

		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: 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

HFS 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
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: 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 12/1/05 to 11/30/06 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) <u>JERRY W. JENNINGS</u>	
	(Title) <u>CONTROLLER</u>	
Paid Preparer	(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: 12/1/05 Ending: 11/30/06

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>59</u>	Skilled (SNF)	<u>59</u>	<u>21,535</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>27</u>	Intermediate (ICF)	<u>27</u>	<u>9,855</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>86</u>	TOTALS	<u>86</u>	<u>31,390</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>2,612</u>	<u>2,612</u>	8
9	SNF/PED					9
10	ICF	<u>7,822</u>	<u>5,912</u>		<u>13,734</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,822</u>	<u>5,912</u>	<u>2,612</u>	<u>16,346</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.07%

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)

NONEF. 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 2,612Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 11/30/06 Fiscal Year: 11/30/06

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/05 Ending: 11/30/06

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	107,083	11,256	5,026	123,365		123,365		123,365		1
2	Food Purchase		69,917		69,917		69,917	(1,842)	68,075		2
3	Housekeeping	39,602	11,816		51,418		51,418		51,418		3
4	Laundry	23,763	7,504		31,267		31,267		31,267		4
5	Heat and Other Utilities			51,616	51,616		51,616		51,616		5
6	Maintenance	44,635	22,762	47,991	115,388		115,388	1,164	116,552		6
7	Other (specify):* Utility Workers	14,057			14,057		14,057		14,057		7
8	TOTAL General Services	229,140	123,255	104,633	457,028		457,028	(678)	456,350		8
	B. Health Care and Programs										
9	Medical Director	12,033		12,200	24,233		24,233		24,233		9
10	Nursing and Medical Records	775,241	156,131	57,156	988,528	(119,239)	869,289	4,551	873,840		10
10a	Therapy	32,571	3,637	160,173	196,381	(160,173)	36,208		36,208		10a
11	Activities	42,679	1,773		44,452		44,452		44,452		11
12	Social Services	13,825		4,155	17,980		17,980		17,980		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	876,349	161,541	233,684	1,271,574	(279,412)	992,162	4,551	996,713		16
	C. General Administration										
17	Administrative	56,177		9,733	65,910	2,106	68,016	24,654	92,670		17
18	Directors Fees										18
19	Professional Services			106,391	106,391		106,391	(100,283)	6,108		19
20	Dues, Fees, Subscriptions & Promotions			17,161	17,161		17,161	(9,376)	7,785		20
21	Clerical & General Office Expenses	49,143	13,697	5,217	68,057		68,057	19,740	87,797		21
22	Employee Benefits & Payroll Taxes			253,983	253,983		253,983	12,761	266,744		22
23	Inservice Training & Education			2,567	2,567		2,567	1,587	4,154		23
24	Travel and Seminar			8,319	8,319	(3,382)	4,937	427	5,364		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			70,425	70,425		70,425	396	70,821		26
27	Other (specify):*			57,081	57,081		57,081	(57,081)			27
28	TOTAL General Administration	105,320	13,697	530,877	649,894	(1,276)	648,618	(107,175)	541,443		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,210,809	298,493	869,194	2,378,496	(280,688)	2,097,808	(103,302)	1,994,506		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 MENARD CONVALESCENT CENTER #0003020 Report Period Beginning: 12/1/05 Ending: 11/30/06

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	
	D. Ownership											
30	Depreciation			19,059	19,059		19,059	4,157	23,216			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			31,085	31,085		31,085		31,085			33
34	Rent-Facility & Grounds							3,291	3,291			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			50,144	50,144		50,144	7,448	57,592			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers						280,688		280,688			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	TOTAL Special Cost Centers			47,085	47,085		280,688		327,773			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,210,809	298,493	966,423	2,475,725		2,475,725	(95,854)	2,379,871			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: 12/1/05

Ending: 11/30/06

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	(420)	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	2,862	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(474)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,421)	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	(128)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,660)	27		24
25	Fund Raising, Advertising and Promotional	(8,846)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(660)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(1,422)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,169)		\$	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)	(29,685)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (29,685)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (95,854)		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		160,173	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		8,978	10	42
43	Prescription Drugs	X		90,392	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>Oxy, Supp</u>	X		15,712	10	45
46	Other-Attach Schedule <u>Ambulance</u>	X		5,433	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 280,688		47

BHF USE ONLY						
48		49		50		52

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/1/05

Ending: 11/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	(420)	0	0	0	0	0	0	0	0	0	0	(420)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(420)	0	0	0	0	0	0	0	0	0	0	(420)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	192	0	0	0	0	0	0	0	0	0	192	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(128)	(100,345)	0	0	0	0	0	0	0	0	0	(100,473)	19
20	Fees, Subscriptions & Promotions	(9,506)	0	0	0	0	0	0	0	0	0	0	(9,506)	20
21	Clerical & General Office Expenses	(474)	0	0	0	0	0	0	0	0	0	0	(474)	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	(192)	0	0	0	0	0	0	0	0	0	(192)	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):*	(57,081)	0	0	0	0	0	0	0	0	0	0	(57,081)	27
28	TOTAL General Administration	(67,189)	(100,345)	0	(167,534)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(67,609)	(100,345)	0	(167,954)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	2,862	0	0	0	0	0	0	0	0	0	0	2,862	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	TOTAL Ownership	2,862	0	0	0	0	0	0	0	0	0	0	2,862	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(64,747)	(100,345)	0	(165,092)	45								

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	\$ 105,954	NURSING HOME MANAGERS		\$	\$ (105,954)	1
2	V	VAR SEE ATTACHED		NURSING HOME MANAGERS		70,660	70,660	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		5,609	5,609	3
4	V	24 TRAVEL	192	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(192)	4
5	V	17 ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		192	192	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		\$ 106,146			\$ 76,461	\$ * (29,685)	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: 12/1/05 Ending: 11/30/06

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	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: 12/1/05

Ending: 11/30/06

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

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: 12/1/05 Ending: 11/30/06

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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	SAM KLEIN	X		WORKING CAPITAL		5/30/03	25,000	1,212,000	DEMAND	0.0400	6									
7										7										
8										8										
9	TOTAL Facility Related						\$ 25,000	\$ 1,212,000			9									
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$ 25,000	\$ 1,212,000		\$	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.)

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 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 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. <u>11-14-227-001</u>	<u>MENARD CONVALESCENT CENT</u>	\$ <u>2,520.34</u>	\$ <u>2,520.34</u>
2. <u>11-14-228-001</u>	<u>MENARD CONVALESCENT CENT</u>	\$ <u>25,371.98</u>	\$ <u>25,371.98</u>
3. <u>11-14-228-002</u>	<u>MENARD CONVALESCENT CENT</u>	\$ <u>505.40</u>	\$ <u>505.40</u>
4. <u>11-14-229-001</u>	<u>MENARD CONVALESCENT CENT</u>	\$ <u>315.08</u>	\$ <u>315.08</u>
5. <u>11-14-219-006</u>	<u>MENARD CONVALESCENT CENT</u>	\$ <u>315.08</u>	\$ <u>315.08</u>
6. <u>11-14-219-009</u>	<u>MENARD CONVALESCENT CENT</u>	\$ <u>1,347.00</u>	\$ <u>1,347.00</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>30,374.88</u>	\$ <u>30,374.88</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 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 MENARD CONVALESCENT CENTER

0003020 Report Period Beginning:

12/1/05 Ending:

11/30/06

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).

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	TOTALS	43,436		\$ 9,919	3

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

Report Period Beginning:

12/1/05

Ending:

11/30/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1966	1966	\$ 172,985	\$ 232	30	\$	\$ (232)	\$ 172,985	4
5	32		1974	1974	148,705	329	30		(329)	148,705	5
6											6
7											7
8											8
		Improvement Type**									
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	5,509	12
13		AIR CONDITIONER		1984	1,100		8			1,100	13
14		ELECTICAL & PLUMBING		1985	11,117	158	15		(158)	11,117	14
15		PLUMBING		1986	4,921	207	15		(207)	4,921	15
16		SMOKE DETECTORS		1986	10,445	451	25	418	(33)	8,568	16
17		AIR CONDITIONER		1986	2,235	101	10		(101)	2,235	17
18		PLUMBING		1986	1,145	55	20	32	(23)	1,145	18
19		ROOF		1987	6,362	112	20	318	206	6,201	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	1,534	560	26,843	22
23		WATER HEATER & PARKING LOT		1989	11,502	365	15		(365)	11,502	23
24		FURNACE & FLOORING		1990	19,165	608	15		(608)	19,165	24
25		AIR CONDITIONER		1991	2,633	84	15	83	(1)	2,633	25
26		PLUMBING FAUCETS		1992	8,909	283	15	594	311	8,613	26
27		DOOR ALARM		1992	1,572	50	20	78	28	1,260	27
28		WATER HEATER & GARAGE DOOR		1993	4,348	138	15	290	152	3,914	28
29		WATER HEATER & PLUMBING		1994	5,074	130	15	339	209	4,227	29
30		LANDSCAPING		1994	3,900	260	15	260		3,185	30
31		AIR CONDITIONER & ROOF		1995	7,049	181	15	470	289	5,404	31
32		REMODEL BATHROOMS - TILE, CEILING, FIXTURES		1996	19,751	506	15	1,317	811	13,826	32
33		AIR CONDITIONER		1997	1,710	44	15	114	70	1,083	33
34		FIRE DAMPERS		1998	4,076	105	15	271	166	2,310	34
35		FURNACE		1998	2,200	56	15	147	91	1,248	35
36		GREASE TRAP		1999	2,824	72	15	189	117	1,412	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:

12/1/05

Ending:

11/30/06

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	
	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	\$ 1,618	37
38	AIR CONDITIONING	2002	2,102	54	15	140	86	584	38
39	AIR CONDITIONING & VENTILATION	2004	4,935	127	10	493	366	1,398	39
40	WATER HEATER	2004	1,675	43	15	112	69	233	40
41	DOORS & CONCRETE	2005	33,052	847	20	1,652	805	3,305	41
42	SMOKE DAMPERS	2006	4,504	101	15	275	174	275	42
43	SIDEWALKS	2006	2,480	48	20	93	45	93	43
44	SECURITY DOORS	2006	4,897	94	20	184	90	184	44
45	FIRE SUPPRESSION SYSTEM	2006	1,879	24	25	38	14	38	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)		\$ 575,479	\$ 7,226		\$ 10,014	\$ 2,788	\$ 500,124	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: 12/1/05 Ending: 11/30/06

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	\$ 129,623	\$ 10,702	\$ 10,922	\$ 220	VAR	\$ 79,983	71
72	Current Year Purchases	7,913	1,131	985	(146)	VAR	985	72
73	Fully Depreciated Assets	178,654					178,654	73
74	ASSETS NO LONGER IN SERVICE	(73,230)					(73,230)	74
75	TOTALS	\$ 242,960	\$ 11,833	\$ 11,907	\$ 74		\$ 186,392	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)		\$ 828,358	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 19,059	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 21,921	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 2,862	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 686,516	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	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: \$ _____ 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	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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	1,069	\$ 68,318	\$	1,069	\$ 68,318	1
2	Licensed Speech and Language Development Therapist		hrs		137	7,596		137	7,596	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,062	84,259		2,062	84,259	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				90,392		90,392	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen, Ambulance, Supplies, Labs, Xrays						30,123		30,123	13
14	TOTAL			\$	3,268	\$ 160,173	\$ 120,515	3,268	\$ 280,688	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: 12/1/05

Ending:

11/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 11/30/06

(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	\$ 21,978	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	270,590		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,924		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 302,492	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	575,479		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	311,736		16
17	Accumulated Depreciation (book methods)	(732,694)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 164,440	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 466,932	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,480,295	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,635		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,545		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,843		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,539,318	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,539,318	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,072,386)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 466,932	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (762,513)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (762,513)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ (309,873)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (309,873)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,072,386)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020Report Period Beginning: 12/1/05Ending: 11/30/06**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	\$ 2,119,087	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,119,087	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	34,366	6
7	Oxygen	9,900	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 44,266	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	420	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	67	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 487	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING 1422 ADMIT FEES 450	1,872	28
28a	BAD DEBT RECOVERY 68 W/A 24	92	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,964	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,165,852	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	457,028	31
32	Health Care	1,271,574	32
33	General Administration	649,894	33
B. Capital Expense			
34	Ownership	50,144	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	47,085	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,475,725	40
41	Income before Income Taxes (line 30 minus line 40)**	(309,873)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (309,873)	43

* 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:

12/1/05

Ending:

11/30/06

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	2,000	2,080	\$ 51,848	\$ 24.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,066	5,241	98,157	18.73	3
4	Licensed Practical Nurses	19,547	20,068	260,611	12.99	4
5	CNAs & Orderlies	45,221	46,430	364,625	7.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,743	3,791	32,571	8.59	8
9	Activity Director	832	840	8,615	10.26	9
10	Activity Assistants	3,524	3,780	34,064	9.01	10
11	Social Service Workers	1,612	1,804	13,825	7.66	11
12	Dietician					12
13	Food Service Supervisor	2,383	2,624	26,148	9.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,984	12,392	80,935	6.53	15
16	Dishwashers					16
17	Maintenance Workers	5,381	5,476	44,635	8.15	17
18	Housekeepers	6,350	6,436	39,602	6.15	18
19	Laundry	3,641	3,796	23,763	6.26	19
20	Administrator	2,000	2,080	56,177	27.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,755	5,242	49,143	9.37	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>	1,621	1,745	14,057	8.06	33
34	TOTAL (lines 1 - 33)	119,960	124,125	\$ 1,210,809 *	\$ 9.75	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	140	\$ 5,026	1-3	35
36	Medical Director	100	12,200	9-3	36
37	Medical Records Consultant	13	429	10-3	37
38	Nurse Consultant	562	25,789	10-3	38
39	Pharmacist Consultant	96	2,549	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	68	4,155	12-3	45
46	Other(specify) <u>SEE ATTACHED</u>	525	35,370	VAR	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,503	\$ 85,518		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	65	2,233	10-3	51
52	Certified Nurse Assistants/Aides	26	519	10-3	52
53	TOTAL (lines 50 - 52)	91	\$ 2,752		53

Facility Name & ID Number MENARD CONVALESCENT CENTER

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? 15 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (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

SCHEDULE V - PAGE 3 - LINE 24 - COLUMN 8

PAGE 3 - LINE 27 - COLUMN 3
OTHER GENERAL ADMINISTRATION

SALES TAX	\$ 2,421
BAD DEBT	54,660
	<u>\$ 57,081</u>

COLUMN 5 - RECLASSIFICATIONS

RECLASS FROM:		LINE #
AMBULANCE	\$ (5,433)	10
X - RAYS	(3,292)	10
LABS	(5,686)	10
MEDICARE DRUGS	(90,392)	10
MEDICARE SUPPLIES	(194)	10
OXYGEN	(15,518)	10
PHYSICAL THERAPY	(84,259)	10A
SPEECH THERAPY	(7,596)	10A
OCCUPATIONAL THERAPY	<u>(68,318)</u>	10A

RECLASS TO:		
ANCILLARY	<u>\$ 280,688</u>	39

RECLASS TO:		
NURSE CONSULTANT TRAVEL	\$ 1,276	10
ADMINISTRATIVE CONS. TRAVEL	<u>2,106</u>	17

RECLASS FROM:		
TRAVEL	<u>\$ (3,382)</u>	24

DETAIL - TRAVEL

ADMINISTRATOR REIMBURSEMENT	\$ 251
ACTIVITY TRAVEL	522
MAINTANANCE TRAVEL	1,065
PATIENT SCREENING TRAVEL	1,515
MISCELLANEOUS MILEAGE	48
TRAVEL TO MEETINGS / SEMINARS	1,536
NHM ALLOCATION	427
	<u>\$ 5,364</u>

SCHEDULE XVIII - PAGE 20 - SECTION B - CONSULTANT SERVICES
DETAIL - LINE 46 - OTHER

	HRS	COST	SCH V REF
ADMINISTRATIVE CONSULTANT	312	\$ 9,733	17-3
PSYCH CONSULTANT	16	4,000	10-3
MEDICARE CONSULTANT	192	21,187	10-3
UTILIZATION REVIEW	4	450	10-3
TOTALS	<u>524</u>	<u>\$ 35,370</u>	

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION	
LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 21,921
NURSING HOME MANAGERS ALLOCATION	<u>1,295</u>

SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 23,216</u>
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SCHEDULE XVII - PAGE 19

RECONCILIATION OF INCOME

LINE 41 - NET INCOME	\$ (309,873)
* ACCRUED MANAGEMENT FEE 11/04	(8,774)
* ACCRUED MANAGEMENT FEE 11/05	15,804
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	<u>(48)</u>
TAXABLE INCOME	<u>\$ (302,891)</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 V - PAGE 3 - LINE 23 - COLUMN 8

DETAIL - INSERVICE TRAINING & EDUCATION

DIETARY MEETINGS	\$ 109
NURSING SEMINARS	390
MDS CLASS & TRAINING	215
MEDICARE SEMINARS	100
HOME OFFICE INSERVICES	920
CPR TRAINING	340
MEDICAID REIMBURSEMENT WORKSHOF	435
ADMINISTRATOR WORKSHOP	30
EMPLOYEE TRAINING	28
NURSING HOME MANAGERS ALLOCATIO	1587
	<u>\$ 4154</u>

SCHEDULE XIX - PAGE 21 - SECTION F - DUES, FEES, SUBSCR
DETAIL - OTHER

FOOD SERVICE PERMIT	\$ 150
ADMINISTRATOR ASSOCIATION DUES	100
LONG TERM CARE NURSES ASSOCIATIO	105
CLIA LAB FEE	150
FRANCHISE FEE	165
	<u>\$ 670</u>

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS
WORKED BASED UPON TIME CARDS.

RIPTIONS

SCHEDULE V - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION
 MENARD
 2005

	DEC 05	JAN 06	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2005 TOTAL	LINE #
SALARIES-ADMIN	\$1,837	\$1,890	\$1,878	\$1,770	\$1,845	\$1,983	\$1,934	\$1,804	\$1,985	\$2,014	\$2,129	\$2,214	\$23,283	17
SALARIES-CLERIC	1,442	1,491	1,482	1,396	1,455	1,564	1,526	1,423	1,612	1,635	1,729	1,798	18,554	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	502	278	277	261	272	292	285	266	261	265	280	292	3,529	10
ACCOUNTING	10	7	7	6	7	7	7	6	32	32	34	35	190	19
WORK COMP INS	34	14	14	13	13	14	14	13	27	27	29	30	241	22
SUPPLIES	40	63	63	59	62	67	65	61	38	39	41	43	641	21
TELEPHONE	81	91	90	85	88	95	93	86	74	75	79	82	1,019	21
EMPL BENEFITS	725	724	720	678	707	760	741	691	813	825	872	907	9,163	22
PAYROLL TAXES	252	291	289	272	284	305	298	278	259	263	278	289	3,357	22
TRAVEL	70	44	44	41	43	46	45	42	58	59	62	64	619	24
IN SERVICE	64	120	119	112	117	126	122	114	165	167	177	184	1,587	23
MEDICAL CONSULT	0	66	66	62	65	69	68	63	134	136	144	150	1,022	10
MACHINE RENTAL	22	14	14	13	13	14	14	13	15	15	16	17	180	6
OWNERS COMP	116	121	121	114	118	127	124	116	53	53	56	59	1,179	17
INS-PROP,LIAB,WC	(21)	20	20	18	19	21	20	19	67	68	72	75	396	26
DEPRECIATION	103	110	109	103	107	115	112	105	102	104	110	114	1,295	30
RENT	255	280	278	262	273	294	286	267	261	264	279	291	3,291	34
MAINTENANCE	74	63	63	59	62	66	64	60	113	114	121	126	984	6
FEES & PUBLICAT	20	8	8	7	8	8	8	8	13	13	14	15	130	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	
TOTAL	\$5,626	\$5,695	\$5,659	\$5,332	\$5,557	\$5,973	\$5,827	\$5,434	\$6,083	\$6,170	\$6,521	\$6,783	\$70,660	
FIXED ASSETS													70,660	
EQUIP - PRIOR	5,697	9,477	9,417	8,873	9,247	9,939	9,696	9,043	8,820	8,946	9,456	9,836	9,037	
EQUIP - CURR	3,155	0	0	83	86	93	151	141	138	140	148	154	357	
EQUIP - FULLY DEP	2,622	2,807	2,789	2,628	2,739	2,944	2,872	2,679	2,613	2,650	2,801	2,914	2,755	
BLDG - PRIOR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	924	989	983	926	965	1,037	1,012	944	920	933	987	1,026	970	

ALLOCATION PERCENTAGES
USED ON MONTHLY ALLOCATIONS - PAGE 27

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

OCCUPIED							
DAYS	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
2006							
JANUARY	2,331	2,170	2,010		1,459	1,952	9,922
FEBRUARY	2,071	1,914	1,868		1,302	1,756	8,911
MARCH	2,411	2,193	2,142		1,383	1,917	10,046
APRIL	2,269	2,014	2,034		1,346	1,718	9,381
MAY	2,177	1,972	2,041		1,447	1,746	9,383
JUNE	2,081	1,987	2,014		1,386	1,745	9,213
JULY	2,181	2,119	2,133		1,338	1,765	9,536
AUGUST	2,154	2,036	2,111		1,269	1,703	9,273
SEPTEMBER	2,072	1,880	2,074		1,249	1,723	8,998
OCTOBER	1,974	2,055	2,267		1,418	1,951	9,665
NOVEMBER	1,830	1,947	2,126		1,414	1,948	9,265
DECEMBER	2,029	2,088	2,182		1,441	1,968	9,708
TOTAL	25,580	24,375	25,002	0	16,452	21,892	113,301
							113,301

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%

ALLOCATION PERCENTAGE							
DAYS	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL	
2006							
JANUARY	23.49%	21.87%	20.26%	14.70%	19.67%	100.00%	
FEBRUARY	23.24%	21.48%	20.96%	14.61%	19.71%	100.00%	
MARCH	24.00%	21.83%	21.32%	13.77%	19.08%	100.00%	
APRIL	24.19%	21.47%	21.68%	14.35%	18.31%	100.00%	
MAY	23.20%	21.02%	21.75%	15.42%	18.61%	100.00%	
JUNE	22.59%	21.57%	21.86%	15.04%	18.94%	100.00%	
JULY	22.87%	22.22%	22.37%	14.03%	18.51%	100.00%	
AUGUST	23.23%	21.96%	22.77%	13.68%	18.37%	100.00%	
SEPTEMBER	23.03%	20.89%	23.05%	13.88%	19.15%	100.00%	
OCTOBER	20.42%	21.26%	23.46%	14.67%	20.19%	100.00%	
NOVEMBER	19.75%	21.01%	22.95%	15.26%	21.03%	100.00%	
DECEMBER	20.90%	21.51%	22.48%	14.84%	20.27%	100.00%	