FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0003020

Facility Name: MENARD CONVALESCENT CENTER

Address: 120 ANTLE STREET (Number) PETERSBURG (City) 62675 (Zip Code)

County: MENARD

Telephone Number: (217) 632-2249 **Fax #** (217) 632-2314

HFS ID Number:

Date of Initial License for Current Owners: 12/1/66

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/09 to 11/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	59	Skilled (SNF)	59	21,535	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,426	2,426	8
9	SNF/PED					9
10	ICF	11,176	3,117		14,293	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,176	3,117	2,426	16,719	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.26%

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)
NONE

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 [X]

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 2,426

Medicare Intermediary NATIONAL GOVERNMENT SERVICE OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/10 Fiscal Year: 11/30/10

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	123,791	17,518	6,978	148,287		148,287		148,287			1
2	Food Purchase		114,893		114,893		114,893	(2,277)	112,616			2
3	Housekeeping	45,212	10,652		55,864		55,864		55,864			3
4	Laundry	39,825	9,503		49,328		49,328		49,328			4
5	Heat and Other Utilities			108,486	108,486		108,486		108,486			5
6	Maintenance	37,173	37,729	71,259	146,161		146,161	8,743	154,904			6
7	Other (specify):* Utility Workers	23,690			23,690		23,690		23,690			7
8	TOTAL General Services	269,691	190,295	186,723	646,709		646,709	6,466	653,175			8
	B. Health Care and Programs											
9	Medical Director	12,033		12,000	24,033		24,033		24,033			9
10	Nursing and Medical Records	968,465	217,218	57,486	1,243,169	(139,114)	1,104,055	8,219	1,112,274			10
10a	Therapy	28,586	9,719	224,505	262,810	(224,505)	38,305		38,305			10a
11	Activities	47,541	1,812		49,353		49,353		49,353			11
12	Social Services	13,664		4,810	18,474		18,474		18,474			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,070,289	228,749	298,801	1,597,839	(363,619)	1,234,220	8,219	1,242,439			16
	C. General Administration											
17	Administrative	54,847		21,565	76,412	4,069	80,481	26,356	106,837			17
18	Directors Fees											18
19	Professional Services			128,373	128,373		128,373	(116,438)	11,935			19
20	Dues, Fees, Subscriptions & Promotions			29,599	29,599		29,599	(15,783)	13,816			20
21	Clerical & General Office Expenses	94,538	15,075	4,693	114,306		114,306	35,585	149,891			21
22	Employee Benefits & Payroll Taxes			243,269	243,269		243,269	308	243,577			22
23	Inservice Training & Education			3,910	3,910		3,910	1,196	5,106			23
24	Travel and Seminar			7,620	7,620	(5,269)	2,351	666	3,017			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			33,893	33,893		33,893	404	34,297			26
27	Other (specify):*			372,749	372,749		372,749	(355,059)	17,690			27
28	TOTAL General Administration	149,385	15,075	845,671	1,010,131	(1,200)	1,008,931	(422,765)	586,166			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,489,365	434,119	1,331,195	3,254,679	(364,819)	2,889,860	(408,080)	2,481,780			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: 12/1/09 Ending: 11/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			13,421	13,421		13,421	9,650	23,071			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			31,222	31,222		31,222		31,222			33
34	Rent-Facility & Grounds							7,705	7,705			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			44,643	44,643		44,643	17,355	61,998			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					364,819	364,819		364,819			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			47,085	47,085	364,819	411,904		411,904			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,489,365	434,119	1,422,923	3,346,407		3,346,407	(390,725)	2,955,682			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: 12/1/09 Ending: 11/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$ (1,920)	2	$	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	8,275	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(299)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,286)	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	(458)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(369,463)	27		24
25	Fund Raising, Advertising and Promotional	(14,739)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,170)	20		28
29	Other-Attach Schedule	(2,877)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (385,937)		$	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 Amount	2 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)	(4,788)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (4,788)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (390,725)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		224,505	10A-3	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		9,330	10-2	42
43	Prescription Drugs	X		95,872	10-2	43
44	AMBULANCE	X		15,387	10-2	44
45	Other-Attach Schedule OXYGEN	X		17,879	10-2	45
46	Other-Attach Schedule SUPPLIES	X		1,846	10-2	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 364,819		47

STATE OF ILLINOIS

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/1/09

Ending: 11/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	EXPENSE REIMBURSEMENT - SALARY	$ (2,520)	21	1
2	VENDING	(357)	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**	(2,877)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,277)	0	0	0	0	0	0	0	0	0	0	(2,277)	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**	(2,277)	0	0	0	0	0	0	0	0	0	0	(2,277)	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	299	0	0	0	0	0	0	0	0	0	299	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(458)	(116,172)	0	0	0	0	0	0	0	0	0	(116,630)	19
20	Fees, Subscriptions & Promotions	(15,909)	0	0	0	0	0	0	0	0	0	0	(15,909)	20
21	Clerical & General Office Expenses	(2,819)	0	0	0	0	0	0	0	0	0	0	(2,819)	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	(299)	0	0	0	0	0	0	0	0	0	(299)	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):*	(372,749)	0	0	0	0	0	0	0	0	0	0	(372,749)	27
28	**TOTAL General Administration**	(391,935)	(116,172)	0	0	0	0	0	0	0	0	0	(508,107)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(394,212)	(116,172)	0	0	0	0	0	0	0	0	0	(510,384)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,275	0	0	0	0	0	0	0	0	0	0	8,275	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**	8,275	0	0	0	0	0	0	0	0	0	0	8,275	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)**	(385,937)	(116,172)	0	0	0	0	0	0	0	0	0	(502,109)	45

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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			
BERRY 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 121,739	NURSING HOME MANAGERS		$	$ (121,739)	1
2	V	VAR	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS		111,384	111,384	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		5,567	5,567	3
4	V	24	TRAVEL	299	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(299)	4
5	V	17	ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		299	299	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			$ 122,038			$ 117,250	$ * (4,788)	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: 12/1/09 Ending: 11/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT SCHAFER	MED DIRECTOR	MED DIRECTOR	25.00		6	12.00		$ 12,033	9-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,033		13

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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 [X] NO [ ]

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

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	4.0000		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.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 28,432	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.)		$ 31,124	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,692	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 28,530	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.		$ 31,222	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	30,375	8
	2006	30,057	9
	2007	30,439	10
	2008	31,017	11
	2009	31,124	12

LINE 4 - 11/12 OF 31124 = 28530

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-229-001	NURSING HOME	$ 318.72	$ 318.72
2.	11-14-227-001	NURSING HOME	$ 2,549.78	$ 2,549.78
3.	11-14-228-001	NURSING HOME	$ 25,668.08	$ 25,668.08
4.	11-14-228-002	NURSING HOME	$ 905.84	$ 905.84
5.	11-14-219-009	NURSING HOME	$ 1,362.70	$ 1,362.70
6.	11-14-219-006	NURSING HOME	$ 318.72	$ 318.72
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,123.84	$ 31,123.84

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 12/1/09 Ending: 11/30/10

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? [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	43,436	1963-1964	$ 9,919	1
2					2
3	TOTALS	43,436		$ 9,919	3

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54			1966	$ 172,985	$	30	$	$	$ 172,985	4
5	32			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	6,487	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	417	417	10,239	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	106	20		(106)	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	251	(723)	30,672	22
23	WATER HEATER & PARKING LOT			1989	11,502	366	15		(366)	11,502	23
24	FURNACE & FLOORING			1990	19,165	609	15		(609)	19,165	24
25	AIR CONDITIONER			1991	2,633	84	15		(84)	2,633	25
26	PLUMBING FAUCETS			1992	8,909	283	15		(283)	8,909	26
27	DOOR ALARM			1992	1,572	50	20	75	25	1,572	27
28	WATER HEATER & GARAGE DOOR			1993	4,348	139	15		(139)	4,348	28
29	WATER HEATER & PLUMBING			1994	5,074	130	15	80	(50)	5,074	29
30	LANDSCAPING			1994	3,900		15			3,900	30
31	AIR CONDITIONER & ROOF			1995	7,049	181	15	235	54	7,049	31
32	REMODEL BATHROOMS - TILE, CEILING, FIXTURES			1996	19,751	507	15	1,317	810	19,094	32
33	AIR CONDITIONER			1997	1,710	44	15	114	70	1,539	33
34	FIRE DAMPERS			1998	4,076	105	15	272	167	3,397	34
35	FURNACE			1998	2,200	56	15	146	90	1,833	35
36	GREASE TRAP			1999	2,824	72	15	189	117	2,165	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: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CEILING REPAIR	2002	$ 4,935	$ 127	15	$ 329	$ 202	$ 2,934	37
38	AIR CONDITIONING	2002	2,102	54	15	141	87	1,145	38
39	AIR CONDITIONING & VENTILATION	2004	4,935	127	10	493	366	3,372	39
40	WATER HEATER	2004	1,675	43	15	111	68	680	40
41	DOORS & CONCRETE	2005	33,052	847	20	1,653	806	9,916	41
42	SMOKE DAMPERS	2006	4,504	115	15	299	184	1,476	42
43	SIDEWALKS	2006	2,480	64	20	124	60	589	43
44	SECURITY DOORS	2006	4,897	126	20	245	119	1,163	44
45	FIRE SUPPRESSION SYSTEM	2006	1,879	48	25	75	27	338	45
46	AIR CONDITIONING	2007	2,260	58	15	151	93	515	46
47	FLOORING	2007	2,098	54	10	210	156	665	47
48	LANDSCAPING	2007	888	111	15	60	(51)	222	48
49	WATER HEATER & DRAFT INDUCER	2008	6,133	157	15	409	252	1,124	49
50	HANDRAILS	2008	3,950	101	15	263	162	680	50
51	DOOR & FRAME	2008	3,290	84	10	329	245	768	51
52	WATER HEATER	2008	4,424	113	15	295	182	615	52
53	BASEBOARD HEATERS	2009	2,245	58	20	112	54	215	53
54	AIR CONDITIONING	2009	8,652	222	20	432	210	792	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)		$ 609,419	$ 6,475		$ 9,072	$ 2,597	$ 538,642	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: 12/1/09 Ending: 11/30/10

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	$ 122,259	$ 6,946	$ 12,624	$ 5,678	VAR	$ 82,934	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	224,281					224,281	73
74	ASSETS NO LONGER IN SERVICE	(73,230)					(73,230)	74
75	TOTALS	$ 273,310	$ 6,946	$ 12,624	$ 5,678		$ 233,985	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)	$ 892,648	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,421	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 21,696	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,275	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 772,627	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.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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? ☐ YES ☐ NO
   If NO, see instructions.

		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.	/2011	$
13.	/2012	$
14.	/2013	$

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.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

		1	2	3	4	5	6	7	8	
	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	10A-3	hrs	$	2,416	$ 104,231	$	2,416	$ 104,231	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		489	33,944		489	33,944	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,246	86,330		1,246	86,330	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10-2	# of prescrpts				95,872		95,872	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABS, XRAY, AMB.	10-2					24,717		24,717	12
13	Other (specify): SUPPLIES, OXYGEN	10-2					19,725		19,725	13
14	TOTAL			$	4,151	$ 224,505	$ 140,314	4,151	$ 364,819	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 MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/10 (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	$ 181,348	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	841,547		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,224		6
7	Other Prepaid Expenses	19,603		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,060,722	$	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	609,420		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	342,086		16
17	Accumulated Depreciation (book methods)	(800,329)		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)**	$ 161,096	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,221,818	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,845,295	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,081		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,617		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,530		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)**	$ 2,918,523	$	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)**	$ 2,918,523	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,696,705)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,221,818	$	48

***(See instructions.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (833,431)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (833,431)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(863,274)	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)**	$ (863,274)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,696,705)	24 *

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,677,619	1
2	Discounts and Allowances for all Levels	(242,836)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,434,783	3
	B. Ancillary Revenue		
4	Day Care	1,920	4
5	Other Care for Outpatients		5
6	Therapy	37,332	6
7	Oxygen	5,584	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 44,836	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***	305	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 305	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING 357, BAD DEBT RECOVERY 33, W/A 24	414	28
28a	EXP. REIMB - SALARY 2520, OLD CK 275	2,795	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,209	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,483,133	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	646,709	31
32	Health Care	1,597,839	32
33	General Administration	1,010,131	33
	B. Capital Expense		
34	Ownership	44,643	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,346,407	40
41	**Income before Income Taxes (line 30 minus line 40)****	(863,274)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (863,274)	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: 12/1/09 Ending: 11/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,617	1,657	$ 42,660	$ 25.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,559	6,064	162,438	26.79	3
4	Licensed Practical Nurses	13,860	14,907	294,752	19.77	4
5	CNAs & Orderlies	40,234	42,639	468,615	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,267	2,354	28,586	12.14	8
9	Activity Director	1,628	1,787	20,517	11.48	9
10	Activity Assistants	2,570	2,672	27,024	10.11	10
11	Social Service Workers	1,208	1,376	13,664	9.93	11
12	Dietician					12
13	Food Service Supervisor	1,983	2,161	28,036	12.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,592	10,107	95,755	9.47	15
16	Dishwashers					16
17	Maintenance Workers	3,337	3,558	37,173	10.45	17
18	Housekeepers	5,018	5,184	45,212	8.72	18
19	Laundry	4,127	4,191	39,825	9.50	19
20	Administrator	2,005	2,085	54,847	26.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,839	7,412	94,538	12.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	144	144	12,033	83.56	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) Utility Workers	2,125	2,215	23,690	10.70	33
34	TOTAL (lines 1 - 33)	104,113	110,513	$ 1,489,365 *	$ 13.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	171	$ 6,978	1-3	35
36	Medical Director	120	12,000	9-3	36
37	Medical Records Consultant	16	515	10-3	37
38	Nurse Consultant	560	21,193	10-3	38
39	Pharmacist Consultant	96	3,748	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	67	4,810	12-3	45
46	Other(specify)				46
47	PSYCH CONSULTANT	24	5,500	10-3	47
48	ADMINISTRATIVE CONSULTANT	656	21,565	17-3	48
49	TOTAL (lines 35 - 48)	1,710	$ 76,309		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	43	$ 1,978	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	43	$ 1,978		53

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JANICE TABOR	ADMINISTRATOR	0	$ 54,847
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 54,847

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 21,565
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 21,565

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT FEE	$ 121,739
CSC	CORP REPRESENTATION	356
FELDMAN, WASSER, ET AL	LEGAL	458
ACCUCARE	ACCOUNTING	5,820
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 128,373

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,541
Unemployment Compensation Insurance	35,308
FICA Taxes	112,333
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE CAFETERIA PLAN	55,708
EMPLOYEE LIFE INSURANCE	3,096
HOLIDAY PARTY	490
GIFT CERTIFICATES	975
EMPLOYEE LABS & VACCINES	2,818
NHM ALLOCATION	308
TOTAL (agree to Schedule V, line 22, col.8)	$ 243,577

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HOLIDAY PARTY	22	$ 490
GIFT CERTIFICATES	22	975
EMPLOYEE LABS & VACCINES	22	2,818
TOTAL		$ 4,283

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,700
Health Care Worker Background Check	
(Indicate # of checks performed 58)	940
Patient Background Checks 70	1,120
YELLOW PAGES	1,170
PUBLIC RELATIONS	14,739
SEE ATTACHED SCHEDULE	930
NHM ALLOCATION	126
Less: Public Relations Expense	(14,739)
Non-allowable advertising	( )
Yellow page advertising	(1,170)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,816

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISC MILEAGE REIMBURSEMENT	2,351
NHM ALLOCATION	965
TSF 31 % HOME OFFICE TO ADMIN	(299)
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,017

**See instructions.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/09 Ending: 11/30/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING	6/90	$ 1,471	3 YR	$	$	$	$	$	$	$	$	$
2	PAINTING	7/91	1,450	3 YR									
3	PAINTING	7/94	2,726	3 YR									
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,647		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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? **0**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,467** 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. $ **47,085**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(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

OTHER GENERAL ADMINISTRATION
PAGE 3 - LINE 27 - COLUMN 3

SALES TAX	3,286
BAD DEBT	369,463
	$ 372,749

PAGE 3 - LINE 27 - COLUMN 8

NHM ALLOCATION - PER 2004 DESK REVIEW	$ 17,690

COLUMN 5 - RECLASSIFICATIONS

RECLASS FROM:		LINE #
AMBULANCE	$ (15,387)	10
X - RAYS	(2,266)	10
LABS	(7,064)	10
MEDICARE DRUGS	(91,348)	10
IV'S	(4,524)	10
MEDICARE SUPPLIES	(1,846)	10
OXYGEN	(17,879)	10
PHYSICAL THERAPY	(86,330)	10A
SPEECH THERAPY	(33,944)	10A
OCCUPATIONAL THERAPY	(104,231)	10A

RECLASS TO:		
ANCILLARY	$ 364,819	39

RECLASS TO:		
NURSE CONSULTANT TRAVEL	$ 1,200	10
ADMINISTRATIVE CONS. TRAVEL	4,069	17

RECLASS FROM:		
TRAVEL	$ (5,269)	24

SCHEDUL V - PAGE 3 - LINE 24 - COLUMN 8

DETAIL - TRAVEL

COMMUNITY RELATIONS TRAVEL	$	1,289
MISCELLANEOUS MILEAGE REIMBURSEMENT		1,062
NHM ALLOCATION		666
	$	3,017

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATIION	$	21,696
NURSING HOME MANAGERS ALLOCATION		1,375
SCHEDULE V - LINE 30 - COLUMN 8	$	23,071

SCHEDULE XVII - PAGE 19

RECONCILIATION OF INCOME

	LINE 41 - NET INCOME	$	(863,274)
*	ACCRUED MANAGEMENT FEE 11/09		(312,824)
*	ACCRUED MANAGEMENT FEE 11/10		434,564
	INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS		62
	TAXABLE INCOME	$	(741,472)

* 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	$	65
SOCIAL SERVICE WORKSHOPS		76
HOME OFFICE INSERVICES		2,082
CPR TRAINING		806
ACCUCARE SOFTWARE TRAINING		881
NURSING HOME MANAGERS ALLOCATION		1,196
	$	5,106

SCHEDULE XIX - PAGE 21 - SECTION F - DUES, FEES, SUBS(

DETAIL - OTHER

FOOD SERVICE PERMIT	$	550
DUES & SUBSCRIPTIONS		125
FRANCHISE FEE		105
CLIA LAB FEE		150
	$	930

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS WORKED BASED UPON TIME CARDS.

CRIPTIONS

SCHEDULE V - PAGE 6 - LINE 2

CENTRAL OFFICE COST ALLOCATION
MENARD
2009

	DEC 09	JAN 10	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2009 TOTAL	LINE #
SALARIES-ADMIN	1,943	$1,314	$1,340	$1,289	$1,237	$1,315	$1,220	$1,315	$1,268	$1,196	$1,209	$1,138	$15,785	$17
SALARIES-CLERIC	3,061	2,906	2,964	2,851	2,735	2,908	2,698	2,909	3,155	2,976	3,008	2,830	35,001	21
SALARIES-CONTR	(360)	983	1,003	965	926	984	913	984	1,021	963	974	916	10,272	17
SALARIES-NURSE	1,240	549	560	539	517	549	510	550	348	328	332	312	6,334	10
ACCOUNTING	(60)	31	32	30	29	31	29	31	10	10	10	9	192	19
WORK COMP INS	89	82	84	81	78	82	77	83	(92)	(86)	(87)	(82)	308	22
SUPPLIES	102	152	155	149	143	152	141	152	73	69	70	66	1,424	21
TELEPHONE	217	270	275	265	254	270	250	270	(24)	(23)	(23)	(22)	1,979	21
EMPL BENEFITS	1,688	739	754	725	696	740	687	740	1,477	1,393	1,408	1,325	12,372	27
PAYROLL TAXES	543	403	411	396	380	404	375	404	528	498	503	473	5,318	27
TRAVEL	45	91	93	89	85	91	84	91	78	73	74	70	965	24
IN SERVICE	37	162	165	159	153	162	151	162	12	11	11	11	1,196	23
MEDICAL CONSULT	165	161	165	158	152	161	150	161	161	152	154	145	1,885	10
MACHINE RENTAL	637	626	639	615	590	627	582	627	372	351	354	333	6,353	6
OWNERS COMP	0	0	0	0	0	0	0	0	0	0	0	0	0	17
INS-PROP,LIAB,WC	122	27	27	26	25	27	25	27	26	25	25	23	404	26
DEPRECIATION	43	187	191	183	176	187	174	187	13	12	12	11	1,375	30
RENT	661	567	579	557	534	568	527	568	829	782	790	743	7,705	34
MAINTENANCE	243	178	182	175	168	178	165	178	244	230	232	218	2,390	6
FEES & PUBLICAT	26	10	10	10	10	10	9	10	8	8	8	7	126	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
MEDICAL DIRECTOF	0	0	0	0	0	0	0	0	0	0	0	0	0	10
TOTAL	10,442	$9,439	$9,628	$9,262	$8,886	$9,447	$8,765	$9,449	$9,507	$8,967	$9,065	$8,527	$111,384	
FIXED ASSETS	0												111,384	
EQUIP - PRIOR	10,745	10,485	10,695	10,288	9,870	10,494	9,737	10,496	10,474	9,879	9,987	9,395	10,212	
EQUIP - CURR	3,509	3,424	3,493	3,360	3,223	3,427	3,180	3,428	3,420	3,226	3,261	3,068	3,335	
EQUIP - FULLY DEP	4,148	4,048	4,129	3,972	3,810	4,051	3,759	4,052	4,043	3,814	3,855	3,627	3,942	
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	1,059	1,033	1,054	1,014	972	1,034	959	1,034	1,032	973	984	926	1,006	

MONTHLY CENTRAL OFFICE COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2009

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	16.46%	23.01%	25.85%	15.74%	18.94%	100.00%
SALARIES-ADMIN	$0	$2,032	$2,840	$3,190	$1,943	$2,337	$12,343
SALARIES-CLERIC	0	3,202	4,475	5,027	3,061	3,683	19,448
SALARIES-CONTR	0	(376)	(526)	(590)	(360)	(432)	(2,284)
SALARIES-NURSE	0	1,297	1,812	2,036	1,240	1,491	7,875
ACCOUNTING	0	(63)	(88)	(98)	(60)	(72)	(381)
WORK COMP INS	0	93	130	145	89	107	563
SUPPLIES	0	107	149	167	102	123	647
TELEPHONE	0	227	318	357	217	262	1,381
EMPL BENEFITS	0	1,766	2,468	2,772	1,688	2,031	10,724
PAYROLL TAXES	0	568	794	892	543	653	3,450
TRAVEL	0	47	66	74	45	54	286
IN SERVICE	0	38	54	60	37	44	233
MEDICAL CONSULT	0	173	242	271	165	199	1,050
MACHINE RENTAL	0	666	931	1,046	637	766	4,047
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP,LIAB,WC	0	127	178	200	122	146	773
DEPRECIATION	0	45	62	70	43	51	271
RENT	0	691	966	1,085	661	795	4,199
MAINTENANCE	0	254	355	399	243	292	1,543
FEES & PUBLIC	0	27	38	43	26	31	165
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$10,921	$15,264	$17,146	$10,442	$12,561	$66,334
FIXED ASSETS							
EQUIP - PRIOR	0	11,238	15,706	17,643	10,745	12,925	68,256
EQUIP - CURR	0	3,670	5,129	5,762	3,509	4,221	22,290
EQUIP - FULLY DEP	0	4,338	6,063	6,811	4,148	4,990	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,107	1,547	1,738	1,059	1,273	6,725

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	16.35%	22.30%	26.89%	15.36%	19.11%	100.00%
SALARIES-ADMIN	$0	$1,398	$1,907	$2,300	$1,314	$1,634	$8,554
SALARIES-CLERIC	0	3,092	4,218	5,085	2,906	3,614	$18,915
SALARIES-CONTR	0	1,046	1,427	1,721	983	1,223	$6,401
SALARIES-NURSE	0	584	797	961	549	683	$3,574
ACCOUNTING	0	33	45	54	31	38	$201
WORK COMP INS	0	88	120	144	82	103	$537
SUPPLIES	0	162	220	266	152	189	$988
TELEPHONE	0	287	391	472	270	335	$1,755
EMPL BENEFITS	0	787	1,073	1,294	739	920	$4,813
PAYROLL TAXES	0	429	586	706	403	502	$2,626
TRAVEL	0	97	132	159	91	113	$591
IN SERVICE	0	173	235	284	162	202	$1,055
MEDICAL CONSULT	0	172	234	282	161	201	$1,050
MACHINE RENTAL	0	667	909	1,096	626	779	$4,078
OWNERS COMP	0	0	0	0	0	0	$0
INS-PROP,LIAB,WC	0	28	39	47	27	33	$174
DEPRECIATION	0	199	271	327	187	232	$1,217
RENT	0	604	824	993	567	706	$3,694
MAINTENANCE	0	189	258	312	178	221	$1,159
FEES & PUBLIC	0	11	15	18	10	13	$66
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$10,045	$13,702	$16,521	$9,439	$11,741	$61,447
FIXED ASSETS							
EQUIP - PRIOR	0	11,158	15,220	18,351	10,485	13,042	68,256
EQUIP - CURR	0	3,644	4,970	5,993	3,424	4,259	22,290
EQUIP - FULLY DEP	0	4,307	5,876	7,084	4,048	5,035	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,099	1,500	1,808	1,033	1,285	6,725

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	16.95%	21.85%	26.52%	15.67%	19.01%	100.00%
SALARIES-ADMIN	$0	$1,450	$1,869	$2,268	$1,340	$1,626	$8,554
SALARIES-CLERIC	0	3,206	4,133	5,016	2,964	3,596	$18,915
SALARIES-CONTR	0	1,085	1,398	1,697	1,003	1,217	$6,401
SALARIES-NURSE	0	606	781	948	560	679	$3,574
ACCOUNTING	0	34	44	53	32	38	$201
WORK COMP INS	0	91	117	142	84	102	$537
SUPPLIES	0	167	216	262	155	188	$988
TELEPHONE	0	298	384	465	275	334	$1,755
EMPL BENEFITS	0	816	1,052	1,276	754	915	$4,813
PAYROLL TAXES	0	445	574	696	411	499	$2,626
TRAVEL	0	100	129	157	93	112	$591
IN SERVICE	0	179	231	280	165	201	$1,055
MEDICAL CONSULT	0	178	229	278	165	200	$1,050
MACHINE RENTAL	0	691	891	1,082	639	775	$4,078
OWNERS COMP	0	0	0	0	0	0	$0
INS-PROP,LIAB,WC	0	29	38	46	27	33	$174
DEPRECIATION	0	206	266	323	191	231	$1,217
RENT	0	626	807	980	579	702	$3,694
MAINTENANCE	0	196	253	307	182	220	$1,159
FEES & PUBLIC	0	11	14	17	10	13	$66
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$10,416	$13,426	$16,296	$9,628	$11,682	$61,447
FIXED ASSETS							
EQUIP - PRIOR	0	11,570	14,914	18,101	10,695	12,976	68,256
EQUIP - CURR	0	3,778	4,870	5,911	3,493	4,238	22,290
EQUIP - FULLY DEP	0	4,467	5,757	6,988	4,129	5,009	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,140	1,469	1,783	1,054	1,278	6,725

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	17.98%	22.22%	25.91%	15.07%	18.81%	100.00%
SALARIES-ADMIN	$0	$1,538	$1,901	$2,216	$1,289	$1,609	$8,554
SALARIES-CLERIC	0	3,401	4,203	4,901	2,851	3,559	$18,915
SALARIES-CONTR	0	1,151	1,422	1,658	965	1,204	$6,401
SALARIES-NURSE	0	643	794	926	539	672	$3,574
ACCOUNTING	0	36	45	52	30	38	$201
WORK COMP INS	0	96	119	139	81	101	$537
SUPPLIES	0	178	220	256	149	186	$988
TELEPHONE	0	316	390	455	265	330	$1,755
EMPL BENEFITS	0	865	1,070	1,247	725	906	$4,813
PAYROLL TAXES	0	472	584	680	396	494	$2,626
TRAVEL	0	106	131	153	89	111	$591
IN SERVICE	0	190	235	273	159	199	$1,055
MEDICAL CONSULT	0	189	233	272	158	198	$1,050
MACHINE RENTAL	0	733	906	1,057	615	767	$4,078
OWNERS COMP	0	0	0	0	0	0	$0
INS-PROP,LIAB,WC	0	31	39	45	26	33	$174
DEPRECIATION	0	219	270	315	183	229	$1,217
RENT	0	664	821	957	557	695	$3,694
MAINTENANCE	0	208	258	300	175	218	$1,159
FEES & PUBLIC	0	12	15	17	10	12	$66
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$11,047	$13,655	$15,922	$9,262	$11,561	$61,447
FIXED ASSETS							
EQUIP - PRIOR	0	12,271	15,168	17,686	10,288	12,842	68,256
EQUIP - CURR	0	4,007	4,953	5,776	3,360	4,194	22,290
EQUIP - FULLY DEP	0	4,737	5,856	6,828	3,972	4,958	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,209	1,494	1,743	1,014	1,265	6,725

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.61%	21.66%	26.12%	14.46%	19.15%	100.00%
SALARIES-ADMIN	$0	$1,592	$1,853	$2,234	$1,237	$1,638	$8,554
SALARIES-CLERIC	0	3,520	4,098	4,941	2,735	3,622	$18,915
SALARIES-CONTR	0	1,191	1,387	1,672	926	1,225	$6,401
SALARIES-NURSE	0	665	774	933	517	684	$3,574
ACCOUNTING	0	37	44	53	29	39	$201
WORK COMP INS	0	100	116	140	78	103	$537
SUPPLIES	0	184	214	258	143	189	$988
TELEPHONE	0	327	380	458	254	336	$1,755
EMPL BENEFITS	0	896	1,043	1,257	696	922	$4,813
PAYROLL TAXES	0	489	569	686	380	503	$2,626
TRAVEL	0	110	128	154	85	113	$591
IN SERVICE	0	196	229	276	153	202	$1,055
MEDICAL CONSULT	0	195	227	274	152	201	$1,050
MACHINE RENTAL	0	759	884	1,065	590	781	$4,078
OWNERS COMP	0	0	0	0	0	0	$0
INS-PROP,LIAB,WC	0	32	38	45	25	33	$174
DEPRECIATION	0	226	264	318	176	233	$1,217
RENT	0	687	800	965	534	707	$3,694
MAINTENANCE	0	216	251	303	168	222	$1,159
FEES & PUBLIC	0	12	14	17	10	13	$66
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$11,435	$13,312	$16,050	$8,886	$11,765	$61,447
FIXED ASSETS							
EQUIP - PRIOR	0	12,702	14,787	17,828	9,870	13,068	68,256
EQUIP - CURR	0	4,148	4,829	5,822	3,223	4,268	22,290
EQUIP - FULLY DEP	0	4,904	5,708	6,882	3,810	5,045	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,252	1,457	1,757	972	1,288	6,725

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	17.75%	21.90%	25.09%	15.37%	19.88%	100.00%
SALARIES-ADMIN	$0	$1,518	$1,873	$2,147	$1,315	$1,701	$8,554
SALARIES-CLERIC	0	3,357	4,142	4,747	2,908	3,761	$18,915
SALARIES-CONTR	0	1,136	1,402	1,606	984	1,273	$6,401
SALARIES-NURSE	0	634	783	897	549	711	$3,574
ACCOUNTING	0	36	44	51	31	40	$201
WORK COMP INS	0	95	117	135	82	107	$537
SUPPLIES	0	175	216	248	152	196	$988
TELEPHONE	0	312	384	440	270	349	$1,755
EMPL BENEFITS	0	854	1,054	1,208	740	957	$4,813
PAYROLL TAXES	0	466	575	659	404	522	$2,626
TRAVEL	0	105	129	148	91	118	$591
IN SERVICE	0	187	231	265	162	210	$1,055
MEDICAL CONSULT	0	186	230	263	161	209	$1,050
MACHINE RENTAL	0	724	893	1,023	627	811	$4,078
OWNERS COMP	0	0	0	0	0	0	$0
INS-PROP,LIAB,WC	0	31	38	44	27	35	$174
DEPRECIATION	0	216	266	305	187	242	$1,217
RENT	0	656	809	927	568	734	$3,694
MAINTENANCE	0	206	254	291	178	230	$1,159
FEES & PUBLIC	0	12	14	17	10	13	$66
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$10,906	$13,457	$15,420	$9,447	$12,217	$61,447
FIXED ASSETS							
EQUIP - PRIOR	0	12,115	14,948	17,129	10,494	13,571	68,256
EQUIP - CURR	0	3,956	4,882	5,594	3,427	4,432	22,290
EQUIP - FULLY DEP	0	4,677	5,771	6,612	4,051	5,239	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,194	1,473	1,688	1,034	1,337	6,725

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	17.98%	22.79%	25.78%	14.26%	19.18%	100.00%
SALARIES-ADMIN	$0	$1,538	$1,950	$2,206	$1,220	$1,641	$8,554
SALARIES-CLERIC	0	3,400	4,311	4,877	2,698	3,628	18,915
SALARIES-CONTR	0	1,151	1,459	1,650	913	1,228	6,401
SALARIES-NURSE	0	642	815	921	510	685	3,574
ACCOUNTING	0	36	46	52	29	39	201
WORK COMP INS	0	96	122	138	77	103	537
SUPPLIES	0	178	225	255	141	190	988
TELEPHONE	0	316	400	453	250	337	1,755
EMPL BENEFITS	0	865	1,097	1,241	687	923	4,813
PAYROLL TAXES	0	472	599	677	375	504	2,626
TRAVEL	0	106	135	152	84	113	591
IN SERVICE	0	190	241	272	151	202	1,055
MEDICAL CONSULT	0	189	239	271	150	201	1,050
MACHINE RENTAL	0	733	930	1,052	582	782	4,078
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP,LIAB,WC	0	31	40	45	25	33	174
DEPRECIATION	0	219	277	314	174	233	1,217
RENT	0	664	842	952	527	709	3,694
MAINTENANCE	0	208	264	299	165	222	1,159
FEES & PUBLIC	0	12	15	17	9	13	66
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$11,047	$14,005	$15,844	$8,765	$11,786	$61,447
FIXED ASSETS							
EQUIP - PRIOR	0	12,271	15,557	17,600	9,737	13,092	68,256
EQUIP - CURR	0	4,007	5,080	5,747	3,180	4,275	22,290
EQUIP - FULLY DEP	0	4,737	6,006	6,794	3,759	5,054	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,209	1,533	1,734	959	1,290	6,725

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	17.37%	22.74%	26.32%	15.38%	18.20%	100.00%
SALARIES-ADMIN	$0	$1,486	$1,945	$2,251	$1,315	$1,556	$8,554
SALARIES-CLERIC	0	3,285	4,301	4,979	2,909	3,442	18,915
SALARIES-CONTR	0	1,112	1,455	1,685	984	1,165	6,401
SALARIES-NURSE	0	621	813	941	550	650	3,574
ACCOUNTING	0	35	46	53	31	37	201
WORK COMP INS	0	93	122	141	83	98	537
SUPPLIES	0	172	225	260	152	180	988
TELEPHONE	0	305	399	462	270	319	1,755
EMPL BENEFITS	0	836	1,094	1,267	740	876	4,813
PAYROLL TAXES	0	456	597	691	404	478	2,626
TRAVEL	0	103	134	156	91	108	591
IN SERVICE	0	183	240	278	162	192	1,055
MEDICAL CONSULT	0	182	239	276	161	191	1,050
MACHINE RENTAL	0	708	927	1,073	627	742	4,078
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP,LIAB,WC	0	30	39	46	27	32	174
DEPRECIATION	0	211	277	320	187	221	1,217
RENT	0	642	840	972	568	672	3,694
MAINTENANCE	0	201	263	305	178	211	1,159
FEES & PUBLIC	0	11	15	17	10	12	66
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$10,671	$13,972	$16,174	$9,449	$11,181	$61,447
FIXED ASSETS							
EQUIP - PRIOR	0	11,854	15,520	17,966	10,496	12,420	68,256
EQUIP - CURR	0	3,871	5,068	5,867	3,428	4,056	22,290
EQUIP - FULLY DEP	0	4,576	5,991	6,936	4,052	4,795	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,168	1,529	1,770	1,034	1,224	6,725

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	17.01%	23.19%	26.10%	15.34%	18.36%	100.00%
SALARIES-ADMIN	$0	$1,405	$1,917	$2,157	$1,268	$1,517	$8,265
SALARIES-CLERIC	0	3,497	4,769	5,366	3,155	3,775	20,561
SALARIES-CONTR	0	1,132	1,543	1,737	1,021	1,222	6,655
SALARIES-NURSE	0	386	526	592	348	417	2,269
ACCOUNTING	0	11	16	17	10	12	67
WORK COMP INS	0	(101)	(138)	(156)	(92)	(109)	(596)
SUPPLIES	0	81	111	125	73	88	479
TELEPHONE	0	(27)	(37)	(41)	(24)	(29)	(158)
EMPL BENEFITS	0	1,637	2,232	2,512	1,477	1,767	9,623
PAYROLL TAXES	0	585	798	898	528	631	3,439
TRAVEL	0	86	118	132	78	93	508
IN SERVICE	0	13	18	20	12	14	78
MEDICAL CONSULT	0	179	244	274	161	193	1,050
MACHINE RENTAL	0	412	562	632	372	445	2,423
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP,LIAB,WC	0	29	39	44	26	31	170
DEPRECIATION	0	14	19	21	13	15	82
RENT	0	918	1,252	1,409	829	991	5,400
MAINTENANCE	0	270	368	414	244	291	1,587
FEES & PUBLIC	0	9	12	14	8	10	53
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$10,536	$14,369	$16,170	$9,507	$11,374	$61,955
FIXED ASSETS							
EQUIP - PRIOR	0	11,607	15,830	17,814	10,474	12,530	68,256
EQUIP - CURR	0	3,791	5,170	5,818	3,420	4,092	22,290
EQUIP - FULLY DEP	0	4,481	6,111	6,877	4,043	4,837	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,144	1,560	1,755	1,032	1,235	6,725

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.13%	22.17%	26.81%	14.47%	18.43%	100.00%
SALARIES-ADMIN	$0	$1,498	$1,832	$2,216	$1,196	$1,523	$8,265
SALARIES-CLERIC	0	3,727	4,558	5,512	2,976	3,789	20,561
SALARIES-CONTR	0	1,206	1,475	1,784	963	1,226	6,655
SALARIES-NURSE	0	411	503	608	328	418	2,269
ACCOUNTING	0	12	15	18	10	12	67
WORK COMP INS	0	(108)	(132)	(160)	(86)	(110)	(596)
SUPPLIES	0	87	106	128	69	88	479
TELEPHONE	0	(29)	(35)	(42)	(23)	(29)	(158)
EMPL BENEFITS	0	1,744	2,133	2,580	1,393	1,773	9,623
PAYROLL TAXES	0	623	762	922	498	634	3,439
TRAVEL	0	92	113	136	73	94	508
IN SERVICE	0	14	17	21	11	14	78
MEDICAL CONSULT	0	190	233	281	152	193	1,050
MACHINE RENTAL	0	439	537	649	351	446	2,423
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP,LIAB,WC	0	31	38	46	25	31	170
DEPRECIATION	0	15	18	22	12	15	82
RENT	0	979	1,197	1,448	782	995	5,400
MAINTENANCE	0	288	352	426	230	292	1,587
FEES & PUBLIC	0	10	12	14	8	10	53
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$11,229	$13,733	$16,609	$8,967	$11,416	$61,955
FIXED ASSETS							
EQUIP - PRIOR	0	12,371	15,130	18,299	9,879	12,577	68,256
EQUIP - CURR	0	4,040	4,941	5,976	3,226	4,107	22,290
EQUIP - FULLY DEP	0	4,776	5,841	7,064	3,814	4,855	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,219	1,491	1,803	973	1,239	6,725

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.45%	23.14%	24.89%	14.63%	18.89%	100.00%
SALARIES-ADMIN	$0	$1,525	$1,912	$2,057	$1,209	$1,561	$8,265
SALARIES-CLERIC	0	3,794	4,758	5,118	3,008	3,883	20,561
SALARIES-CONTR	0	1,228	1,540	1,657	974	1,257	6,655
SALARIES-NURSE	0	419	525	565	332	429	2,269
ACCOUNTING	0	12	15	17	10	13	67
WORK COMP INS	0	(110)	(138)	(148)	(87)	(113)	(596)
SUPPLIES	0	88	111	119	70	90	479
TELEPHONE	0	(29)	(36)	(39)	(23)	(30)	(158)
EMPL BENEFITS	0	1,776	2,227	2,395	1,408	1,817	9,623
PAYROLL TAXES	0	635	796	856	503	649	3,439
TRAVEL	0	94	117	126	74	96	508
IN SERVICE	0	14	18	19	11	15	78
MEDICAL CONSULT	0	194	243	261	154	198	1,050
MACHINE RENTAL	0	447	561	603	354	458	2,423
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP,LIAB,WC	0	31	39	42	25	32	170
DEPRECIATION	0	15	19	20	12	15	82
RENT	0	996	1,250	1,344	790	1,020	5,400
MAINTENANCE	0	293	367	395	232	300	1,587
FEES & PUBLIC	0	10	12	13	8	10	53
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$11,432	$14,336	$15,422	$9,065	$11,700	$61,955
FIXED ASSETS							
EQUIP - PRIOR	0	12,595	15,794	16,990	9,987	12,890	68,256
EQUIP - CURR	0	4,113	5,158	5,548	3,261	4,210	22,290
EQUIP - FULLY DEP	0	4,862	6,097	6,559	3,855	4,976	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,241	1,556	1,674	984	1,270	6,725

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2010

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.25%	24.18%	25.25%	13.76%	18.56%	100.00%
SALARIES-ADMIN	$0	$1,508	$1,998	$2,087	$1,138	$1,534	$8,265
SALARIES-CLERIC	0	3,752	4,971	5,191	2,830	3,816	20,561
SALARIES-CONTR	0	1,214	1,609	1,680	916	1,235	6,655
SALARIES-NURSE	0	414	549	573	312	421	2,269
ACCOUNTING	0	12	16	17	9	12	67
WORK COMP INS	0	(109)	(144)	(151)	(82)	(111)	(596)
SUPPLIES	0	87	116	121	66	89	479
TELEPHONE	0	(29)	(38)	(40)	(22)	(29)	(158)
EMPL BENEFITS	0	1,756	2,327	2,430	1,325	1,786	9,623
PAYROLL TAXES	0	628	832	868	473	638	3,439
TRAVEL	0	93	123	128	70	94	508
IN SERVICE	0	14	19	20	11	14	78
MEDICAL CONSULT	0	192	254	265	145	195	1,050
MACHINE RENTAL	0	442	586	612	333	450	2,423
OWNERS COMP	0	0	0	0	0	0	0
INS-PROP,LIAB,WC	0	31	41	43	23	32	170
DEPRECIATION	0	15	20	21	11	15	82
RENT	0	985	1,306	1,363	743	1,002	5,400
MAINTENANCE	0	290	384	401	218	295	1,587
FEES & PUBLIC	0	10	13	13	7	10	53
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$11,305	$14,980	$15,643	$8,527	$11,499	$61,955
FIXED ASSETS							
EQUIP - PRIOR	0	12,455	16,504	17,234	9,395	12,669	68,256
EQUIP - CURR	0	4,067	5,389	5,628	3,068	4,137	22,290
EQUIP - FULLY DEP	0	4,808	6,371	6,653	3,627	4,891	26,350
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,227	1,626	1,698	926	1,248	6,725

ALLOCATION PERCENTAGES USED ON MONTHLY ALLOCATIONS - PAGE 27

OCCUPIED DAYS 2009	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1,861	2,413	2,389		1,630	1,859	10,152
FEBRUARY	1,752	2,160	2,088		1,341	1,588	8,929
MARCH	1,882	2,368	2,469		1,567	1,841	10,127
APRIL	1,701	2,113	2,469		1,466	1,768	9,517
MAY	1,816	2,090	2,434		1,499	1,857	9,696
JUNE	1,718	2,003	2,476		1,350	1,754	9,301
JULY	1,838	2,163	2,658		1,510	1,826	9,995
AUGUST	1,833	2,214	2,647		1,481	1,952	10,127
SEPTEM	1,651	2,186	2,501		1,427	1,873	9,638
OCTOBER	1,707	2,208	2,569		1,441	1,898	9,823
NOVEMBER	1,597	2,165	2,407		1,414	1,801	9,384
DECEMBER	1,572	2,197	2,468		1,503	1,808	9,548
							0
TOTAL	20,928	26,280	29,575	0	17,629	21,825	116,237
							116,237

OCCUPIED DAYS 2010	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1,593	2,173	2,620		1,497	1,862	9,745
FEBRUARY	1,481	1,909	2,317		1,369	1,661	8,737
MARCH	1,720	2,126	2,479		1,442	1,800	9,567
APRIL	1,700	1,979	2,386		1,321	1,749	9,135
MAY	1,689	2,084	2,388		1,463	1,892	9,516
JUNE	1,598	2,026	2,292		1,268	1,705	8,889
JULY	1,633	2,138	2,475		1,446	1,711	9,403
AUGUST	1,597	2,178	2,451		1,441	1,724	9,391
SEPTEM	1,628	1,991	2,408		1,300	1,655	8,982
OCTOBER	1,748	2,192	2,358		1,386	1,789	9,473
NOVEMBER	1,689	2,238	2,337		1,274	1,718	9,256
DECEMBER	1,749	2,120	2,524		1,424	1,807	9,624
							0
TOTAL	19,825	25,154	29,035	0	16,631	21,073	111,718
							111,718

ALLOCATION PERCENTAGE 2009	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.33%	23.77%	23.53%	16.06%	18.31%	100.00%
FEBRUARY	19.62%	24.19%	23.38%	15.02%	17.78%	100.00%
MARCH	18.58%	23.38%	24.38%	15.47%	18.18%	100.00%
APRIL	17.87%	22.20%	25.94%	15.40%	18.58%	100.00%
MAY	18.73%	21.56%	25.10%	15.46%	19.15%	100.00%
JUNE	18.47%	21.54%	26.62%	14.51%	18.86%	100.00%
JULY	18.39%	21.64%	26.59%	15.11%	18.27%	100.00%
AUGUST	18.10%	21.86%	26.14%	14.62%	19.28%	100.00%
SEPTEMBER	17.13%	22.68%	25.95%	14.81%	19.43%	100.00%
OCTOBER	17.38%	22.48%	26.15%	14.67%	19.32%	100.00%
NOVEMBER	17.02%	23.07%	25.65%	15.07%	19.19%	100.00%
DECEMBER	16.46%	23.01%	25.85%	15.74%	18.94%	100.00%

ALLOCATION PERCENTAGE 2010	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	16.35%	22.30%	26.89%	15.36%	19.11%	100.00%
FEBRUARY	16.95%	21.85%	26.52%	15.67%	19.01%	100.00%
MARCH	17.98%	22.22%	25.91%	15.07%	18.81%	100.00%
APRIL	18.61%	21.66%	26.12%	14.46%	19.15%	100.00%
MAY	17.75%	21.90%	25.09%	15.37%	19.88%	100.00%
JUNE	17.98%	22.79%	25.78%	14.26%	19.18%	100.00%
JULY	17.37%	22.74%	26.32%	15.38%	18.20%	100.00%
AUGUST	17.01%	23.19%	26.10%	15.34%	18.36%	100.00%
SEPTEMBER	18.13%	22.17%	26.81%	14.47%	18.43%	100.00%
OCTOBER	18.45%	23.14%	24.89%	14.63%	18.89%	100.00%
NOVEMBER	18.25%	24.18%	25.25%	13.76%	18.56%	100.00%
DECEMBER	18.17%	22.03%	26.23%	14.80%	18.78%	100.00%