

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0033159

Facility Name: Clinton Manor Living Center, Inc

Address: 111 East Illinois New Baden 62265
Number City Zip Code

County: Clinton

Telephone Number: 618-588-3826 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 01/01/88

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

X "Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: James G. Hull, C.P.A. Telephone Number: 217-228-1950
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 01/01/11 to 12/31/11 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)

(Title)

Paid Preparer

(Signed) (Date)

(Print Name and Title) James G. Hull, C.P.A. Vice President

(Firm Name & Address) WDM Computer Services, Inc. 1900 Harrison, Quincy IL 62301

(Telephone) 217-228-1950 Fax # 217-222-6053

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 Clinton Manor Living Center, Inc

0033159 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 <u>05/24/11</u>					
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>40</u>	Skilled (SNF)	<u>35</u>	<u>13,490</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)	<u>4</u>	<u>888</u>	<u>3</u>
4	<u>50</u>	Intermediate/DD	<u>51</u>	<u>18,472</u>	<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	<u>7</u>

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>7,950</u>	<u>3,988</u>	<u>978</u>	<u>12,916</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD	<u>17,605</u>			<u>17,605</u>	<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>25,555</u>	<u>3,988</u>	<u>978</u>	<u>30,521</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.91%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 35 and days of care provided 978

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Clinton Manor Living Center, Inc # 0033159 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	207,298	17,941	6,469	231,708		231,708		231,708			1
2	Food Purchase		171,677		171,677		171,677	(4,806)	166,871			2
3	Housekeeping	110,342	16,266	315	126,923		126,923		126,923			3
4	Laundry	49,308	14,434	4,763	68,505		68,505		68,505			4
5	Heat and Other Utilities			79,759	79,759	(300)	79,459	(130)	79,329			5
6	Maintenance	73,673	25,640	77,508	176,821	386	177,207		177,207			6
7	Other (specify):*							(22,000)	(22,000)			7
8	TOTAL General Services	440,621	245,958	168,814	855,393	86	855,479	(26,936)	828,543			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,689,593	117,658	26,138	1,833,389	646	1,834,035	(163)	1,833,872			10
10a	Therapy			218,420	218,420		218,420		218,420			10a
11	Activities	12,504	22,933		35,437		35,437		35,437			11
12	Social Services	164,712		2,310	167,022		167,022	(37,136)	129,886			12
13	CNA Training											13
14	Program Transportation		22,769		22,769	87	22,856		22,856			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,866,809	163,360	261,268	2,291,437	733	2,292,170	(37,299)	2,254,871			16
	C. General Administration											
17	Administrative	146,513		41,000	187,513		187,513	(41,000)	146,513			17
18	Directors Fees											18
19	Professional Services			167,118	167,118	(704)	166,414	(41,000)	125,414			19
20	Dues, Fees, Subscriptions & Promotions			52,617	52,617	1,290	53,907	(35,555)	18,352			20
21	Clerical & General Office Expenses	117,638	14,924	25,757	158,319	245	158,564	(9,570)	148,994			21
22	Employee Benefits & Payroll Taxes			452,695	452,695		452,695		452,695			22
23	Inservice Training & Education			7,537	7,537	308	7,845		7,845			23
24	Travel and Seminar			8,244	8,244	(1,572)	6,672		6,672			24
25	Other Admin. Staff Transportation		2,932		2,932		2,932		2,932			25
26	Insurance-Prop.Liab.Malpractice			53,880	53,880		53,880		53,880			26
27	Other (specify):*			1,835	1,835		1,835		1,835			27
28	TOTAL General Administration	264,151	17,856	810,683	1,092,690	(433)	1,092,257	(127,125)	965,132			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,571,581	427,174	1,240,765	4,239,520	386	4,239,906	(191,360)	4,048,546			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.

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			116,244	116,244		116,244	270	116,514			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,396	87,396		87,396	(2,114)	85,282			32
33	Real Estate Taxes			22,188	22,188		22,188		22,188			33
34	Rent-Facility & Grounds			1,271	1,271	(386)	885		885			34
35	Rent-Equipment & Vehicles			1,294	1,294		1,294		1,294			35
36	Other (specify):*			8,111	8,111		8,111	(8,111)				36
37	TOTAL Ownership			236,504	236,504	(386)	236,118	(9,955)	226,163			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,669		28,669		28,669		28,669			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		13,032		13,032		13,032		13,032			41
42	Provider Participation Fee			148,921	148,921		148,921		148,921			42
43	Other (specify):*			67,540	67,540		67,540	(67,540)				43
44	TOTAL Special Cost Centers		41,701	216,461	258,162		258,162	(67,540)	190,622			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,571,581	468,875	1,693,730	4,734,186		4,734,186	(268,855)	4,465,331			45

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

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
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,914)	2		4
5	Telephone, TV & Radio in Resident Rooms	(130)	5		5
6	Rented Facility Space	(22,000)	7		6
7	Sale of Supplies to Non-Patients	(163)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	270	30		9
10	Interest and Other Investment Income	(2,114)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,892)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,175)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,715)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,825)	43		24
25	Fund Raising, Advertising and Promotional	(35,555)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,372)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(49,270)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (186,855)		\$	30

BHF USE ONLY							
48		49		50		51	

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (186,855)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0033159

Report Period Beginning:01/01/11

Ending:12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (1,888)	36	1
2	Amortization of Loan Costs	(510)	36	2
3	Political Contributions	(166)	36	3
4	CSS Labor:Admin Progr.	(37,136)	12	4
5	CSS Labor:Admin Asst.	(9,570)	21	5
6	CSS Labor:Nursing	0	10	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	(49,270)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clinton Manor Living Center, Inc # 0033159 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,806)	0	0	0	0	0	0	0	0	0	0	(4,806)	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	(130)	0	0	0	0	0	0	0	0	0	0	(130)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(22,000)	0	0	0	0	0	0	0	0	0	0	(22,000)	7
8	TOTAL General Services	(26,936)	0	0	0	0	0	0	0	0	0	0	(26,936)	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	(163)	0	0	0	0	0	0	0	0	0	0	(163)	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	(37,136)	0	0	0	0	0	0	0	0	0	0	(37,136)	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	(37,299)	0	0	0	0	0	0	0	0	0	0	(37,299)	16
	C. General Administration													
17	Administrative	0	(41,000)	0	0	0	0	0	0	0	0	0	(41,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(41,000)	0	0	0	0	0	0	0	0	0	(41,000)	19
20	Fees, Subscriptions & Promotions	(35,555)	0	0	0	0	0	0	0	0	0	0	(35,555)	20
21	Clerical & General Office Expenses	(9,570)	0	0	0	0	0	0	0	0	0	0	(9,570)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(45,125)	(82,000)	0	0	0	0	0	0	0	0	0	(127,125)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,360)	(82,000)	0	0	0	0	0	0	0	0	0	(191,360)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Clinton Manor Living Center, Inc # 0033159 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	270	0	0	0	0	0	0	0	0	0	0	270	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,114)	0	0	0	0	0	0	0	0	0	0	(2,114)	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):*	(8,111)	0	0	0	0	0	0	0	0	0	0	(8,111)	36
37	TOTAL Ownership	(9,955)	0	0	0	0	0	0	0	0	0	0	(9,955)	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):*	(67,540)	0	0	0	0	0	0	0	0	0	0	(67,540)	43
44	TOTAL Special Cost Centers	(67,540)	0	0	0	0	0	0	0	0	0	0	(67,540)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(186,855)	(82,000)	0	0	0	0	0	0	0	0	0	(268,855)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Michael Brave</u>	<u>25</u>			<u>Brave Inc.</u>	<u>New Baden</u>	<u>Management</u>
<u>Ann Reis</u>	<u>25</u>	<u>Carlyle Healthcare Center</u>	<u>Carlyle</u>	<u>DAR Mngmt</u>	<u>Quincy</u>	<u>Management</u>
		<u>St. Vincent's Home. Inc.</u>	<u>Quincy</u>	<u>Wdm Computer Servi</u>	<u>Quincy</u>	<u>Data Processing</u>
<u>Blain Richard</u>	<u>25</u>	<u>St. Ann's Healthcare Center, Inc.</u>	<u>Chester</u>	<u>RDR Mngmt</u>	<u>Albers</u>	<u>Management</u>
<u>Michael Greer</u>	<u>12.5</u>	<u>St. Ann's Healthcare Center, Inc.</u>	<u>Chester</u>	<u>Greer Mngmt</u>	<u>Trenton</u>	<u>Management</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	<u>Management</u>	\$ <u>41,000</u>	<u>Brave Management</u>	<u>0.00%</u>	\$	\$ <u>(41,000)</u>	1
2	V	19	<u>Management</u>	<u>41,000</u>	<u>DAR Management</u>	<u>0.00%</u>		<u>(41,000)</u>	2
3	V	19	<u>Data Processing</u>	<u>20,800</u>	<u>WDM Computer Services, Inc.</u>	<u>0.00%</u>	<u>20,800</u>		3
4	V								4
5	V								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			\$ <u>102,800</u>			\$ <u>20,800</u>	\$ * <u>(82,000)</u>	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Greer	Vice President	Owner	12.50	0	14	33.00	Wages	\$ 9,750	17-1	1
2	Blain Richard	President	Owner	25.00	0	10	25.00	Wages	19,500	17-1	2
3	Ann Reis	n/a	Owner	25.00	0	0	0.00	n/a	0	17-1	3
4	Dave Reis	Treasurer	Board Member	0.00	0	10	25.00	Wages	19,500	17-1	4
5	Michael Brave	Administrator	Administrator	25.00	0	40	100.00	Wages	19,500	17-1	5
6	RDR Mngmt	Management	Management	0.00	0	5	12.00	Mngt Fees	88,013	19-3	6
7	DAR Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	41,000	19-3	7
8	Greer Mngt	Management	Management	0.00	0	5	12.00	Mngt Fees	41,000	19-3	8
9	Brave, Inc.	Management	Management	0.00	0	5	12.00	Mngt Fees	41,000	17-3	9
10	Gail Greer	n/a	Owner	12.50		0	0.00	Wages	9,750	17-1	10
11	See Attatched List (Pg 28)										11
12											12
13								TOTAL	\$ 289,013		13

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

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

Facility Name & ID Number Clinton Manor Living Center, Inc # 0033159 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

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	First National Bank		X	Construction	\$952.45	12/19/03	\$ 95,000	\$ 28,642	08/15/14	4.5000	\$ 1,748	1
2	First National Bank		X	New Storage Shed	\$1,177.54	12/16/11	18,949	18,949	01/16/17	5.1250	5	2
3	First National Bank		X	Refinance & 2nd Mortgage	\$13,720.25	12/31/06	1,305,581	973,708	07/21/16	5.1250	55,535	3
4	First County Bank		X	Auto Loan	\$746.00	01/24/08	45,000	17,344	01/24/14	5.9000	1,271	4
5	GMAC		X	Auto Loan	\$583.33	08/31/09	35,000	18,667	08/31/14	0.0000		5
	Working Capital											
6	First National Bank		X	Cash Flow	Interest Only	09/27/07	175,000	350,000	04/13/12	varies	7,837	6
7	Owners	X		Cash Flow	Interest Only	04/13/07	48,000	400,000	12/31/11	5.2500	21,000	7
8												8
9	TOTAL Facility Related				\$17,179.57		\$ 1,722,530	\$ 1,807,310			\$ 87,396	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,722,530	\$ 1,807,310			\$ 87,396	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.)

HFS 3745 (N-4-99)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	23,126	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.)		\$	22,657	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(469)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	22,657	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.		\$	22,188	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	20,212	8		
	2007	21,714	9		
	2008	22,046	10		
	2009	23,059	11		
	2010	23,126	12		
				FOR BHF USE ONLY	
				13 FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clinton Manor Living Center, Inc COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0033159

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </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 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,794

B. General Construction Type: Exterior BrickFrame Wood, Steel & Contret

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).

N/A

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	26,669	1987	\$ 66,000	1
2					2
3	TOTALS	26,669		\$ 66,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	69		1987	1969	\$ 594,000	\$ 19,800	30	\$ 19,800	\$	\$ 475,202	4
5	12		1991	1991	511,306	17,096	30	17,044	(52)	344,616	5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER			1990	3,140		20			3,143	9
10	LAND IMPROVEMENT			1992	5,410		10			5,410	10
11	BUILDING IMPROVEMENT			1992	37,505	1,629	20,10	1,620	(9)	36,281	11
12	BUILDING IMPROVEMENT			1992	26,098	1,312	20	1,305	(7)	24,895	12
13	CON			1992	3,000		30	100	100	2,000	13
14	BUILDING IMPROVEMENT			1994	12,580	296	20,10	294	(2)	11,939	14
15	PLUMBING			1995	12,200	613	20	610	(3)	10,208	15
16	LANDSCAPING			1997	1,675		10			1,675	16
17	BOILER			1997	8,858		8			8,858	17
18	REMODEL OF DINING ROOM			1997	35,389	1,769	20	1,769		24,920	18
19	HEETING/COOLING SYSTEM			1999	13,826		10			13,826	19
20	FIRE ALARM UPGRADE			2001	2,610	239	10	239		2,610	20
21	FRONT ADDITION			2001	115,835	5,792	20	5,792		58,401	21
22	DINING ROOM REMODEL			2001	84,135	4,207	20	4,207		42,419	22
23	Kitchen Improvements			2004	3,852	197	20	193	(4)	1,491	23
24	Flooring			2004	2,790	279	10	279		2,023	24
25	Laundry Building			2004	106,437	5,322	20	5,322		39,471	25
26	Bathroom Flooring			2005	3,650	183	20	183		1,232	26
27	Concrete			2005	2,367	237	10	237		1,518	27
28	Flooring			2005	3,032	152	20	152		973	28
29	Bathroom Remodel			2005	3,550	177	20	178	1	1,109	29
30	Roof Repairs			2005	4,225	211	20	211		1,338	30
31	Flooring			2006	5,960	298	20	298		1,788	31
32	New A/C Units			2006	6,141	412	15	410	(2)	2,299	32
33	New Office Building			2006	93,901	3,130	30	3,130		16,167	33
34	Flooring			2007	6,293	787	8	787		3,671	34
35	Entrance Canopy			2007	3,765	188	20	188		800	35
36	Replace Roof			2007	36,366	909	40	909		3,712	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Range Hood	2008	\$ 8,586	\$ 1,241	7	\$ 1,227	\$ (14)	\$ 4,552	37
38	Alarm System	2008	7,224	903	8	903		2,860	38
39	New Patio	2009	3,346	223	15	223		502	39
40	Sprinkler	2010	33,827	1,353	25	1,353		2,706	40
41	Nursing Cabinets	2010	2,003	134	15	134		179	41
42	New Deck and Siding	2010	11,361	456	25	454	(2)	759	42
43	Hanover Office Building	1997	45,776	1,526	30	1,526		22,253	43
44	Storage Builgind	2011	18,949	122	39	122		122	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,880,968	\$ 71,193		\$ 71,199	\$ 6	\$ 1,177,928	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 216,535	\$ 23,655	\$ 23,655	\$	9	\$ 134,741	71
72	Current Year Purchases	32,694	2,123	2,517	394	9	2,123	72
73	Fully Depreciated Assets	392,658				9	392,649	73
74								74
75	TOTALS	\$ 641,887	\$ 25,778	\$ 26,172	\$ 394		\$ 529,513	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2003 Ford Van	2003	\$ 40,507	\$	\$	\$	5	\$ 40,507	76
77	Facility Use	2007 Chevy Van	2008	49,936	9,987	9,987		5	39,949	77
78	Facility Use	2008 Dodge Caravan	2009	40,458	8,222	8,092	(130)	5	19,219	78
79	Facility Use	01 Ford F150	2011	6,385	1,064	1,064		5	1,064	79
80	TOTALS			\$ 137,286	\$ 19,273	\$ 19,143	\$ (130)		\$ 100,739	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,726,141 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,244 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 116,514 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 270 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,808,180 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:
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

**

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
- .

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☒ YES
- ☐ NO
16. Rental Amount for movable equipment:
- \$
- 1,294
- Description:
- Dishwasher Lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.
- /2012
- \$
13.
- /2013
- \$
14.
- /2014
- \$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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.

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	\$		\$ 58,683	\$		\$ 58,683	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			31,891			31,891	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			123,271			123,271	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				28,669		28,669	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	10-3	hrs			12,880			12,880	10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 226,725	\$ 28,669		\$ 255,394	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (344,576)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,407,048		3
4	Supply Inventory (priced at FIFO)	23,830		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,654		6
7	Other Prepaid Expenses	12,844		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Rounding	1		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,116,801	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	(34,707)		12
13	Land	116,387		13
14	Buildings, at Historical Cost	2,413,104		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	807,855		16
17	Accumulated Depreciation (book methods)	(2,093,530)		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): CIP	36,629		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,245,738	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,362,539	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 164,300	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,000		29
30	Accrued Salaries Payable	184,822		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,436		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,819		32
33	Accrued Interest Payable	2,330		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	(9,694)		36
37	Rounding	1		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 739,014	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	64,653		39
40	Mortgage Payable	1,061,259		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Loans from Shareholders	400,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,525,912	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,264,926	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 97,613	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,362,539	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 143,971	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 143,971	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	66,739	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	(157,300)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net Income from Rental Divisions	44,204	15
16	Other (describe) Rounding	(1)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (46,358)	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)	\$ 97,613	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Clinton Manor Living Center, Inc

0033159

Report Period Beginning: 01/01/11

Ending: 12/31/11

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	\$ 4,428,925	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,428,925	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	116,165	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 116,165	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	11,443	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,914	14
15	Telephone, Television and Radio	130	15
16	Rental of Facility Space		16
17	Sale of Drugs	696	17
18	Sale of Supplies to Non-Patients	163	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,256	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,602	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,114	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,114	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See List Attached</u>	235,119	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 235,119	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,800,925	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	855,393	31
32	Health Care	2,291,437	32
33	General Administration	1,092,690	33
	B. Capital Expense		
34	Ownership	236,504	34
	C. Ancillary Expense		
35	Special Cost Centers	109,241	35
36	Provider Participation Fee	148,921	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,734,186	40
41	Income before Income Taxes (line 30 minus line 40)**	66,739	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 66,739	43

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

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

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

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

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	1,984	2,131	\$ 61,747	\$ 28.98	1
2	Assistant Director of Nursing	1,908	2,088	52,726	25.25	2
3	Registered Nurses	3,898	3,978	91,275	22.94	3
4	Licensed Practical Nurses	20,198	21,389	412,576	19.29	4
5	CNAs & Orderlies	25,901	27,135	287,842	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,446	1,516	12,504	8.25	10
11	Social Service Workers	5,464	6,134	95,853	15.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,977	2,088	34,037	16.30	14
15	Cook Helpers/Assistants	9,109	9,910	113,393	11.44	15
16	Dishwashers	6,769	6,998	59,868	8.56	16
17	Maintenance Workers	5,030	5,334	73,673	13.81	17
18	Housekeepers	11,256	11,989	110,342	9.20	18
19	Laundry	4,575	5,005	49,308	9.85	19
20	Administrator	1,884	2,088	88,013	42.15	20
21	Assistant Administrator					21
22	Other Administrative			58,500		22
23	Office Manager					23
24	Clerical	5,903	6,569	117,638	17.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,846	6,291	101,898	16.20	28
29	Resident Services Coordinator	1,867	2,088	68,859	32.98	29
30	Habilitation Aides (DD Homes)	60,113	63,421	628,505	9.91	30
31	Medical Records	1,389	1,529	16,560	10.83	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	3,336	3,561	36,464	10.24	33
34	TOTAL (lines 1 - 33)	179,853	191,242	\$ 2,571,581 *	\$ 13.45	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	136	\$ 6,392	1-3	35
36	Medical Director	Contract	14,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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	37	2,310	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	173	\$ 23,102		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Michael Brave	Administrator	25	\$ 88,013	Workers' Compensation Insurance		\$ 100,379	IDPH License Fee		\$ 1,990		
Blain Richard	Owner	25	19,500	Unemployment Compensation Insurance		43,022	Advertising: Employee Recruitment		4,114		
Michael Greer	Owner	12.5	9,750	FICA Taxes		189,843	Health Care Worker Background Check		1,334		
Dave Reis	Owner	25	19,500	Employee Health Insurance		108,980	(Indicate # of checks performed _____)				
Gail Greer	Owner	12.5	9,750	Employee Meals			Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			Promotion/Public Relation		35,583		
				Deffered Compensation		3,500	Employee Drug Testing		611		
TOTAL (agree to Schedule V, line 17, col. 1)				401 9k) Match		2,507	See List Attached		10,275		
(List each licensed administrator separately.)			\$ 146,513	Employee Physicals		2,360					
B. Administrative - Other				Employee Benefits-Other		2,103					
Description			Amount	Rounding		1					
Brave Management			\$ 41,000				Less: Public Relations Expense		(35,555)		
							Non-allowable advertising	(			
							Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 41,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 452,695	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,352		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
C. Professional Services				Description	Line #	Amount	Description		Amount		
Vendor/Payee	Type		Amount	n/a		\$ 0	Out-of-State Travel		\$		
RDR Management	Management		\$ 41,000								
DAR Management	Management		41,000								
Greer Management	Management		41,000								
WDM Computer Svcs	Data Processing		20,800				In-State Travel				
Accumed	Software Support		6,234								
Ability	Software Support		1,031								
The Hartford	Retirement Plan Admin.		732								
Harter, Larson, Dodd	Legal		2,500				Seminar Expense				
Giffen, Winning, Bodewes	Legal		8,325				See List Attached		6,672		
Oakridge Company	Drafting/Architecture		1,575								
See List Attached			2,217								
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 166,414				TOTAL		\$ 6,672		

*** Attach copy of IMRF notifications**

****See instructions.**

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?
- (2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. LSN \$1,322.64
- (3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (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?

9
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$26,088

Line10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.
- (9) Are you presently operating under a sublease agreement?

YES

X

NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$148,921

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 benefit on Schedule V.

\$0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$2,914
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

Yes

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$16,397

c. What percent of all travel expense relates to transportation of nurses and patients?

75

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:
- (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?

Yes

Attach invoices and a summary of services for all architect and appraisal fees

Clinton Manor Living Center, Inc.
01/01/11 thru 12/31/11
0031159

The following is a breakdown of Schedule V Line 6 Column 3

Repairs & Maint. Dietary	\$0.00
Repairs & Maint. Laundry	\$0.00
Repairs & Maint. Housekeeping	\$0.00
Repairs & Maint. Equipment	\$28,561.45
Repairs & Maint. Ground	\$5,139.74
Repairs & Maint. Building	\$15,206.23
Repairs & Maint. Wheelchairs	\$0.00
Repairs & Maint. Outside services	\$24,141.49
Repairs & Maint. Gen/Admin.	\$4,458.76
	<u>\$77,807.67</u>

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

Printing	\$153.57
Postage	\$3,255.28
Copier	\$4,485.64
Telephone	\$17,863.00
	<u>\$25,757.49</u>

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

Sales Tax	\$3,175.00
State Replacement Tax	\$2,372.00
Bank & service fees	\$1,888.33
Amortization of Loan Costs	\$509.50
Political Contributions	\$166.16
Rounding	
	<u>\$8,110.99</u>

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

Bad Debt Expense	\$64,825.00
Contributions	\$2,715.00
	<u>\$67,540.00</u>

The following is a breakdown of Schedule V Line 27 Column 3

Miscellaneous	\$133.80
Meetings Exp.	\$1,701.28
	<u>\$1,835.08</u>

The following is a breakdown of Schedule XVII Line 28a

CBS Labor: Admin. Program	\$37,136.00
CBS Labor: Admin. Assist.	\$9,570.00
CBS Labor: Nursing Labor	\$0.00
CBS Labor: Maintenance	\$0.00
Misc. Revenue	\$4,046.80
Personal Purchases Income	\$73.42
Office Lease	\$22,000.00
Discounts/Rabates	\$1,892.19
In-House Day Training Revenue	\$136,065.58
Gain/Loss on Sale of Asset	\$0.00
Income from Transportation (IDPA Trans. Reptymt)	\$16,396.58
In-service Training Revenue	\$83.03
Education Reimbursement	\$7,855.32
Rounding	
	<u>\$235,118.92</u>

The following is a breakdown of Schedule XIX, Section F

INHA Dues	Membership	\$100.00
LSN Dues	Membership	\$1,322.64
AANAC	Membership	\$110.00
Misc Subscriptions		\$2,443.84
Sec of State	Vehicle Licenses	\$370.00
First County Bar	New Truck License	\$104.50
IL Ann of Neha	Membership	\$5,048.31
Clinton County	Food Permit	\$55.00
Klasing License	Vehicle Inspections	\$21.00
Vang	Software License	\$560.40
State Fire Marshal	License	\$140.00
Rounding		-\$1.00
		<u>\$10,274.69</u>

The following is a breakdown of Schedule XIX, Section C.

Stepanie Kavana	Clerical Support	\$150.00
Lindsey Brave	Clerical Support	\$186.66
Carfax	Auto Support	\$80.35
Anderson Consult	Energy Consulting	\$1,800.00
		<u>\$2,217.01</u>

Schedule XIII, Section A.

Cha's are responsible for their own training and testing.

Clinton Manor Living Center, Inc.
01/01/11 thru 12/31/11
0033159

The following is a breakdown of the reclassifications:

- 1.Reclass \$386.07 from storage to building supplies. Due to supplies being miscoded to w
- 2. Reclass \$49.64 from Legal to Mileage reimbursement, due to coding error.
- 3. Reclass \$300.00 from Electric to Professional Fees, due to miscoding Anderson Consulti
- 4 Reclass \$308 from Professional fees to In-Service training, due to miscoding of RTW test
- 5. Reclass \$645.58 from Professional fees to Pharmacy, due to miscoding Omnicare Pharmacy
- 6. Reclass \$70.00 From Seminar to 902 Office Supplies, due to coding error.
- 7. Reclass \$174.71 From Seminar to 902 Office Supplies, due to coding error.
- 8. Reclass \$28.51 from Seminar to Promotion due to coding error.
- 9. Reclass \$1262.07 from Seminar to Memberships due to coding error.
- 10. Reclass \$36.72 from Seminars to Mileage Reimbursement, due to coding error.

11

12

Clinton Manor Living Center, Inc.
01/01/11 thru 12/31/11
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Schedule VII Attatchment

Name	Function	Nursing Home	Compensation	
			Ownership Interest	from other Nursing Homes
RDR Management	Management	St. Ann's Healthcare Ctr.	0	\$40,000.00
Greer Management	Management	St. Ann's Healthcare Ctr.	0	\$40,000.00
Mike Greer	Owner	St. Ann's Healthcare Ctr.	25	
Gail Greer	Owner	St. Ann's Healthcare Ctr.	25	
Blain Richard	Owner	St. Ann's Healthcare Ctr.	50	
Dar Mngt	Management	Southern Illinois Comm. Support Se	0	\$20,729.70
Greer Management	Management	Southern Illinois Comm. Support Se	0	\$20,729.70
Advanced Options	Management	Southern Illinois Comm. Support Se	0	\$41,459.45
RDR Management	Management	Southern Illinois Comm. Support Se	0	\$20,729.70

The following is a breakdown of Schedule V Line 24 Column 3

0160 GJ 855	04/11	04/12/11 N U	Sams Discover 529.88	Food	Hotel	Gas	
Ill Nursing Administrator's Seminar, Springfield, IL			Jim & Michael	41.28	256.35	45.71	
				17.14			
				58.42	256.35	45.71	529.88
0130 GJ 902	10/11	1 0/10/11 N U	Sams Discover 1,160.48	Meals	Hotel		
			National Pioneer Network	225.30	870.24	64.94	
			Michael, Cheryl, Darla, Kristie	\$225.30	\$870.24	\$64.94	\$1,160.48
0186 GJ 39277	12/11	12/09/11 N U	Sams Discover 593.87	Breakout Not Available			593.87
91720-0-00 GEN/ADM:TRAVEL/SEMINAR-OTHERS							
0016 PRCH AC0127	01/11	01/27/11 N U	CONEY EXPENSES 44.20	Food	Gas		
			Food Sevice Sanitation Ciurse	\$20.31	\$23.89		
			Gerald Coney	\$20.31	\$23.89		\$44.20
0074 PRCH 021711	01/11	01/31/11 N U	CORPO TRAINING 115.00				\$115.00
0095 PRCH MH0207	01/11	02/07/11 N U	HOLTG EXPENSES 65.00	Registration Fee			
			Medicare Overview				\$65.00
0020 PRCH 021720	02/11	02/17/11 N U	NORBE TRAVEL/MEETING	Mileage			
0021 PRCH 022420	02/11	02/24/11 N U	NORBE TRAVEL/MEETING	17.34			
			Food Sanitation Course	17.34			
				34.68			
0133 GJ 852	03/11	03/31/11 N U	AADD 780.00	Flight	Meals	Taxi	Parking
			Michael, Jim	\$338.80	\$54.35	\$70.00	\$11.95
				\$338.80	\$54.35	\$70.00	\$11.95
					\$475.10		\$780.00
0166 GJ 858	04/11	04/13/11 N U	WPS Medicare 230.00	Hotel			
			Margie Holtgrave	\$230.00			
			Kristie Green (Cancelled)				
0170 GJ 860	04/11	04/19/11 N U	Hitz Memorial Home 62.00	Registration Fee			
			Roxanne Bickner	\$62.00			
0109 GJ 878	06/11	06/22/11 N U	Area Agency On Aging 100.00	Registration Fee			
			Cheryl Smith	\$100.00			
0064 GJ 39049	08/11	08/05/11 N U	MC5 40.00	Registration Fee			
			Michael & Cheryl	\$40.00			
0097 GJ 39063	08/11	08/10/11 N U	Capital One 1,130.00	Registration Fee			
			Mara Jackson, Michael, Jim, Gerald	\$1,130.00			
0142 GJ 39090	08/11	08/26/11 N U	Illinois Pioneer Coali 1,431.00	Hotel	Meals		
			Michael, Cheryl, Dan, Darla, Mara	1101.91	329.09		
			Kristie, Gerald, Trishia, Ashley	1101.91	329.09		\$1,431.00
0259 GJ 896	09/11	09/23/11 N U	Illinois Pioneer Coali 378.00	Registration Fee			
				\$378.00			
0012 PRCH AC1220	01/11	12/31/11 N S	CONEY EXPENSES -22.43	Reimbursement for Meals			-22.43
						Total	\$6,671.68

Clinton Manor Living Center, Inc.
01/01/11 thru 12/31/11

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

2/4/2011	Professional Services	\$39.95	Hab-Tech Training
2/10/2011	Professional Services	\$239.70	Hab-Tech Training
2/10/2011	Sams	\$157.18	In-Service Supplies
2/18/2011	JJ Keller	\$30.81	In-Service Supplies
2/28/2011	Petty Cash	\$30.39	In-Service Supplies
3/11/2011	Professional Services	\$39.95	Hab-Tech Training
3/11/2011	Sams	\$52.00	In-Service Supplies
3/26/2011	Contemporary Life Saving Training	\$20.00	CPR Triainig
3/31/2011	Petty Cash	\$41.32	In-Service Supplies
4/25/2011	Alzhemier Association	\$1,452.00	Training
4/30/2011	Professional Services	\$39.95	Hab-Tech Training
4/30/2011	Petty Cash	\$16.00	In-Service Supplies
5/5/2011	Professional Services	\$39.95	Hab-Tech Training
5/11/2011	Sams	\$500.22	In-Service Supplies
5/31/2011	Sams	\$50.00	In-Service Supplies
5/31/2011	Petty Cash	\$39.97	In-Service Supplies
6/20/2011	Andrea Hudson	\$25.27	In-Service Supplies
6/20/2011	Professional Services	\$39.95	Hab-Tech Training
6/20/2011	Contemporary Life Saving Training	\$600.00	CPR Triainig
6/22/2011	G. Neil	\$59.99	In-Service Supplies
6/29/2011	Joan Brave	\$100.00	In-Service Supplies
6/29/2011	Kathy Markus	\$300.00	In-Service Supplies
6/30/2011	Petty Cash	\$20.00	In-Service Supplies
7/11/2011	Sams	\$499.27	In-Service Supplies
7/12/2011	Professional Services	\$39.95	Hab-Tech Training
7/31/2011	Petty Cash	\$62.96	In-Service Supplies
8/3/2011	Professional Services	\$39.95	Hab-Tech Training
8/5/2011	Contemporary Life Saving Training	\$37.50	CPR Triainig
8/10/2011	Capital One	\$30.00	In-Service Supplies
8/17/2011	Office Depot	\$143.10	In-Service Supplies
8/31/2011	Petty Cash	\$148.94	In-Service Supplies
9/6/2011	Channing Bete	\$177.19	In-Service Supplies
9/7/2011	Professional Services	\$39.95	Hab-Tech Training
9/8/2011	Ingenix	\$226.60	In-Service Supplies
9/8/2011	Contemporary Life Saving Training	\$80.00	CPR Triainig
9/23/2011	Lorman Education	\$329.00	In-Service Supplies
10/3/2011	Professional Services	\$39.95	Hab-Tech Training
10/13/2011	Ingenix	\$146.91	In-Service Supplies
10/30/2011	Contemporary Life Saving Training	\$20.50	CPR Triainig
10/31/2011	Petty Cash	\$35.23	In-Service Supplies
11/1/2011	Professional Services	\$11.75	Hab-Tech Training
11/2/2011	Professional Services	\$39.95	Hab-Tech Training
11/30/2011	Petty Cash	\$39.95	In-Service Supplies
12/8/2011	Professional Services	\$39.95	Hab-Tech Training
12/8/2011	Andrea Coney	\$100.00	In-Service Supplies
12/9/2011	Sams	\$95.00	In-Service Supplies
4/20/2011	Kaskaskia College	\$752.00	Tuition
7/15/2011	Cheryl Smith	\$60.00	Books
7/26/2011	Kaskaskia College	\$23.00	Books
2/22/2011	Quill	\$237.29	Books
5/24/2011	Cheryl Smith	\$106.14	Books
Reclass	RTWIN	\$308.00	RTW Testing Fees
		<u>\$7,844.63</u>	