

Facility Name & ID Number Clinton Manor Living Center

0033159 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	40	Skilled (SNF)	40	14,640	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	50	Intermediate/DD	50	18,300	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,940	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 Medicaid Recipient		4 Other	Total	
		Private Pay				
8	SNF		127	1,515	1,642	8
9	SNF/PED					9
10	ICF	7,739	2,763		10,502	10
11	ICF/DD	17,596	190		17,786	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,335	3,080	1,515	29,930	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.86%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
n/a

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 40 and days of care provided 1,447

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: 12/31/08 Fiscal Year: 12/31/08

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

STATE OF ILLINOIS

Facility Name & ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/08 Ending: 12/31/08

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
A. General Services											
1	Dietary	194,675	15,448	4,903	215,026		215,026		215,026		1
2	Food Purchase		161,360		161,360		161,360	(5,572)	155,788		2
3	Housekeeping	109,030	13,380	258	122,668		122,668		122,668		3
4	Laundry	52,984	23,694	985	77,663		77,663		77,663		4
5	Heat and Other Utilities			99,604	99,604		99,604		99,604		5
6	Maintenance	50,888	19,522	87,497	157,907	332	158,239		158,239		6
7	Other (specify):*							(24,000)	(24,000)		7
8	TOTAL General Services	407,577	233,404	193,247	834,228	332	834,560	(29,572)	804,988		8
B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,585,591	163,255	86,810	1,835,656		1,835,656	(14,940)	1,820,716		10
10a	Therapy			315,481	315,481		315,481		315,481		10a
11	Activities	31,040	15,543	1,835	48,418		48,418		48,418		11
12	Social Services	168,851		2,408	171,259		171,259	(42,652)	128,607		12
13	CNA Training										13
14	Program Transportation	39,302		10,986	50,288		50,288		50,288		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,824,784	178,798	431,920	2,435,502		2,435,502	(57,592)	2,377,910		16
C. General Administration											
17	Administrative	136,830		33,000	169,830		169,830	(33,000)	136,830		17
18	Directors Fees										18
19	Professional Services			133,312	133,312		133,312	(99,000)	34,312		19
20	Dues, Fees, Subscriptions & Promotions			68,294	68,294		68,294	(37,458)	30,836		20
21	Clerical & General Office Expenses	102,983	18,838	23,065	144,886		144,886	(14,851)	130,035		21
22	Employee Benefits & Payroll Taxes			401,026	401,026		401,026		401,026		22
23	Inservice Training & Education			5,709	5,709		5,709		5,709		23
24	Travel and Seminar			14,030	14,030		14,030		14,030		24
25	Other Admin. Staff Transportation			2,441	2,441		2,441		2,441		25
26	Insurance-Prop.Liab.Malpractice			53,303	53,303		53,303		53,303		26
27	Other (specify):* Meeting Exp.			3,508	3,508		3,508		3,508		27
28	TOTAL General Administration	239,813	18,838	737,688	996,339		996,339	(184,309)	812,030		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,472,174	431,040	1,362,855	4,266,069	332	4,266,401	(271,473)	3,994,928		29

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

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

Facility Name & ID Number

Clinton Manor Living Center

#0033159

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
	D. Ownership											
30	Depreciation			110,539	110,539		110,539	(1,552)	108,987			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			124,437	124,437		124,437	(189)	124,248			32
33	Real Estate Taxes			22,378	22,378		22,378	(2,250)	20,128			33
34	Rent-Facility & Grounds			1,483	1,483	(332)	1,151		1,151			34
35	Rent-Equipment & Vehicles			1,478	1,478		1,478		1,478			35
36	Other (specify):*			13,504	13,504		13,504	(13,503)	1			36
37	TOTAL Ownership			273,819	273,819	(332)	273,487	(17,494)	255,993			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			10,987	10,987		10,987		10,987			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		11,325		11,325		11,325		11,325			41
42	Provider Participation Fee			49,410	49,410		49,410		49,410			42
43	Other (specify):*			36,395	36,395		36,395	(28,992)	7,403			43
44	TOTAL Special Cost Centers		11,325	96,792	108,117		108,117	(28,992)	79,125			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,472,174	442,365	1,733,466	4,648,005		4,648,005	(317,959)	4,330,046			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: 01/01/08

Ending: 12/31/08

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	(5,522)	2		4
5	Telephone, TV & Radio in Resident Rooms	(25)	21		5
6	Rented Facility Space	(24,000)	7		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(26)	30		9
10	Interest and Other Investment Income	(189)	32		10
11	Discounts, Allowances, Rebates & Refunds	(50)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,260)	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	(900)	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	(28,092)	43		24
25	Fund Raising, Advertising and Promotional	(37,458)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,511)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(149,926)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (251,959)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (251,959)		37

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

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

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

Clinton Manor Living Center

ID# 0033159

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Bank Fees	\$ (2,383)	36	1
2	Amortization of Loan Costs	(5,349)	36	2
3	Political Contributions	0	36	3
4	CSS Labor:Admin Progr.	(42,652)	12	4
5	CSS Labor:Admin Asst.	(14,826)	21	5
6	CSS Labor:Nursing	(14,940)	10	6
7	CSS Labor: Maintenance	0	6	7
8	Non-care Related Depreciation	(1,526)	30	8
9	Related Party Management Fees	(66,000)	19	9
10	Payroll Tax Reimbursements	0	22	10
11	2005 Seminar Expense	0	24	11
12	Non-care Related Legal Expenses	0	19	12
13	Office building Property Tax	(2,250)	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	Total	(149,926)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clinton Manor Living Center# 0033159

Report Period Beginning:

01/01/08

Ending:

12/31/08**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	(5,572)	0	0	0	0	0	0	0	0	0	0	(5,572)	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):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	7
8	TOTAL General Services	(29,572)	0	0	0	0	0	0	0	0	0	0	(29,572)	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	(14,940)	0	0	0	0	0	0	0	0	0	0	(14,940)	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	(42,652)	0	0	0	0	0	0	0	0	0	0	(42,652)	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	(57,592)	0	0	0	0	0	0	0	0	0	0	(57,592)	16
	C. General Administration													
17	Administrative	0	(33,000)	0	0	0	0	0	0	0	0	0	(33,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(66,000)	(33,000)	0	0	0	0	0	0	0	0	0	(99,000)	19
20	Fees, Subscriptions & Promotions	(37,458)	0	0	0	0	0	0	0	0	0	0	(37,458)	20
21	Clerical & General Office Expenses	(14,851)	0	0	0	0	0	0	0	0	0	0	(14,851)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(118,309)	(66,000)	0	(184,309)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(205,473)	(66,000)	0	(271,473)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning:

01/01/08

Ending:

12/31/08

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)
	D. Ownership												
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	(189)	0	0	0	0	0	0	0	0	0	0	(189) 32
33	Real Estate Taxes	(2,250)	0	0	0	0	0	0	0	0	0	0	(2,250) 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):*	(13,503)	0	0	0	0	0	0	0	0	0	0	(13,503) 36
37	TOTAL Ownership	(17,494)	0	0	0	0	0	0	0	0	0	0	(17,494) 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):*	(28,992)	0	0	0	0	0	0	0	0	0	0	(28,992) 43
44	TOTAL Special Cost Centers	(28,992)	0	0	0	0	0	0	0	0	0	0	(28,992) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(251,959)	(66,000)	0	(317,959) 45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Brave	25			Brave Inc.	New Baden	Management
Ann Reis	25	Carlyle Healthcare Center	Carlyle	DAR Mngmt	Quincy	Management
		St. Vincent's Home, Inc.	Quincy	Wdm Computer Serv	Quincy	Data Processing
Blain Richard	25	St. Ann's Healthcare Center, Inc.	Chester	RDR Mngmt	Albers	Management
Michael Greer	12.5	St. Ann's Healthcare Center, Inc.	Chester	Greer Mngmt	Trenton	Management
Gail Greer	12.5	O'Fallon Healthcare Center, Inc.	O'Fallon	The Manor at Craig F	Chester	Supportive Living

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	\$ 33,000	Brave Management	0.00%	\$	\$ (33,000) 1
2	V	19 Management	33,000	DAR Management	0.00%		(33,000) 2
3	V	19 Data Processing	22,995	WDM Computer Services	0.00%	22,995	
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 88,995			\$ 22,995	\$ * (66,000) 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: 01/01/08 Ending: 12/31/08

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	12.50	0	14	33.00	Wages	\$ 13,525	17-1	1
2	Blain Richard	President	Owner	25.00	0	10	25.00	Wages	17,800	17-1	2
3	Ann Reis	n/a	Owner	25.00	0	0	0.00	n/a		17-1	3
4	Dave Reis	Treasurer	Board Member	0.00	0	10	25.00	Wages	17,800	17-1	4
5	Michael Brave	Administrator	Administrator	25.00	0	40	100.00	Wages	81,847	17-1	5
6	RDR Mngmt	Management	Management	0.00	0	5	12.00	Mngt Fees	33,000	19-3	6
7	DAR Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	33,000	19-3	7
8	Greer Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	33,000	19-3	8
9	Brave, Inc.	Management	Management	0.00	0	5	12.00	Mngt Fees	33,000	17-3	9
10	Gail Greer	n/a	Owner	12.50		0	0.00	Wages	4,275	17-1	10
11	See Attached List (Pg 28)										11
12											12
13								TOTAL	\$ 267,247		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: 01/01/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Clinton Manor Living Center # 0033159 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	
						Original	Balance					
	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									
A. Directly Facility Related												
Long-Term												
1	First National Banl		X	Contruction Loan	\$966.99	12/19/03	\$ 95,000	\$ 56,267	08/15/11	5.5000	\$ 4,154	1
2	First County Bank		X	Auto Loan	\$174.00	11/30/05	7,254	1,821	11/23/09	5.9000	168	2
3	First National Banl		X	Refinance & 2nd Mortgage	\$14,096.88	12/31/06	1,305,581	1,228,272	07/21/11	5.5000	82,026	3
4	First County Bank		X	Auto Loan	\$746.00	01/24/08	45,000	39,087	01/24/14	5.9000	2,337	4
5												5
Working Capital												
6	First National Banl		X	Cash Flow	Interest	09/27/07	175,000	200,000	04/15/09	4.7500	11,752	6
7	Owners	X		Cash Flow	Interest	04/13/07	48,000	400,000	12/31/09	6.0000	24,000	7
8												8
9	TOTAL Facility Related				\$15,983.87		\$ 1,675,835	\$ 1,925,447			\$ 124,437	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,675,835	\$ 1,925,447			\$ 124,437	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

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2007 report.		\$ 21,714	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.)		\$ 19,796	2
3.	Under or (over) accrual (line 2 minus line 1).		\$ (1,918)	3
4.	Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 22,046	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 20,128	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2003	20,137	8	
	2004	19,209	9	
	2005	20,257	10	
	2006	20,212	11	
	2007	21,714	12	
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	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: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 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 618-588-5066 FAX #: ()

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of total 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 2007.

(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>17,886.76</u>	\$ <u>17,886.76</u>
2. <u>11-10-18-175-023</u>	<u>Hanover Office Building</u>	\$ <u>2,249.97</u>	\$ _____
3. <u>11-10-18-175-024</u>	<u>Nursing Home Offices</u>	\$ <u>1,909.65</u>	\$ <u>1,909.65</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>22,046.38</u>	\$ <u>19,796.41</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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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:

01/01/08 Ending: 12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,794 B. General Construction Type: Exterior Brick Frame Wood, Steel & Concret 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	TOTALS	26,669		\$ 66,000	3

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 415,803	4
5	12	1991	1991	511,306	17,096	30	17,044	(52)	293,326	5
6										6
7										7
8										8
Improvement Type**										
9	SPRINKLER	1990		3,140	158	20	157	(1)	2,866	9
10	LAND IMPROVEMENT	1992		5,410		10			5,410	10
11	BUILDING IMPROVEMENT	1992		37,505	1,629	20,10	1,620	(9)	31,394	11
12	BUILDING IMPROVEMENT	1992		26,098	1,312	20	1,305	(7)	20,960	12
13	CON	1992		3,000		30	100	100	1,700	13
14	BUILDING IMPROVEMENT	1994		12,580	296	20,10	294	(2)	11,052	14
15	PLUMBING	1995		12,200	613	20	610	(3)	8,368	15
16	LANDSCAPING	1997		1,675		10			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		19,611	18
19	HEATING/COOLING SYSTEM	1999		13,826	1,384	10	1,383	(1)	12,673	19
20	FIRE ALARM UPGRADE	2001		2,610	261	10	261		1,849	20
21	FRONT ADDITION	2001		115,835	5,792	20	5,792		41,026	21
22	DINING ROOM REMODEL	2001		84,135	4,207	20	4,207		29,799	22
23	Kitchen Improvements	2004		3,852	197	20	193	(4)	901	23
24	Flooring	2004		2,790	279	10	279		1,186	24
25	Laundry Building	2004		106,437	5,322	20	5,322		23,505	25
26	Bathroom Flooring	2005		3,650	183	20	183		684	26
27	Concrete	2005		2,367	237	10	237		809	27
28	Flooring	2005		3,032	152	20	152		518	28
29	Bathroom Remodel	2005		3,550	177	20	178	1	577	29
30	Roof Repairs	2005		4,225	211	20	211		704	30
31	Flooring	2006		5,960	298	20	298		894	31
32	New A/C Units	2006		6,141	412	15	410	(2)	1,064	32
33	New Office Building	2006		93,901	3,130	30	3,130		6,777	33
34	Flooring	2007		6,293	787	8	787		1,311	34
35	Entrance Canopy	2007		3,765	188	20	188		235	35
36	Replace Roof	2007		36,366	909	40	909		985	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:

01/01/08

Ending:

12/31/08

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	Range Hood	2008	\$ 8,586	\$ 828	7	\$ 828		\$ 828	37
38	Smoke Alarm System	2008	7,224	151	8	151		151	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,765,706	\$ 67,778		\$ 67,798	\$ 20	\$ 947,499	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	\$ 215,312	\$ 25,548	\$ 25,548	\$	7	\$ 109,370	71
72	Current Year Purchases	16,719	941	941		7	941	72
73	Fully Depreciated Assets	339,766				7	339,758	73
74								74
75	TOTALS	\$ 571,797	\$ 26,489	\$ 26,489	\$		\$ 450,069	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	2003 Ford Van E350	2003	\$ 40,507	\$ 2,025	\$ 2,025	\$ (0)	5	\$ 40,507	76
77	Facility	Used Truck	2004	5,497	1,118	1,099	(19)	5	4,566	77
78	Facility	Station Wagon	2005	7,943	1,616	1,589	(27)	5	4,980	78
79	Facility	Chevy Turtle Top Van	2008	49,936	9,987	9,987		5	9,987	79
80	TOTALS			\$ 103,883	\$ 14,746	\$ 14,700	\$ (46)		\$ 60,040	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)	\$	2,507,386	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	109,013	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	108,987	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)	\$	1,457,608	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	Hanovor Office Building	\$ 45,776	\$ 1,526	\$ 17,675	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 45,776	\$ 1,526	\$ 17,675	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	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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: \$ 1,478 Description: Dishwasher Lease

(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.

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
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)	
TOTAL TRAINED	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					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			3,811							3,811	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			254	12,600					254	12,600	10
11	Academic Education		hrs											11
12	Other (specify):													12
13	Other (specify):													13
14	TOTAL			\$		254	\$ 16,411	\$				254	\$ 16,411	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

Facility Name & ID Number **Clinton Manor Living Center**

0033159

Report Period Beginning: **01/01/08**

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/08**

(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	\$ (199,280)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,228,013		3
4	Supply Inventory (priced at <u>FIFO</u>)	23,947		4
5	Short-Term Investments			5
6	Prepaid Insurance	50,776		6
7	Other Prepaid Expenses	3,452		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Rounding</u>	1		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,106,909	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	(10,621)		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	705,408		16
17	Accumulated Depreciation (book methods)	(1,709,483)		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: <u>Loan Org. Fees</u>)	2,547		22
23	Other(specify): <u>C-I-P</u>	19,941		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,460,636	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,567,545	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 119,352	\$	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	166,388		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,442		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,984		32
33	Accrued Interest Payable	3,629		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll withholdings</u>	(10,595)		36
37	<u>Rounding</u>	(1)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 527,199	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	97,175		39
40	Mortgage Payable	1,383,928		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Loans from Owners</u>	400,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,881,103	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,408,302	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 159,243	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,567,545	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 262,054	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 262,054	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	123,094	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	(233,256)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Income from Rental divisions	7,351	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (102,811)	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)	\$ 159,243	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Clinton Manor Living Center

0033159

Report Period Beginning: 01/01/08

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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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,279,634	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,279,634	3
B. Ancillary Revenue			
4	Day Care	200	4
5	Other Care for Outpatients		5
6	Therapy	225,765	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 225,965	8
C. Other Operating Revenue			
9	Payments for Education	14,890	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	10,719	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,522	14
15	Telephone, Television and Radio	25	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,525	17
18	Sale of Supplies to Non-Patients	(95)	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	2,473	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,059	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	189	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 189	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See List Attached</u>	230,248	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 230,248	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,771,095	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	834,560	31
32	Health Care	2,435,502	32
33	General Administration	996,339	33
B. Capital Expense			
34	Ownership	273,487	34
C. Ancillary Expense			
35	Special Cost Centers	58,707	35
36	Provider Participation Fee	49,410	36
D. Other Expenses (specify):			
37	<u>Rounding</u>	(4)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,648,001	40
41	Income before Income Taxes (line 30 minus line 40)**	123,094	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 123,094	43

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

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

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

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

Facility Name & ID Number Clinton Manor Living Center

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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	2,865	3,045	\$ 77,303	\$ 25.39	1
2	Assistant Director of Nursing	1,940	2,088	53,828	25.78	2
3	Registered Nurses	2,281	2,397	53,787	22.44	3
4	Licensed Practical Nurses	21,006	21,926	409,799	18.69	4
5	CNAs & Orderlies	21,619	22,825	251,730	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,007	22,784	11.35	9
10	Activity Assistants	767	782	6,096	7.80	10
11	Social Service Workers	5,723	6,282	96,726	15.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,890	2,148	33,217	15.46	14
15	Cook Helpers/Assistants	9,770	10,365	112,317	10.84	15
16	Dishwashers	5,784	6,038	49,141	8.14	16
17	Maintenance Workers	3,191	3,466	50,888	14.68	17
18	Housekeepers	11,378	12,229	109,030	8.92	18
19	Laundry	6,027	6,313	52,984	8.39	19
20	Administrator	1,881	2,088	83,430	39.96	20
21	Assistant Administrator					21
22	Other Administrative			53,400		22
23	Office Manager					23
24	Clerical	5,606	6,304	102,982	16.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,183	5,551	84,410	15.21	28
29	Resident Services Coordinator	1,854	2,088	72,125	34.54	29
30	Habilitation Aides (DD Homes)	61,064	64,296	641,934	9.98	30
31	Medical Records	1,186	1,210	12,801	10.58	31
32	Other Health Care(specify)	144	144	2,160	15.00	32
33	Other(specify) <u>Transportation</u>	3,244	3,567	39,302	11.02	33
34	TOTAL (lines 1 - 33)	176,307	187,159	\$ 2,472,174 *	\$ 13.21	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	98	\$ 4,903	1-3	35
36	Medical Director	Contract	14,400	9-3	36
37	Medical Records Consultant	18	642	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	300	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	92	1,835	11-3	44
45	Social Service Consultant	35	2,407	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	243	\$ 24,487		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	29	\$ 1,167	10-3	50
51	Licensed Practical Nurses	228	7,494	10-3	51
52	Certified Nurse Assistants/Aides	2,131	42,325	10-3	52
53	TOTAL (lines 50 - 52)	2,388	\$ 50,986		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 \$848.76
- (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? _____
- (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. \$ 24,026 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. \$ 49,410
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. \$ 5,522
- (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. \$ 17,064
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.
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The following is a breakdown of Schedule V Line 6 Column 3

Repairs & Maint. Dietary	\$6,190.33
Repairs & Maint. Laundry	\$2,807.51
Repairs & Maint. Housekeeping	\$0.00
Repairs & Maint. Equipment	\$17,444.11
Repairs & Maint. Ground	\$2,662.49
Repairs & Maint. Building	\$21,090.20
Repairs & Maint. Wheelchairs	\$192.39
Repairs & Maint. Outside services	\$28,022.03
Repairs & Maint. Gen/Admin.	\$8,885.22
Storage Rental	\$203.00
	<u>\$97,497.28</u>

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

Printing	\$46.10
Postage	\$4,861.71
Copier	\$3,373.88
Telephone	\$14,783.35
	<u>\$23,065.04</u>

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

Sales Tax	\$2,260.00
State Replacement Tax	\$3,511.00
Bank & service fees	\$2,383.23
Amortization of Loan Costs	\$5,349.27
Mutual contributions	\$0.00
Rounding	
	<u>\$13,503.50</u>

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

Bad Debt Expense	\$34,416.00
Misc. Exp.	\$1,078.89
Contributions	\$900.00
	<u>\$36,394.89</u>

The following is a breakdown of Schedule V Line 14, 25, 38 Column 3

Auto Repair Maint.	\$2,686.44
Auto Gas & Oil	<u>\$21,727.18</u>
* 10¢ to 25¢ 40¢ each to 14 & 38.	<u>\$24,413.62</u>

The following is a breakdown of Schedule XVII Line 28a

CSC Labor: Adm. Program	\$42,651.75
CSC Labor: Adm. Assist.	\$14,826.30
CSC Labor: Nursing Labor	\$14,940.00
CSC Labor: Maintenance	\$0.00
CSC Labor:Fica & Fed Ins.	\$0.00
CSC Labor-Fed Unemployment	\$0.00
CSC Labor-State Unemployment	\$0.00
CSC Labor-Administrative	\$0.00
Misc. Revenue	\$6.12
Personal Purchases Income	\$2,822.05
Office Lease	\$24,000.00
Discounts/Sabates	\$50.00
In-House Day Training Revenue	\$13,887.99
Gain/Loss on Sale of Asset	\$0.00
Income from Transportation (DDA Trans. Payrol)	\$17,063.82
Rounding	
	<u>\$230,248.01</u>

The following is a breakdown of Schedule XIX, Section F

AMID	\$320.00
Sam's Club	\$385.00
Misc Subscriptions	\$404.66
Health Account Fees	\$1,500.00
Sec of State Auto Reg.	\$415.50
Clinton County - Food Permit	\$55.00
Nurses Association	\$10.00
CMSE	\$168.00
CLIA	\$150.00
Rounding	-\$1.00
	<u>\$4,303.16</u>

Schedule XII, Section A.

Cha's 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.
1/6/08 thru 12/31/08

Date	Seminar	Location	Who Attended	Registration	Materials	Air Fare Mileage Auto Exp	Per Diem	Meals	Hotels	Refunded	Total
1/11/2008	AAIDD Meeting		Jim Lopresto						\$25.07		\$25.07
1/10/2008	Federal/State Wage Hour Seminar	Mt. Vernon, IL	Michael Brave	\$198.00							\$198.00
1/22/2008	DC Conference	Washington	Michael Brave	\$219.00					\$610.90		\$829.90 -\$789.22
2/15/2008	Medicare Part A & B Reimbursement for SNFs & Subacute	St. Louis, MO	Margie Holtgrave			\$51.51		\$17.96			\$69.47
2/19/2008	Medicaid Rule Changes What it means to Your Medicaid Reimbursement	LSN Audio Seminar	Daria Loomis	\$115.00							\$115.00
3/6/2008	Medicaid Restorative It's More Than Just One!	Springfield, IL	Daria Loomis Kristie Green	\$198.00		\$97.46					\$295.46
3/19/2008	Meeting the Psychosocial Survey Requirements for Residents in Long Term Care	St. Louis, MO	Mara Jackson Kelly Linck	\$338.00		\$45.93		\$19.78			\$403.71
4/8/2008	Illinois Healthcare Asso Technology Symposium	Springfield, IL	Michael Brave Cheryl Smith Holly Szopinski	Sic \$300.00 Siccs \$100.00							\$300.00 -\$100.00
4/8-9/08	Institute Meeting	Chicago, IL	Jim Lopresto	\$272.46		\$151.69	\$119.00		\$149.85		\$683.00
May	First Transit	Chicago, IL	Margie Holtgrave	\$250.00		\$384.83	\$112.00				\$746.83
5/20/2008	Culture Change a Tale of Transformation	Belleville, IL	Michael Brave Cheryl Smith Mara Jackson Kelly Linck John Davis Ashley Hitch Sandra Baker	\$385.00		n/a		n/a			\$385.00
5/21/2008	Human Rights Committee Training	Carbondale IL	Daniele Belva					\$12.90			\$12.90
6/3/2008	Clinical Updates in Mental Health & Developmental Disabilities	Springfield, IL	Daniele Belva Cristal Leonard	\$535.60		\$97.34	\$301.00	\$183.53			\$1,117.47
6/5/2008	*	*	Rita Hicks Emily Smith								
6/17-19/08	MDS RAC-CT Certification in 3 days Life Services Network	Fairview Heights, IL	Daria Loomis	\$450.00							\$450.00
7/17-18/08	Human Resources and the Law	Springfield	Joan Varej	\$499.00							\$499.00
6/25&6/26 7/9&7/10 7/16&7/17	Outcome Services 36 Hour Director	Springfield, IL Activity Course	Christine Blombe	\$360.00			\$220.50		\$325.74		\$906.24
8/4/78/11	Dietary Sanitaton Course	Belleville, IL	Kevin Lanter Cathie Lanter Nicole Maxwell	\$215.00							\$215.00
8/15/2008	Pioneer Network Culture Change	Washington	Michael Brave Cheryl Smith	\$1,480.00		\$518.00	\$456.00		\$1,225.85		\$3,679.85
25-Aug	Southwestern IL		Kayti Tipton	\$100.00							\$100.00
26-Aug	New Obra Regulations	Springfield, IL	Cathie Lanter	\$85.00		\$103.53					\$188.53
9/24/2008	The Institute on Public Policy For people with disabilities	Peru, IL	Jim Lopresto	\$279.00		\$224.00			\$320.34		\$823.34
10/14& 15-Oct	Culture Change Conference	Springfield, IL	Daria Loomis			\$95.96					\$95.96
10/13/2008	IL Pioneer Coalition Summit	Springfield, IL	Kristie Green Ashley Hitch Mara Jackson Chris Blomberg Cathie Lanter Deb Norbeck Cheryl Smith Daria Loomis Susan Hunter Michael Brave	\$1,185.00			\$747.25		\$837.15		\$2,769.40
				\$7,464.06		\$1,770.25	\$1,955.75	\$259.24	\$3,469.83	\$889.22	\$14,029.91

Clinton Manor Living Center, Inc.

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Schedule VII Attachment

Name	Function	Nursing Home	Ownership Interest	Compensation from other Nursing Homes
RDR Management	Management	St. Ann's Healthcare Ctr.	0	\$61,000.00
Greer Management	Management	St. Ann's Healthcare Ctr.	0	\$61,000.00
Mike Greer	Owner	St. Ann's Healthcare Ctr.	25	
Gail Greer	Owner	St. Ann's Healthcare Ctr.	25	
Blain Richard	Owner	St. Ann's Healthcare Ctr.	50	
Dar Mngt	Management	Southern Illinois Comm. Suppor	0	\$15,853.37
Greer Management	Management	Southern Illinois Comm. Suppor	0	\$15,853.37
Advanced Options	Management	Southern Illinois Comm. Suppor	0	\$31,706.77
RDR Management	Management	Southern Illinois Comm. Suppor	0	\$15,853.37

Clinton Manor Living Center, Inc.

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The following is a breakdown of the reclassifications:

1. Reclassify \$331.91 from Rent to Maintenance. Buildings supplies coded incorrectly.

2.

3

4

5

Clinton Manor Living Center, Inc.

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	dd med	dd pvt	med	med a	pvt	Total
Jan	1,493	31	733	110	220	2,587
Feb	1,377	29	675	92	222	2,395
Mar	1,462	31	651	158	222	2,524
Apr	1,449	30	603	160	262	2,504
May	1,497	31	652	73	254	2,507
Jun	1,429	30	658	115	153	2,385
Jul	1,470	8	684	113	158	2,433
Aug	1,500		678	167	217	2,562
Sep	1,471		604	179	255	2,509
Oct	1,529		633	135	283	2,580
Nov	1,446		562	145	330	2,483
Dec	1,473		606	68	314	2,461
	17,596	190	7,739	1,515	2,890	<u>29,930</u>