakery	Food For staff training meeting	\$110.83
		<u>\$4,026.60</u>

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The following is a breakdown of Schedule V Line 6 Column 3

Repairs & Maint. Dietary	\$2,939.50
Repairs & Maint. Laundry	\$1,056.43
Repairs & Maint. Housekeeping	\$187.17
Repairs & Maint. Equipment	\$18,316.05
Repairs & Maint. Ground	\$1,450.81
Repairs & Maint. Building	\$20,810.72
Repairs & Maint. Wheelchairs	\$172.13
Repairs & Maint. Outside services	\$17,450.46
Repairs & Maint. Gen/Admin.	\$4,037.55
	<u>\$68,401.28</u>

The following is a breakdown of Schedule V Line 21 Column 3

Printing	\$1,345.19
Postage	\$4,383.12
Copies	\$2,509.69
Telephone	\$12,750.11
	<u>\$20,788.11</u>

The following is a breakdown of Schedule V Line 36 Column 3

Sales Tax	\$1,323.00
State Replacement Tax	\$1,610.00
Contributions	\$91.00
Bank & service fees	\$2,034.54
Amortization of Loan Costs	\$1,075.61
Political Contributions	\$449.20
Rounding	
	<u>\$6,783.35</u>

The following is a breakdown of Schedule V Line 43 Column 3

Bad Debt Expense	\$20,044.00
Misc. Exp.	\$1,862.43
	<u>\$22,806.43</u>

The following is a breakdown of Schedule XVII Line 28a

CSS Labor-Admin. Program	\$27,427.44
CSS Labor-Admin. Assist.	\$22,304.04
CSS Labor-Nursing Labor	\$36,000.00
CSS Labor-Maintenance	\$509.50
CNC Labor-Fica & Fed Ins.	\$1,083.29
CNC Labor-Fed Unemployment	\$113.26
CNC Labor-State Unemployment	\$283.20
CNC Labor-Administrative	\$120.00
Misc. Revenue	-\$190.42
Personal Purchases Income	\$2,118.21
Office Lease	\$12,000.00
Rabates	\$9.93
Discounts	\$0.00
In-House Day Training Revenue	\$64,789.83
Gain/Loss on Sale of Asset	\$0.00
Acou-Checks	\$0.00
Income from Transpo (IDPA Trans. Regym)	\$3,016.48
Rounding	-\$1.00
	<u>\$169,882.76</u>

The following is a breakdown of Schedule XIX, Section F

CLIA Cert. Fee	\$150.00
Illinois Health Care Association Dues	\$2,280.80
Sen's Club	\$610.00
ANW Dues	\$100.00
Misc Subscriptions	\$156.63
Vehicle Licenses	\$414.00
IL Charity Bureau Fee	\$15.00
IDPA License	\$1,890.00
Rounding	
	<u>\$5,576.43</u>

Schedule XIII, Section A.

Cna's are responsible for their own training and testing.

2003 Long term Real Estate Tax Statement

Section B :

Part of the office building is rented out to another corporation. That rent is then taken ta of the cost report.

Schedule XI, Section D Line 79

Use	Make	Mod Year	Acq/Coat	Current	S/L Deprec	Life	Accum Depre
Facility	St. Wagon	2005	\$7,942.50	\$1,615.92	\$1,615.92	5	\$1,748.29
Facility	Mai Used Tru9	2004	\$5,497.27	\$1,138.10	\$1,138.10	5	\$2,329.32
			<u>\$13,439.77</u>	<u>\$2,754.02</u>	<u>\$2,754.02</u>		<u>\$4,077.61</u>

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Schedule V, Line 24 Column 3

Date	Seminar	Location	Who Attended	Air Fare/ Mileage/					Total
				Regist.	Auto Exp.	Meals	Hotel	Materials	
Jan-06	AAMR Conference	Chicago, IL	M. Brave J. Hicks C. Leonard J. Kramer L. Knepper	\$1,310.00	\$158.60	\$607.50	\$886.95	\$110.00	\$3,073.05
Feb-06	AAHSA Meeting		M. Brave			\$149.00			\$149.00
Feb-06	Medicare:Back to Basics	Mt. Vernon, IL	J. Varel C. Smith D. Loomis M. Holtgrave M. Brave	\$395.00					\$395.00
Feb-06	The Area of Human Resources	Fairview Heights, IL	J. Varel	\$309.00					\$309.00
Mar-06	Skilled Nursing Facility Billing Compliant	Bloomington, IL	M. Brave C. Smith M. Holtgrave	\$90.00		\$132.00	\$266.56		\$488.56
Mar-06	AAHSA Conference	Washington, DC	M. Brave		\$539.60	\$160.00	\$476.00		\$1,175.60
Apr-06	IHCA-Dietary Seminar	Springfield, IL	C. Lanter	\$170.00					\$170.00
Mar-06	New Rules-New Tools Medicaid 2006	Rend Lake, IL	C. Smith D. Loomis H. Lohman M. Jackson	\$380.00					\$380.00
Mar-06	IHCA Meeting	Mt. Vernon, IL	M. Brave C. Smith D. Loomis	\$210.00	\$18.02				\$228.02
Jul-06	Goodbye MSA- Hello HAS	Collinsville, IL	M. Brave	\$30.00					\$30.00
Aug-07	Job Fair		J. Cramer		\$25.00				\$25.00
Jun-07	IHCA -Seminar for Act. & Social Services	Springfield, IL	H. Lohman M. Jackson	\$200.00					\$200.00
Jun-06	Clinical Updates in Mental Health	Springfiled, IL	J. Kramer C. Leonard L. Knepper C. Hummert H. Szopinski J. Lopresto	\$125.00					\$125.00
Jun-07	INHAA Conference	Springfield, IL	M. Brave	\$190.00	\$173.14	\$74.50	\$365.20		\$802.84
Oct-06	Pioneer Project Conference	Springfield, IL	C. Smith H. Lohman J. Koontz M. Jackson K. Green D. Loomis M. Brave C. Lanter	\$600.00		\$393.00	\$965.93	\$390.00	\$2,348.93
Dec-06	American Association of Rehab Facilities	Washington, DC	J. Lopresto	\$150.00		\$93.72			\$243.72
Feb-06	Medicare Billing for SNF's	St. Louis, MO	C. Smith M. Holtgrave	\$338.00					\$338.00
Total Expenses									\$10,481.72

Clinton Manor Living Center, Inc.

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Schedule VII Attachment

Name	Function	Nursing Home	Compensation	
			Ownership Interest	from other Nursing Homes
RDR Management	Management	St. Ann's Healthcare Ctr.	0	\$0.00
Greer Manager	Management	St. Ann's Healthcare Ctr.	0	\$0.00
Greer Manager	Management	O'Fallon Healthcare Ctr.	0	
Mike Greer	Owner	O'Fallon Healthcare Ctr.	100	
Mike Greer	Owner	St. Ann's Healthcare Ctr.	26	
Gail Greer	Owner	St. Ann's Healthcare Ctr.	24	
Blain Richard	Owner	St. Ann's Healthcare Ctr.	50	
Dar Mngt	Management	Southern Illinois Comm. Suppo:	0	\$166,547.17
Greer Manager	Management	Southern Illinois Comm. Suppo:	0	\$16,654.17
Advanced Optior	Management	Southern Illinois Comm. Suppo:	0	\$33,308.33
RDR Management	Management	Southern Illinois Comm. Suppo:	0	\$16,654.17

Schedule IX

Lender	Related	Purpose	Monthly pym	Date of note	Orig. amt	Balance	Maturity	Rate	Expense
First National No		Auto Loan	\$174.00	11/30/2005	\$7,254.00	\$5,547.77	11/23/2009	5.9000	\$389.38
First National No		Refinance Mortgage & 2nd	\$14,125.00	12/31/2006	\$1,305,580.60	\$1,305,580.60		7.2500	\$4,149.12
			<u>\$14,299.00</u>		<u>\$1,312,834.60</u>	<u>\$1,311,128.37</u>			<u>\$4,538.50</u>

\$2,625,669.20 \$2,622,256.74 \$9,077.00

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The following is a breakdown of the reclassifications:

1. Reclassify \$338.00 of Seminar expense out of Line 23 to Line 24.
2. Reclassify \$110.83 of staff meeting supplies out of Seminar line 24 to In-service line 23
3. Reclassify \$403.16 of hotel costs out of Seminar and into Line 15-3 Other Program Exp.
Costs were for trip to Indiana to screen a DD resident.
- 4
- 5

Clinton Manor Living Center, Inc.
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Patient days

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Private	222	170	185	233	276	300	336	318	313	317	328	341	3339
IDPA	664	542	584	508	563	568	601	589	596	619	620	671	7125
IDPA-Res	24	7	1	3	3	3	0	0	1	0	1	1	44
DD	1434	1311	1402	1371	1453	1403	1452	1445	1371	1451	1426	1463	16982
DD-Res	17	5	36	15	6	25	35	39	39	33	31	39	320
Medicare	64	115	115	117	116	54	51	110	63	31	2	20	858
Medicare-Co Ins.													0
Medicaid-Co Ins.													
	2425	2150	2323	2247	2417	2353	2475	2501	2383	2451	2408	2535	28668