

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020 Report Period Beginning: 12/1/07 Ending: 11/30/08

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	<u>59</u>	Skilled (SNF)	<u>59</u>	<u>21,594</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>27</u>	Intermediate (ICF)	<u>27</u>	<u>9,882</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>86</u>	TOTALS	<u>86</u>	<u>31,476</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			<u>3,689</u>	<u>3,689</u>	8
9	SNF/PED					9
10	ICF	<u>9,586</u>	<u>5,505</u>		<u>15,091</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,586</u>	<u>5,505</u>	<u>3,689</u>	<u>18,780</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.66%

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

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

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

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

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

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

YES NO

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

YES NO

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

Date started / / 66

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 30 and days of care provided 3,689Medicare Intermediary NATIONAL GOVERNMENT SERVICES OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 11/30/08 Fiscal Year: 11/30/08

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/07 Ending: 11/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	134,425	10,683	6,859	151,967		151,967		151,967		1
2	Food Purchase		103,416		103,416		103,416	(927)	102,489		2
3	Housekeeping	49,695	10,469		60,164		60,164		60,164		3
4	Laundry	32,522	8,620		41,142		41,142		41,142		4
5	Heat and Other Utilities			97,930	97,930		97,930		97,930		5
6	Maintenance	39,054	33,386	47,034	119,474		119,474	10,583	130,057		6
7	Other (specify):* Utility Workers	19,183			19,183		19,183		19,183		7
8	TOTAL General Services	274,879	166,574	151,823	593,276		593,276	9,656	602,932		8
	B. Health Care and Programs										
9	Medical Director	12,066		12,000	24,066		24,066		24,066		9
10	Nursing and Medical Records	953,766	406,492	57,709	1,417,967	(281,413)	1,136,554	8,548	1,145,102		10
10a	Therapy	37,924	5,248	333,004	376,176	(333,004)	43,172		43,172		10a
11	Activities	71,555	3,451		75,006		75,006		75,006		11
12	Social Services	21,910		5,632	27,542		27,542		27,542		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,097,221	415,191	408,345	1,920,757	(614,417)	1,306,340	8,548	1,314,888		16
	C. General Administration										
17	Administrative	48,847		5,251	54,098	1,730	55,828	28,763	84,591		17
18	Directors Fees										18
19	Professional Services			148,573	148,573		148,573	(139,641)	8,932		19
20	Dues, Fees, Subscriptions & Promotions			32,462	32,462		32,462	(13,720)	18,742		20
21	Clerical & General Office Expenses	81,416	18,107	3,812	103,335		103,335	29,020	132,355		21
22	Employee Benefits & Payroll Taxes			303,702	303,702		303,702	267	303,969		22
23	Inservice Training & Education			4,152	4,152		4,152	863	5,015		23
24	Travel and Seminar			8,306	8,306	(4,578)	3,728	790	4,518		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			36,388	36,388		36,388	353	36,741		26
27	Other (specify):*			52,939	52,939		52,939	(37,578)	15,361		27
28	TOTAL General Administration	130,263	18,107	595,585	743,955	(2,848)	741,107	(130,883)	610,224		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,502,363	599,872	1,155,753	3,257,988	(617,265)	2,640,723	(112,679)	2,528,044		29

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER #0003020 Report Period Beginning: 12/1/07 Ending: 11/30/08

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			15,527	15,527		15,527	7,310	22,837		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			30,789	30,789		30,789		30,789		33
34	Rent-Facility & Grounds							3,513	3,513		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			46,316	46,316		46,316	10,823	57,139		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					617,265	617,265		617,265		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			47,214	47,214		47,214		47,214		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			47,214	47,214	617,265	664,479		664,479		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,502,363	599,872	1,249,283	3,351,518		3,351,518	(101,856)	3,249,662		45

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

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning: 12/1/07

Ending: 11/30/08

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,233	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(324)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,815)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(492)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,124)	27		24
25	Fund Raising, Advertising and Promotional	(13,016)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(821)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(927)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,286)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(39,570)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (39,570)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (101,856)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39	<u>THERAPY</u>	X		333,004		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		18,596		42
43	Prescription Drugs	X		208,216		43
44	<u>OXYGEN</u>	X		18,049		44
45	Other-Attach Schedule <u>SUPPLIES</u>	X		7,359		45
46	Other-Attach Schedule <u>AMBULANCE</u>	X		32,041		46
47	TOTAL (C): (sum of lines 38-46)			\$ 617,265		47

BHF USE ONLY					
48		49		50	51
					52

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/1/07

Ending: 11/30/08

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	355	0	0	0	0	0	0	0	0	0	355	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(492)	(139,451)	0	0	0	0	0	0	0	0	0	(139,943)	19
20	Fees, Subscriptions & Promotions	(13,837)	0	0	0	0	0	0	0	0	0	0	(13,837)	20
21	Clerical & General Office Expenses	(324)	0	0	0	0	0	0	0	0	0	0	(324)	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	(355)	0	0	0	0	0	0	0	0	0	(355)	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):*	(52,939)	0	0	0	0	0	0	0	0	0	0	(52,939)	27
28	TOTAL General Administration	(67,592)	(139,451)	0	0	0	0	0	0	0	0	0	(207,043)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(67,592)	(139,451)	0	0	0	0	0	0	0	0	0	(207,043)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	6,233	0	0	0	0	0	0	0	0	0	0	6,233	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	6,233	0	0	0	0	0	0	0	0	0	0	6,233	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(61,359)	(139,451)	0	(200,810)	45								

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/07

Ending:

11/30/08

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 MANAGEMENT FEE	\$ 146,050	NURSING HOME MANAGERS		\$	\$ (146,050)	1
2	V	VAR SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS		99,881	99,881	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		6,599	6,599	3
4	V	24 TRAVEL	355	TO TRANSFER 31% OF HOME OFFICE TRAVE			(355)	4
5	V	17 ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		355	355	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 146,405			\$ 106,835	\$ * (39,570)	14

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/07 Ending: 11/30/08

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	ROBERT SCHAFFER	MED. DIRECTOR	MED. DIRECTOR	25.00		6	12.00		\$ 12,066	9-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,066		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning: 12/1/07

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	SEE ATTACHED SCHEDULES				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	SAM KLEIN	X		WORKING CAPITAL		5/30/03	25,000	150,000	DEMAND	0.0400	6									
7										7										
8										8										
9	TOTAL Facility Related						\$ 25,000	\$ 150,000			9									
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related						\$	\$			14									
15	TOTALS (line 9+line14)						\$ 25,000	\$ 150,000			15									

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 27,552	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.)		\$ 30,439	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 2,887	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 27,902	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.		\$ 30,789	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	13,917	8
	2004	29,600	9
	2005	30,375	10
	2006	30,057	11
	2007	30,439	12
LINE 4 ACCRUAL: 11/12 OF \$30,439 = \$27,902			
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, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MENARD CONVALESCENT CENTER COUNTY MENARD

FACILITY IDPH LICENSE NUMBER 0003020

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 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>11-14-219-006</u>	<u>NURSING HOME</u>	\$ <u>311.74</u>	\$ <u>311.74</u>
2. <u>11-14-228-002</u>	<u>NURSING HOME</u>	\$ <u>885.90</u>	\$ <u>885.90</u>
3. <u>11-14-228-001</u>	<u>NURSING HOME</u>	\$ <u>25,103.10</u>	\$ <u>25,103.10</u>
4. <u>11-14-227-001</u>	<u>NURSING HOME</u>	\$ <u>2,493.62</u>	\$ <u>2,493.62</u>
5. <u>11-14-219-009</u>	<u>NURSING HOME</u>	\$ <u>1,332.72</u>	\$ <u>1,332.72</u>
6. <u>11-14-229-001</u>	<u>NURSING HOME</u>	\$ <u>311.74</u>	\$ <u>311.74</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>30,438.82</u>	\$ <u>30,438.82</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 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 MENARD CONVALESCENT CENTER

0003020 Report Period Beginning:

12/1/07 Ending:

11/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,211 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

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

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

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

Report Period Beginning:

12/1/07

Ending:

11/30/08**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	54		1966	1966	\$ 172,985	\$	30	\$	\$	\$ 172,985	4
5	32		1974	1974	148,705		30			148,705	5
6											6
7											7
8											8
	Improvement Type**										
9		LANDSCAPING	1966		5,308					5,308	9
10		FIRE DOORS	1979		1,433					1,433	10
11		FIRE DOORS	1981		8,340					8,340	11
12		BATHROOM	1984		7,335		30	245	245	5,998	12
13		AIR CONDITIONER	1984		1,100		8			1,100	13
14		ELECTRICAL & PLUMBING	1985		11,117		15			11,117	14
15		PLUMBING	1986		4,921		15			4,921	15
16		SMOKE DETECTORS	1986		10,445		25	418	418	9,404	16
17		AIR CONDITIONER	1986		2,235		10			2,235	17
18		PLUMBING	1986		1,145		20			1,145	18
19		ROOF	1987		6,362	105	20	35	(70)	6,362	19
20		WATER HEATER & WINDOWS	1988		6,530	207	15		(207)	6,530	20
21		NURSE CALL	1988		1,674	53	10		(53)	1,674	21
22		ROOF	1989		30,672	974	20	1,533	559	29,910	22
23		WATER HEATER & PARKING LOT	1989		11,502	365	15		(365)	11,502	23
24		FURNACE & FLOORING	1990		19,165	608	15		(608)	19,165	24
25		AIR CONDITIONER	1991		2,633	84	15		(84)	2,633	25
26		PLUMBING FAUCETS	1992		8,909	283	15	134	(149)	8,909	26
27		DOOR ALARM	1992		1,572	50	20	80	30	1,418	27
28		WATER HEATER & GARAGE DOOR	1993		4,348	138	15	123	(15)	4,327	28
29		WATER HEATER & PLUMBING	1994		5,074	130	15	338	208	4,904	29
30		LANDSCAPING	1994		3,900	138	15	260	122	3,705	30
31		AIR CONDITIONER & ROOF	1995		7,049	181	15	470	289	6,344	31
32		REMODEL BATHROOMS - TILE, CEILING, FIXTURES	1996		19,751	506	15	1,317	811	16,460	32
33		AIR CONDITIONER	1997		1,710	44	15	114	70	1,311	33
34		FIRE DAMPERS	1998		4,076	105	15	272	167	2,854	34
35		FURNACE	1998		2,200	56	15	145	89	1,540	35
36		GREASE TRAP	1999		2,824	72	15	188	116	1,788	36

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

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

See Page 12A, Line 70 for total

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

0003020

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	CEILING REPAIR	2002	\$ 4,935	\$ 127	15	\$ 329	\$ 202	\$ 2,276	37
38	AIR CONDITIONING	2002	2,102	54	15	140	86	864	38
39	AIR CONDITIONING & VENTILATION	2004	4,935	127	10	493	366	2,385	39
40	WATER HEATER	2004	1,675	43	15	111	68	456	40
41	DOORS & CONCRETE	2005	33,052	847	20	1,653	806	6,610	41
42	SMOKE DAMPERS	2006	4,504	115	15	301	186	876	42
43	SIDEWALKS	2006	2,480	64	20	124	60	341	43
44	SECURITY DOORS	2006	4,897	126	20	244	118	673	44
45	FIRE SUPPRESSION SYSTEM	2006	1,879	48	25	75	27	188	45
46	AIR CONDITIONING	2007	2,260	58	15	150	92	213	46
47	FLOORING	2007	2,098	54	10	210	156	245	47
48	LANDSCAPING	2007	888	217	15	59	(158)	103	48
49	WATER HEATER & DRAFT INDUCER	2008	6,133	125	15	307	182	307	49
50	HANDRAILS	2008	3,950	55	15	154	99	154	50
51	DOOR & FRAME	2008	3,290	32	10	110	78	110	51
52	WATER HEATER	2008	4,424	14	15	25	11	25	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)		\$ 598,522	\$ 6,205		\$ 10,157	\$ 3,952	\$ 519,853	70

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/07 Ending: 11/30/08

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	\$ 108,963	\$ 6,800	\$ 10,306	\$ 3,506	VAR	\$ 69,645	71
72	Current Year Purchases	17,122	2,522	1,297	(1,225)	VAR	1,297	72
73	Fully Depreciated Assets	211,003					211,003	73
74	ASSETS NO LONGER IN SERVICE	(73,230)					(73,230)	74
75	TOTALS	\$ 263,858	\$ 9,322	\$ 11,603	\$ 2,281		\$ 208,715	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 872,299	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,527	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,760	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,233	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 728,568	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	1,911	\$ 133,437	\$	1,911	\$ 133,437	1
2	Licensed Speech and Language Development Therapist		hrs		404	24,313		404	24,313	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,504	175,254		3,504	175,254	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				208,216		208,216	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab, Xray, Oxygen, Supp, Amb						76,045		76,045	13
14	TOTAL			\$	5,819	\$ 333,004	\$ 284,261	5,819	\$ 617,265	14

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/07 Ending: 11/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/08 (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	\$ 19,661	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,042,167		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,309		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,087,137	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	598,523		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	332,634		16
17	Accumulated Depreciation (book methods)	(764,280)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 176,796	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,263,933	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,648,547	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,441		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,039		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,902		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,717,929	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,717,929	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (453,996)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,263,933	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (97,456)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (97,456)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(356,540)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (356,540)	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)	\$ (453,996)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020Report Period Beginning: 12/1/07Ending: 11/30/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,920,991	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,920,991	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	67,458	6
7	Oxygen	4,465	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 71,923	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	533	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 533	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING 927 ADMIT FEE 300	1,227	28
28a	DAYCARE 280 W/A 24	304	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,531	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,994,978	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	593,276	31
32	Health Care	1,920,757	32
33	General Administration	743,955	33
B. Capital Expense			
34	Ownership	46,316	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	47,214	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,351,518	40
41	Income before Income Taxes (line 30 minus line 40)**	(356,540)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (356,540)	43

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

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

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	1,442	1,522	\$ 34,922	\$ 22.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,261	5,500	147,685	26.85	3
4	Licensed Practical Nurses	15,738	16,683	290,404	17.41	4
5	CNAs & Orderlies	44,744	45,795	480,755	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,404	3,597	37,924	10.54	8
9	Activity Director	1,538	1,681	21,427	12.75	9
10	Activity Assistants	5,108	5,269	50,128	9.51	10
11	Social Service Workers	1,868	1,970	21,910	11.12	11
12	Dietician					12
13	Food Service Supervisor	2,200	2,328	28,386	12.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,072	11,405	106,039	9.30	15
16	Dishwashers					16
17	Maintenance Workers	3,927	4,048	39,054	9.65	17
18	Housekeepers	5,805	5,913	49,695	8.40	18
19	Laundry	3,413	3,780	32,522	8.60	19
20	Administrator	2,046	2,126	48,847	22.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,959	6,284	81,416	12.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	146	146	12,066	82.64	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Utility Workers</u>	1,855	1,962	19,183	9.78	33
34	TOTAL (lines 1 - 33)	115,526	120,009	\$ 1,502,363 *	\$ 12.52	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	182	\$ 6,859	1-3	35
36	Medical Director	100	12,000	9-3	36
37	Medical Records Consultant	16	515	10-3	37
38	Nurse Consultant	788	36,021	10-3	38
39	Pharmacist Consultant	88	2,349	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	90	5,631	12-3	45
46	Other(specify) <u>PSYCH CONSULTANT</u>	24	6,000	10-3	46
47	<u>ADMINISTRATIVE CONSULTANT</u>	208	5,251	17-3	47
48					48
49	TOTAL (lines 35 - 48)	1,496	\$ 74,626		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	212	6,151	10-3	51
52	Certified Nurse Assistants/Aides	22	394	10-3	52
53	TOTAL (lines 50 - 52)	234	\$ 6,545		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 303 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 47,214
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$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.

SCHEDULE V - PAGES 3 & 4

SCHEDULE V - PAGE 3 - LINE 24 - COLUMN 8

OTHER GENERAL ADMINISTRATION
PAGE 3 - LINE 27 - COLUMN 3

SALES TAX	\$ 3,815
BAD DEBT	49,124
	<u>\$ 52,939</u>

PAGE 3 - LINE 27 - COLUMN 8

NHM ALLOCATION - PER 2004 DESK REVIEW	<u>\$ 15,361</u>
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COLUMN 5 - RECLASSIFICATIONS

RECLASS FROM:

		LINE #
AMBULANCE	\$ (32,041)	10
X - RAYS	(6,488)	10
LABS	(12,108)	10
MEDICARE DRUGS	(190,532)	10
IV'S	(17,684)	10
MEDICARE SUPPLIES	(7,359)	10
OXYGEN	(18,049)	10
PHYSICAL THERAPY	(175,254)	10A
SPEECH THERAPY	(24,313)	10A
OCCUPATIONAL THERAPY	<u>(133,437)</u>	10A

RECLASS TO:

ANCILLARY	<u>\$ 617,265</u>	39
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RECLASS TO:

NURSE CONSULTANT TRAVEL	\$ 2,848	10
ADMINISTRATIVE CONS. TRAVEL	<u>1,730</u>	17

RECLASS FROM:

TRAVEL	<u>\$ (4,578)</u>	24
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DETAIL - TRAVEL

ADMINISTRATIVE REIMBURSEMENT	\$ 1,534
ACTIVITY & SOCIAL SERVICE TRAVEL	2,194
NHM ALLOCATION	790
	<u>\$ 4,518</u>

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 21,760
NURSING HOME MANAGERS ALLOCATION	<u>1,077</u>

SCHEDULE V - LINE 30 - COLUMN 8

	<u>\$ 22,837</u>
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SCHEDULE XVII - PAGE 19

RECONCILIATION OF INCOME

LINE 41 - NET INCOME	\$ (356,540)
* ACCRUED MANAGEMENT FEE 11/07	(34,615)
* ACCRUED MANAGEMENT FEE 11/08	0
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	<u>(120)</u>
TAXABLE INCOME	<u>\$ (391,275)</u>

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

SCHEDULE V - PAGE 3 - LINE 23 - COLUMN 8

DETAIL - INSERVICE TRAINING & EDUCATION

DIETARY MEETINGS	\$ 35
ACTIVITY MEETING	145
HOME OFFICE INSERVICES	2,607
CPR TRAINING	670
ADMINISTRATOR WORKSHOP	695
NURSING HOME MANAGERS ALLOCATIC	<u>863</u>
	<u>\$ 5,015</u>

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

CLIA LAB FEE	\$ 150
FOOD SERVICE PERMIT	150
DUES & SUBSCRIPTIONS	200
FRANCHISE FEE	<u>105</u>
	<u>\$ 605</u>

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS
WORKED BASED UPON TIME CARDS.

SCHEDULE V - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION
 MENARD
 2007

	DEC 07	JAN 08	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2007 TOTAL	LINE #
SALARIES-ADMIN	1,129	\$1,158	\$1,161	\$1,180	\$1,232	\$1,377	\$1,361	\$1,296	\$653	\$665	\$639	\$652	\$12,501	17
SALARIES-CLERIC	1,748	1,871	1,875	1,905	1,989	2,225	2,198	2,093	2,552	2,599	2,497	2,549	26,100	21
SALARIES-CONTR	967	930	932	947	989	1,106	1,093	1,040	1,978	2,014	1,936	1,975	15,907	17
SALARIES-NURSE	243	535	536	545	569	636	629	598	641	653	628	641	6,854	10
ACCOUNTING	46	86	86	87	91	102	101	96	(98)	(100)	(96)	(98)	302	19
WORK COMP INS	21	40	40	41	42	47	47	45	(14)	(14)	(14)	(14)	267	22
SUPPLIES	71	96	96	97	102	114	112	107	176	179	172	176	1,499	21
TELEPHONE	82	148	148	150	157	176	173	165	137	139	134	136	1,745	21
EMPL BENEFITS	829	684	685	696	727	813	803	765	1,131	1,151	1,107	1,129	10,521	27
PAYROLL TAXES	371	337	338	343	359	401	396	377	480	489	470	479	4,840	27
TRAVEL	48	86	86	87	91	102	101	96	112	114	110	112	1,145	24
IN SERVICE	141	71	71	73	76	85	84	80	46	47	45	46	863	23
MEDICAL CONSULT	182	143	143	146	152	170	168	160	(225)	(229)	(220)	(225)	366	10
MACHINE RENTAL	387	474	475	483	504	564	557	530	751	765	735	750	6,974	6
OWNERS COMP	0	0	0	0	0	0	0	0	0	0	0	0	0	17
INS-PROP,LIAB,WC	85	3	3	3	3	4	4	4	61	62	60	61	353	26
DEPRECIATION	112	117	118	120	125	140	138	131	19	19	18	19	1,077	30
RENT	275	274	275	279	292	326	322	307	291	297	285	291	3,513	34
MAINTENANCE	246	448	449	456	476	533	526	501	(7)	(7)	(6)	(7)	3,609	6
FEES & PUBLICAT	34	7	7	7	7	8	8	7	8	8	8	8	117	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	(212)	0	0	0	0	0	0	0	386	393	377	385	1,328	10
TOTAL	6,806	\$7,506	\$7,523	\$7,646	\$7,982	\$8,928	\$8,821	\$8,399	\$9,078	\$9,243	\$8,883	\$9,066	\$99,881	
FIXED ASSETS	0												99,881	
EQUIP - PRIOR	9,119	9,296	9,317	9,469	9,885	11,057	10,924	10,401	10,442	10,633	10,218	10,429	10,099	
EQUIP - CURR	1,190	192	192	195	204	228	225	3,307	3,320	3,381	3,249	3,316	1,583	
EQUIP - FULLY DEP	3,282	3,589	3,597	3,656	3,816	4,268	4,217	4,015	4,031	4,105	3,945	4,026	3,879	
BLDG - PRIOR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	971	916	918	933	974	1,089	1,076	1,025	1,029	1,048	1,007	1,028	1,001	

ALLOCATION PERCENTAGES
USED ON MONTHLY ALLOCATIONS - PAGE 27

OCCUPIED DAYS 2007	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,105	2,057	2,233		1,442	1,831	9,668
FEBRUARY	1,883	1,964	1,995		1,398	1,661	8,901
MARCH	2,115	2,213	2,327		1,564	1,816	10,035
APRIL	2,110	2,059	2,367		1,470	1,786	9,792
MAY	2,143	2,106	2,417		1,514	1,774	9,954
JUNE	2,064	2,099	2,224		1,533	1,698	9,618
JULY	2,163	2,215	2,305		1,590	1,731	10,004
AUGUST	2,265	2,186	2,329		1,594	1,714	10,088
SEPTEMBER	2,297	2,135	2,316		1,480	1,606	9,834
OCTOBER	2,414	2,286	2,309		1,478	1,693	10,180
NOVEMBER	2,208	2,308	2,308		1,423	1,649	9,896
DECEMBER	2,162	2,394	2,490		1,505	1,868	10,419
TOTAL	25,929	26,022	27,620	0	17,991	20,827	118,389 118,389

ALLOCATION PERCENTAGE 2007	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	21.77%	21.28%	23.10%	14.92%	18.94%	100.00%
FEBRUARY	21.15%	22.06%	22.41%	15.71%	18.66%	100.00%
MARCH	21.08%	22.05%	23.19%	15.59%	18.10%	100.00%
APRIL	21.55%	21.03%	24.17%	15.01%	18.24%	100.00%
MAY	21.53%	21.16%	24.28%	15.21%	17.82%	100.00%
JUNE	21.46%	21.82%	23.12%	15.94%	17.65%	100.00%
JULY	21.62%	22.14%	23.04%	15.89%	17.30%	100.00%
AUGUST	22.45%	21.67%	23.09%	15.80%	16.99%	100.00%
SEPTEMBER	23.36%	21.71%	23.55%	15.05%	16.33%	100.00%
OCTOBER	23.71%	22.46%	22.68%	14.52%	16.63%	100.00%
NOVEMBER	22.31%	23.32%	23.32%	14.38%	16.66%	100.00%
DECEMBER	20.75%	22.98%	23.90%	14.44%	17.93%	100.00%

OCCUPIED DAYS 2008	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,239	2,512	2,573		1,460	1,936	10,720
FEBRUARY	2,140	2,453	2,399		1,407	1,909	10,308
MARCH	2,260	2,436	2,476		1,475	1,985	10,632
APRIL	2,248	2,186	2,456		1,483	1,867	10,240
MAY	2,356	2,118	2,479		1,731	2,002	10,686
JUNE	2,283	2,143	2,410		1,661	1,881	10,378
JULY	2,369	2,288	2,429		1,632	1,992	10,710
AUGUST	2,137	2,345	2,451		1,620	2,036	10,589
SEPTEMBER	1,988	2,459	2,376		1,627	1,994	10,444
OCTOBER	1,980	2,561	2,592		1,605	1,983	10,721
NOVEMBER	1,777	2,428	2,482		1,567	2,002	10,256
DECEMBER	1,901	2,534	2,445		1,611	2,009	10,500
TOTAL	25,678	28,463	29,568	0	18,879	23,596	126,184 126,184

ALLOCATION PERCENTAGE 2008	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	20.89%	23.43%	24.00%	13.62%	18.06%	100.00%
FEBRUARY	20.76%	23.80%	23.27%	13.65%	18.52%	100.00%
MARCH	21.26%	22.91%	23.29%	13.87%	18.67%	100.00%
APRIL	21.95%	21.35%	23.98%	14.48%	18.23%	100.00%
MAY	22.05%	19.82%	23.20%	16.20%	18.73%	100.00%
JUNE	22.00%	20.65%	23.22%	16.01%	18.12%	100.00%
JULY	22.12%	21.36%	22.68%	15.24%	18.60%	100.00%
AUGUST	20.18%	22.15%	23.15%	15.30%	19.23%	100.00%
SEPTEMBER	19.03%	23.54%	22.75%	15.58%	19.09%	100.00%
OCTOBER	18.47%	23.89%	24.18%	14.97%	18.50%	100.00%
NOVEMBER	17.33%	23.67%	24.20%	15.28%	19.52%	100.00%
DECEMBER	18.10%	24.13%	23.29%	15.34%	19.13%	100.00%