



Facility Name & ID Number Clinton Manor Living Center

# 0033159 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 05/01/07

	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	33	Skilled (SNF)	40	13,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	50	Intermediate/DD	50	18,250	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	90	32,010	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2		4	Total	
		Medicaid Recipient	Private Pay			
8	SNF			1,093	1,093	8
9	SNF/PED					9
10	ICF	7,798	2,915		10,713	10
11	ICF/DD	17,064	402		17,466	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,862	3,317	1,093	29,272	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.45%

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?                     

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                      and days of care provided 1,093

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.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	176,339	147,721	4,532	328,592		328,592		328,592		1
2	Food Purchase		13,832		13,832		13,832	(3,702)	10,130		2
3	Housekeeping	99,817	16,953	427	117,197		117,197		117,197		3
4	Laundry	55,814	18,341	11	74,166		74,166		74,166		4
5	Heat and Other Utilities			92,917	92,917		92,917		92,917		5
6	Maintenance	49,150	10,097	100,328	159,575		159,575	(18)	159,557		6
7	Other (specify):*							(24,000)	(24,000)		7
8	<b>TOTAL General Services</b>	<b>381,120</b>	<b>206,944</b>	<b>198,215</b>	<b>786,279</b>		<b>786,279</b>	<b>(27,720)</b>	<b>758,559</b>		8
<b>B. Health Care and Programs</b>											
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,473,306	115,443	188,526	1,777,275		1,777,275	(2,701)	1,774,574		10
10a	Therapy			160,485	160,485		160,485		160,485		10a
11	Activities	25,470	18,342		43,812		43,812		43,812		11
12	Social Services	160,494	20	5,673	166,187		166,187	(39,780)	126,407		12
13	CNA Training										13
14	Program Transportation	55,111		9,586	64,697		64,697		64,697		14
15	Other (specify):*			1,131	1,131		1,131		1,131		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,714,381</b>	<b>133,805</b>	<b>379,801</b>	<b>2,227,987</b>		<b>2,227,987</b>	<b>(42,481)</b>	<b>2,185,506</b>		16
<b>C. General Administration</b>											
17	Administrative	121,312		24,000	145,312		145,312	(24,000)	121,312		17
18	Directors Fees										18
19	Professional Services			103,018	103,018		103,018	(72,000)	31,018		19
20	Dues, Fees, Subscriptions & Promotions			58,002	58,002	646	58,648	(32,468)	26,180		20
21	Clerical & General Office Expenses	98,054	11,055	21,511	130,620		130,620	(19,588)	111,032		21
22	Employee Benefits & Payroll Taxes			373,857	373,857		373,857	(313)	373,544		22
23	Inservice Training & Education			10,321	10,321	(300)	10,021		10,021		23
24	Travel and Seminar			9,971	9,971	(346)	9,625		9,625		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,648	54,648		54,648		54,648		26
27	Other (specify):* Meetings exp. (food)			2,124	2,124		2,124		2,124		27
28	<b>TOTAL General Administration</b>	<b>219,366</b>	<b>11,055</b>	<b>657,452</b>	<b>887,873</b>		<b>887,873</b>	<b>(148,369)</b>	<b>739,504</b>		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,314,867</b>	<b>351,804</b>	<b>1,235,468</b>	<b>3,902,139</b>		<b>3,902,139</b>	<b>(218,570)</b>	<b>3,683,569</b>		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 &amp; ID Number

Clinton Manor Living Center

#0033159

Report Period Beginning:

01/01/07

Ending:

12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			103,386	103,386		103,386	(1,552)	101,834			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			125,266	125,266		125,266	(350)	124,916			32
33	Real Estate Taxes			23,218	23,218		23,218	(2,233)	20,985			33
34	Rent-Facility & Grounds			1,049	1,049		1,049		1,049			34
35	Rent-Equipment & Vehicles			1,401	1,401		1,401		1,401			35
36	Other (specify):*			5,026	5,026		5,026	(5,025)	1			36
37	<b>TOTAL Ownership</b>			259,346	259,346		259,346	(9,160)	250,186			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			9,587	9,587		9,587		9,587			38
39	Ancillary Service Centers			3,670	3,670		3,670		3,670			39
40	Barber and Beauty Shops		38		38		38		38			40
41	Coffee and Gift Shops		13,158		13,158		13,158		13,158			41
42	Provider Participation Fee			48,376	48,376		48,376		48,376			42
43	Other (specify):*			15,495	15,495		15,495	(15,150)	345			43
44	<b>TOTAL Special Cost Centers</b>		13,196	77,128	90,324		90,324	(15,150)	75,174			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,314,867	365,000	1,571,942	4,251,809		4,251,809	(242,880)	4,008,929			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: 01/01/07

Ending: 12/31/07

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,162)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15)	21		5
6	Rented Facility Space	(24,000)	7		6
7	Sale of Supplies to Non-Patients	(2,701)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(26)	30		9
10	Interest and Other Investment Income	(350)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,540)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,527)	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	(125)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,025)	43		24
25	Fund Raising, Advertising and Promotional	(32,468)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(951)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(112,990)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (194,880)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (194,880)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Clinton Manor Living Center

ID# 0033159

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Bank Fees	\$ (503)	36	1
2	Amortization of Loan Costs	(1,044)	36	2
3	Political Contributions	0	36	3
4	CSS Labor:Admin Progr.	(39,780)	12	4
5	CSS Labor:Admin Asst.	(19,573)	21	5
6	CSS Labor:Nursing	0	10	6
7	CSS Labor: Maintenance	(18)	6	7
8	Non-care Related Depreciation	(1,526)	30	8
9	Related Party Management Fees	(48,000)	19	9
10	Payroll Tax Reimbursements	(313)	22	10
11	2005 Seminar Expense		24	11
12	Non-care Related Legal Expenses		19	12
13	Office building Propert Tax	(2,233)	33	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(112,990)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clinton Manor Living Center# 0033159

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,702)	0	0	0	0	0	0	0	0	0	0	(3,702)	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	(18)	0	0	0	0	0	0	0	0	0	0	(18)	6
7	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	7
8	<b>TOTAL General Services</b>	<b>(27,720)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(27,720)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,701)	0	0	0	0	0	0	0	0	0	0	(2,701)	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	(39,780)	0	0	0	0	0	0	0	0	0	0	(39,780)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(42,481)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(42,481)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(48,000)	(24,000)	0	0	0	0	0	0	0	0	0	(72,000)	19
20	Fees, Subscriptions & Promotions	(32,468)	0	0	0	0	0	0	0	0	0	0	(32,468)	20
21	Clerical & General Office Expenses	(19,588)	0	0	0	0	0	0	0	0	0	0	(19,588)	21
22	Employee Benefits & Payroll Taxes	(313)	0	0	0	0	0	0	0	0	0	0	(313)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(100,369)</b>	<b>(48,000)</b>	<b>0</b>	<b>(148,369)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(170,570)</b>	<b>(48,000)</b>	<b>0</b>	<b>(218,570)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Clinton Manor Living Center

# 0033159

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(1,552)	0	0	0	0	0	0	0	0	0	0	(1,552) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(350)	0	0	0	0	0	0	0	0	0	0	(350) 32
33	Real Estate Taxes	(2,233)	0	0	0	0	0	0	0	0	0	0	(2,233) 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):*	(5,025)	0	0	0	0	0	0	0	0	0	0	(5,025) 36
37	<b>TOTAL Ownership</b>	<b>(9,160)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,160) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(15,150)	0	0	0	0	0	0	0	0	0	0	(15,150) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(15,150)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(15,150) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(194,880)</b>	<b>(48,000)</b>	<b>0</b>	<b>(242,880) 45</b>								

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 Serv	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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
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	18,690	WDM Computer Services	0.00%	18,690	
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 66,690			\$ 18,690	\$ * (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:      01/01/07      Ending:      12/31/07

## 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	78,112	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 Attached List (Pg 28)										10
11											11
12											12
13								TOTAL	\$ 217,312		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: 01/01/07 Ending: 12/31/07

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/07 Ending: 12/31/07

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10
			Related**					Purpose of Loan	Monthly Payment Required				
			YES	NO				Original	Balance				
		<b>A. Directly Facility Related</b>											
		<b>Long-Term</b>											
1		First National Bank		X	Construction Loan	\$1,024.30	12/19/03	\$ 95,000	\$ 64,102	05/19/09	7.5000	\$ 5,194	1
2		Ford Credit		X	Auto Loan	\$633.45	04/03/03	38,007	2,534	04/03/08	0.0000		2
3		See List Attached		X	See List Attached							94,012	3
4													4
5													5
		<b>Working Capital</b>											
6		First National Bank		X	Cash Flow	Interest	09/24/07	175,000	200,000	10/03/07		2,060	6
7		Owners	X		Cash Flow	Interest	04/13/07	48,000	400,000	12/31/08	6.0000	24,000	7
8													8
9		<b>TOTAL Facility Related</b>				\$1,657.75		\$ 356,007	\$ 666,636			\$ 125,266	9
		<b>B. Non-Facility Related*</b>											
10													10
11													11
12													12
13													13
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15		<b>TOTALS (line 9+line14)</b>						\$ 356,007	\$ 666,636			\$ 125,266	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**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2006 report.		\$ 20,212		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.)		\$ 19,482		2
3.	Under or (over) accrual (line 2 minus line 1).		\$ (730)		3
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 21,715		4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 20,985		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2002	19,703	8	
		2003	20,137	9	
		2004	19,209	10	
		2005	20,257	11	
		2006	20,212	12	
<b>FOR BHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2006 \$		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: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

**2006 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 Michael Brave

TELEPHONE 618-588-3826 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2006 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 2006

(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>11-10-18-178-002</u>	<u>Nursing Home</u>	\$ <u>17,883.60</u>	\$ <u>17,883.60</u>
2. <u>11-10-18-175-023</u>	<u>Hanover Office Building</u>	\$ <u>2,233.22</u>	\$ _____
3. <u>11-10-18-175-024</u>	<u>Nursing Home Offices</u>	\$ <u>1,597.94</u>	\$ <u>1,597.94</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>21,714.76</u>	\$ <u>19,481.54</u>

**B. Real Estate Tax Cost Allocation:**

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007

**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:

01/01/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 21,794 B. General Construction Type: Exterior Brick Frame Wood, Steel, & Concre 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 ground (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	<b>TOTALS</b>	<u>26,669</u>		<u>\$ 66,000</u>	<u>3</u>

Facility Name &amp; ID Number Clinton Manor Living Center

# 0033159

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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		\$ 396,003	4
5	12	1991	1991	511,306	17,096	30	17,044	(52)	276,230	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	SPRINKLER		1990	3,140	158	20	157	(1)	2,708	9
10	LAND IMPROVEMENT		1992	5,410		10			5,410	10
11	BUILDING IMPROVEMENT		1992	37,505	1,629	20,10	1,620	(9)	29,765	11
12	BUILDING IMPROVEMENT		1992	26,098	1,312	20	1,305	(7)	19,648	12
13	CON		1992	3,000		30	100	100	1,600	13
14	BUILDING IMPROVEMENT		1994	12,580	296	20,10	294	(2)	10,756	14
15	PLUMBING		1995	12,200	613	20	610	(3)	7,755	15
16	LANDSCAPING		1997	1,675	70	10	70		1,675	16
17	BOILER		1997	8,858		8			8,858	17
18	REMODEL OF DINING ROOM		1997	35,389	1,769	20	1,769		17,842	18
19	HEATING/COOLING SYSTEM		1999	13,826	1,384	10	1,383	(1)	11,289	19
20	FIRE ALARM UPGRADE		2001	2,610	261	10	261		1,588	20
21	FRONT ADDITION		2001	115,835	5,792	20	5,792		35,235	21
22	DINING ROOM REMODEL		2001	84,135	4,207	20	4,207		25,592	22
23	Kitchen Improvements		2004	3,852	197	20	193	(4)	705	23
24	Flooring		2004	2,790	279	10	279		907	24
25	Laundry Building		2004	106,437	5,322	20	5,322		18,183	25
26	Bathroom Flooring		2005	3,650	183	20	183		502	26
27	Concrete		2005	2,367	237	10	237		572	27
28	Flooring		2005	3,032	152	20	152		366	28
29	Bathroom Remodel		2005	3,550	177	20	178	1	399	29
30	Roof Repairs		2005	4,225	211	20	211		493	30
31	Flooring		2006	5,960	298	20	298		596	31
32	New A/C Units		2006	6,141	412	15	410	(2)	652	32
33	New Office Building		2006	93,901	3,130	30	3,130		3,646	33
34	Flooring		2007	6,293	524	8	524		524	34
35	Entrance Canopy		2007	3,765	47	20	47		47	35
36	Replace Roof		2007	36,366	76	40	76		76	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:

01/01/07

Ending:

12/31/07

**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	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,749,896	\$ 65,632		\$ 65,652	\$ 20	\$ 879,622	70

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

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	\$ 201,646	\$ 23,780	\$ 23,780	\$	10	\$ 99,044	71
72	Current Year Purchases	30,513	1,612	1,612		10	1,612	72
73	Fully Depreciated Assets	322,923				10	322,923	73
74								74
75	TOTALS	\$ 555,082	\$ 25,392	\$ 25,392	\$		\$ 423,579	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	\$ 1,589	\$ (27)	5	\$ 3,364	76
77	Facility	03 Ford Van	2003	40,507	8,102	8,102		5	38,482	77
78	Facility	Van	1999	37,719				5	37,719	78
79	Facility	Used Truck	2004	5,497	1,118	1,099	(19)	5	3,447	79
80	TOTALS			\$ 91,666	\$ 10,836	\$ 10,790	\$ (46)		\$ 83,012	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)	\$	2,462,644	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	101,860	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	101,834	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	(26)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,386,213	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	Hanover Office Building	\$ 45,776	\$ 1,526	\$ 16,149	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 45,776	\$ 1,526	\$ 16,149	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: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2008                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010                      \$ \_\_\_\_\_

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: \$ 1,401 Description: Dishwasher \$1,401

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

**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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (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
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			3,670			3,670	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	10-3	hrs		226	11,275		226	11,275	10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	226	\$ 14,945	\$	226	\$ 14,945	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.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Clinton Manor Living Center

# 0033159

Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (29,146)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,139,194		3
4	Supply Inventory (priced at FIFO )	21,809		4
5	Short-Term Investments			5
6	Prepaid Insurance	47,244		6
7	Other Prepaid Expenses	5,479		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,184,580	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	(3,737)		12
13	Land	116,387		13
14	Buildings, at Historical Cost	2,336,457		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	660,661		16
17	Accumulated Depreciation (book methods)	(1,619,617)		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: Loan Orig. Fee)	4,090		22
23	Other(specify): CIP	17,941		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,512,182	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,696,762	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 123,394	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable	153,842		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,890		32
33	Accrued Interest Payable	5,332		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Wqage Garn	402		36
37	Ins. Withheld	(12,125)		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 505,735	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	70,375		39
40	Mortgage Payable	1,458,597		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	Notes Payable Owners	400,000		43
44	Rounding	1		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,928,973	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,434,708	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 262,054	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,696,762	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>131,854</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>131,854</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	199,574	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(89,868)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Income/Loss Rental Properties</b>	20,494	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>130,200</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>262,054</b>	<b>24</b> *

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

STATE OF ILLINOIS

Facility Name & ID Number Clinton Manor Living Center

# 0033159

Report Period Beginning: 01/01/07

Ending:

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12/31/07

**VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,046,073	1
2	Discounts and Allowances for all Levels	(3,435)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,042,638	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,911	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 216,911	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education	17,103	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	12,799	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,162	14
15	Telephone, Television and Radio	15	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,528	17
18	Sale of Supplies to Non-Patients	453	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	280	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 34,340	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	25	24
25	Interest and Other Investment Income***	350	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 375	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Rebates	1,540	28
28a	See List Attached	155,578	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 157,118	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,451,382	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	786,279	31
32	Health Care	2,227,987	32
33	General Administration	887,873	33
<b>B. Capital Expense</b>			
34	Ownership	259,346	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	41,948	35
36	Provider Participation Fee	48,376	36
<b>D. Other Expenses (specify):</b>			
37	Rounding	(1)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,251,808	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	199,574	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 199,574	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 &amp; ID Number Clinton Manor Living Center

# 0033159

Report Period Beginning: 01/01/07

Ending: 12/31/07

## 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	3,488	4,155	\$ 102,406	\$ 24.65	1
2	Assistant Director of Nursing	1,900	2,088	50,049	23.97	2
3	Registered Nurses	3,835	3,988	82,343	20.65	3
4	Licensed Practical Nurses	17,473	18,616	320,255	17.20	4
5	CNAs & Orderlies	19,536	20,681	235,176	11.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,052	2,157	24,689	11.45	9
10	Activity Assistants	99	104	781	7.51	10
11	Social Service Workers	5,772	6,302	92,229	14.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,024	2,088	32,019	15.33	14
15	Cook Helpers/Assistants	8,258	8,794	92,258	10.49	15
16	Dishwashers	6,518	6,785	52,062	7.67	16
17	Maintenance Workers	2,906	3,354	49,150	14.65	17
18	Housekeepers	10,296	11,309	99,817	8.83	18
19	Laundry	6,408	6,893	55,814	8.10	19
20	Administrator	1,912	2,088	78,112	37.41	20
21	Assistant Administrator					21
22	Other Administrative			43,200		22
23	Office Manager					23
24	Clerical	5,785	6,325	98,054	15.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,157	6,466	90,761	14.04	28
29	Resident Services Coordinator	1,884	2,088	68,265	32.69	29
30	Habilitation Aides (DD Homes)	54,717	57,573	592,316	10.29	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Transportation	4,344	4,780	55,111	11.53	33
34	TOTAL (lines 1 - 33)	165,364	176,634	\$ 2,314,867 *	\$ 13.11	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	\$ 4,532	1-3	35
36	Medical Director	Contract	14,400	9-3	36
37	Medical Records Consultant	18	630	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,650	10-3	39
40	Physical Therapy Consultant	Contract	143,376	10a-3	40
41	Occupational Therapy Consultant	Contract	119,540	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Contract	17,109	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	38	2,283	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	152	\$ 303,520		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	465	15,247	10-3	51
52	Certified Nurse Assistants/Aides	1,406	27,457	10-3	52
53	TOTAL (lines 50 - 52)	1,871	\$ 42,704		53





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. LSN \$450.00
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 19,973 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. \$ 48,376  
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,162
- (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. \$ 10,553  
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? 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 \$5,000, 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.

Clinton Manor Living Center, Inc.  
01/01/07 thru 12/31/07

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

Vendor	Purpose	Expense
Legacy	Training	\$314.00
American Legion	Rental	\$165.54
Our Lady of Snow	Mission Statement Retreat	\$394.25
K. Andrews Heart Saver	Employee CPR Training	\$240.00
Washington County CPR	Employee Instryctor Training	\$25.00
Washington County CPR	CPR Cards SILC&SICSS	\$48.00
Target	Annual Training Supplies	\$77.08
Gateway Center	Tom Pomeranz Training	\$325.00
New Baden Market Center	HR Training	\$7.19
Kinko's	Training Materials Tom P,	\$184.77
Target	Transition Fair	\$41.31
Target	HR Orientation/Training	\$135.83
Ritah	Supplies	\$123.28
K Andrews Heart Saver	Employee CPR Training	\$200.00
Gordon	Training	\$329.08
G. Neil	Orientation Training Materials	\$94.55
Universal Lifestyles	Tom Pomeranz Training	\$4,890.16
Gateway Center	Tom Pomeranz Training	\$225.00
Eurest Dining Services	Tom Pomeranz Training	\$1,378.33
Home Pharmacy	Training	\$375.00
Brave Inc.	Materials	\$40.50
Sam's Club	Tom Pomeranz Training	\$397.48
Borders	Training Book	\$17.29
Kelly Linck	CNA Handbook/ Physical	\$35.78
Training Systems	Training Materials	\$121.25
Ramada Inn	Training Seminar	\$100.00
Dierbergs	Food for In-Service	\$35.59
Reimbursement for Tom P. Training		-\$300.00
		<u><u>\$10,021.26</u></u>

Clinton Manor Living Center, Inc.  
01/01/07 thru 12/31/07  
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The following is a breakdown of Schedule V Line 6 Column 3

Repairs & Maint. Dietary	\$4,814.47
Repairs & Maint. Laundry	\$2,197.98
Repairs & Maint. Housekeeping	50.00
Repairs & Maint. Equipment	\$14,510.81
Repairs & Maint. Ground	\$7,348.37
Repairs & Maint. Building	\$42,661.04
Repairs & Maint. Wheelchairs	\$156.34
Repairs & Maint. Outside services	\$20,360.00
Repairs & Maint. Gen/Admin.	\$8,279.94
	<u>\$82,088.95</u>

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

Printing	\$69.40
Postage	\$4,566.02
Copier	\$2,756.62
Telephone	\$14,118.51
	<u>\$21,510.55</u>

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

Sales Tax	\$2,527.00
State Replacement Tax	\$951.00
Bank & service Fees	\$503.42
Amortization of Loan Costs	\$1,044.12
Political Contributions	\$0.00
Rounding	
	<u>\$5,025.54</u>

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

Bad Debt Expense	\$15,025.00
Misc. Exp.	\$144.59
Contributions	\$125.00
	<u>\$15,294.59</u>

The following is a breakdown of Schedule XVII Line 28a

CSS Labor: Admn. Program	\$39,780.00
CSS Labor: Admn. Assiat.	\$19,573.20
CSS Labor: Nursing Labor	\$0.00
CSS Labor: Maintenance	\$18.00
CRC Labor-Pica & Fed Ins.	\$207.20
CRC Labor-Fed Unemployment	\$21.66
CRC Labor-State Unemployment	\$54.16
CRC Labor-Administrative	\$30.00
Misc. Revenue	\$903.77
Personal Purchase Income	\$2,247.79
Office Lease	\$24,000.00
Discounts	\$0.00
In-House Day Training Revenue	\$58,189.73
Gain/Loss on Sale of Asset	\$0.00
Income from Transpor (IDVA Trans. Paymnt)	\$10,552.74
Rounding	
	<u>\$150,036.39</u>

The following is a breakdown of Schedule XIX, Section F

International Readers	\$531.94
LTCMA	\$35.00
Am Assoc. on Merit	\$150.00
INRDA	\$200.00
IDPR	\$284.50
Sea's Club	\$450.00
L&N Dues	\$450.00
Misc Subscriptions	\$199.99
Support Serv. Membership	\$500.00
Auto Licensing	\$16.00
Sec of State Auto Reg.	\$398.00
Clinton County - Food Permit	\$55.00
Norcross Association	\$30.00
Village of New Baden	\$25.00
Rounding	\$1.00
	<u>\$3,483.43</u>

Schedule XIII, Section A.

Chas are responsible for their own training and testing.

2007 Long term Real Estate Tax Statement

Section B :

Part of the office building is rented out to another corporation. The related property taxes and depreciation are adjusted out of the cost report.

Clinton Manor Living Center, Inc.  
1/01/07 thru 12/31/07

Date	Seminar	Location	Who Attended	Airfare Mileage					Total
				Registration	Auto expense	Meals	Hotel	Materials	
3/25/2007	AAMR-AAIDD Conference	Naperville, IL	Jim Lopresto Danielle Belva Rosie Williams Emily Smith Kelly Linck Liz Knepper April Corkwell Holly Szopinski Rick Bates John			\$589.80	\$549.43	\$360.00	\$1,499.23
4/10/2007	Institute Board Retreat	Springfield, IL	Jim Lopresto	\$327.32	\$103.25				\$430.57
4/7/2007	Jack Rend Lake Seminar	Mt. Vernon, IL	Stacy Mays	\$57.85					\$57.85
4/25/2007	IL MDS Based Medicaid Payment System	Mt. Vernon, IL	Cheryl Smith Darla Loomis	\$170.00					\$170.00
5/7/2007	NADONA Conference	Las Vegas, Nv.	Cheryl Smith		\$386.30	\$384.00	\$812.05		\$1,582.35
5/10/2007	Culture Change in Action	Belleville, IL	Michael Brave Cheryl Smith Darla Loomis Heather Lohman Mara Jackson Cathie Lanter	\$120.00					\$120.00
5/16/2007	The Amazing Medicaid Race	Springfield, IL	Michael Brave Margie Holtgrave	\$198.00					\$198.00
5/17/2007	Skilled Nursing Facility Documentations & Clinical Issues	Bloomington, IL	Margie Holtgrave	\$40.00	\$141.12	\$80.15	\$178.08		\$439.35
5/20/2007	Food & Nutrition Update	St. Louis, MO	Cathie Lanter	\$30.00					\$30.00
6/27-28/07	Rameriz Activity Director Training	Mt. Vernon, IL	Kelly Linck	\$600.00			\$89.90		\$689.90
7/17/2007	Creating Moments of Hope and Joy	Glen Carbon, IL	Kristi Green Curt Foster Erin Mc Adams Sandra Baker Wanda Samson Kelly Linck			\$30.00			\$30.00
8/7/2007	Health Sanitation Class	Mt. Vernon, IL	Cathie Lanter Gerald Brooks	\$220.00	\$106.80				\$326.80
9/5/2007	Becoming A People Place Human Resource Symposium	Utica, IL	Michael Brave	\$99.00		\$129.72	\$264.18		\$492.90
9/20/2007	Human resource Audits in IL	Collinsville, IL	Joan Varel	\$299.00					\$299.00
9/20-21/07	IL Healthcare Asso	Mt. Vernon, IL	Cheryl Smith Michael Brave	\$225.00					\$225.00
9/20-21/07	Can Your Kitchen Pass The Food Safety Test	St. Louis, MO	Cathie Lanter	\$215.00					\$215.00
10/4/2007	Transform Your Culture LSN Life Services Network	Fairview Heights, IL	Michael Brave	\$150.00					\$150.00
10/16-17/07	Culture Change Many Paths One Vision	Springfield, IL	Michael Brave Cheryl Smith Darla Loomis Mara Jackson Kelly Linck Cathie Lanter Susan Hunter	\$1,050.00		\$128.40	\$610.56		\$1,788.96
11/28-29/07	Nursing Home Adm Licensure Exam Review	Springfield, IL	Cheryl Smith	\$595.00	\$92.00	\$79.20	\$324.46		\$1,090.66
11/7-30/07	CEU's	St. Louis Mo.	Michael Brave	\$15.00					\$15.00
				\$4,411.17	\$829.47	\$1,421.27	\$2,828.66	\$360.00	\$9,850.57
							Less Reimb.		-\$225.00
							Rounding		-\$1.00
									<u>\$9,624.57</u>

Clinton Manor Living Center, Inc.  
01/01/07 thru 12/31/07  
0033159

**Schedule VII Attachment**

Name	Function	Nursing Home	Ownership	Compensation
			Interest	from other Nursing Homes
RDR Management	Management	St. Ann's Healthcare Ctr.	0	\$36,000.00
Greer Management	Management	St. Ann's Healthcare Ctr.	0	\$36,000.00
Greer Management	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. Suppor	0	\$15,761.18
Greer Management	Management	Southern Illinois Comm. Suppor	0	\$15,761.18
Advanced Options	Management	Southern Illinois Comm. Suppor	0	\$31,522.36
RDR Management	Management	Southern Illinois Comm. Suppor	0	\$15,761.18

**Schedule IX**

Lender	Related	Purpose	Monthly pyn	Date of note	Orig. amt	Balance	Maturity	Rate	Expense
First National bank	No	Auto Loan	\$174.00	11/30/2005	\$7,254.00	\$3,738.60	11/23/2009	5.9000	\$276.51
First National bank	No	Refinance Mortgage & 2nd	\$14,125.00	12/31/2006	\$1,305,580.60	\$1,279,897.22		7.2500	\$93,735.02
			<u>\$14,299.00</u>		<u>\$1,312,834.60</u>	<u>\$1,283,635.82</u>			<u>\$94,011.53</u>

Clinton Manor Living Center, Inc.

01/01/07 thru 12/31/07

0033159

The following is a breakdown of the reclassifications:

1. \$645.59 reclassified from Seminar exp. To Promotion due to promotional food items being incorractly coded to

2. (\$300.00) reclassified from Semiar to In-Service Training due to cash reimbursement for training being code

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