

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0025841

Facility Name: SUNRISE MANOR OF VIRDEN

Address: 333 SOUTH WRIGHTSMAN STREET VIRDEN 62690
 Number City Zip Code

County: MACOUPIN

Telephone Number: 217-787-8530 **Fax #** 217-787-9840

HFS ID Number: 371087841001

Date of Initial License for Current Owners: 10/1/1980

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 8/1/05 to 7/31/06 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) <u>JERRY W. JENNINGS</u>	
	(Title) <u>CONTROLLER</u>	
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 SUNRISE MANOR OF VIRDEN# 0025841 Report Period Beginning: 8/1/05 Ending: 7/31/06

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>25</u>	Skilled (SNF)	<u>25</u>	<u>9,125</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>74</u>	Intermediate (ICF)	<u>74</u>	<u>27,010</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			<u>3,358</u>	<u>3,358</u>	8
9	SNF/PED					9
10	ICF	<u>13,044</u>	<u>6,055</u>		<u>19,099</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,044</u>	<u>6,055</u>	<u>3,358</u>	<u>22,457</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.15%

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

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

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

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

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

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

YES NO

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

YES NO

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

Date started 10/1/80

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

YES Date SEE ATTACHED NO

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

YES NO If YES, enter number of beds certified 25 and days of care provided 3,358Medicare Intermediary ADMINISTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 7/31/06 Fiscal Year: 7/31/06

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

Facility Name & ID Number SUNRISE MANOR OF VIRDEN # 0025841 Report Period Beginning: 8/1/05 Ending: 7/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	106,798	18,466	7,883	133,147		133,147		133,147		1
2	Food Purchase		112,723		112,723		112,723	(813)	111,910		2
3	Housekeeping	45,277	11,251		56,528		56,528		56,528		3
4	Laundry	25,706	6,568		32,274		32,274		32,274		4
5	Heat and Other Utilities			111,851	111,851		111,851		111,851		5
6	Maintenance	38,746	22,227	36,895	97,868		97,868	1,441	99,309		6
7	Other (specify):*										7
8	TOTAL General Services	216,527	171,235	156,629	544,391		544,391	628	545,019		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000	598	9,598		9
10	Nursing and Medical Records	945,131	145,005	109,439	1,199,575	(107,091)	1,092,484	6,430	1,098,914		10
10a	Therapy	39,060	2,410	258,573	300,043	(258,573)	41,470		41,470		10a
11	Activities	41,907	3,724		45,631		45,631		45,631		11
12	Social Services	32,286		5,241	37,527		37,527		37,527		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Utility Workers	31,461			31,461		31,461		31,461		15
16	TOTAL Health Care and Programs	1,089,845	151,139	382,253	1,623,237	(365,664)	1,257,573	7,028	1,264,601		16
	C. General Administration										
17	Administrative	65,236		10,929	76,165	1,690	77,855	33,705	111,560		17
18	Directors Fees										18
19	Professional Services			135,709	135,709		135,709	(126,862)	8,847		19
20	Dues, Fees, Subscriptions & Promotions			20,257	20,257		20,257	(11,489)	8,768		20
21	Clerical & General Office Expenses	46,387	11,429	5,160	62,976		62,976	26,555	89,531		21
22	Employee Benefits & Payroll Taxes			252,539	252,539		252,539	17,182	269,721		22
23	Inservice Training & Education			3,473	3,473		3,473	1,580	5,053		23
24	Travel and Seminar			5,243	5,243	(3,023)	2,220	653	2,873		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			80,664	80,664		80,664	12	80,676		26
27	Other (specify):*			19,589	19,589		19,589	(19,589)			27
28	TOTAL General Administration	111,623	11,429	533,563	656,615	(1,333)	655,282	(78,253)	577,029		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,417,995	333,803	1,072,445	2,824,243	(366,997)	2,457,246	(70,597)	2,386,649		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 SUNRISE MANOR OF VIRDEN

#0025841

Report Period Beginning:

8/1/05

Ending:

7/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,620	36,620	36,620	30,609	67,229				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,760	10,760	10,760	(10,760)					32
33	Real Estate Taxes			24,582	24,582	24,582		24,582				33
34	Rent-Facility & Grounds			144,000	144,000	144,000	(139,481)	4,519				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			215,962	215,962	215,962	(119,632)	96,330				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					366,997		366,997				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203	54,203		54,203				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			54,203	54,203	366,997		421,200				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,417,995	333,803	1,342,610	3,094,408	3,094,408	(190,229)	2,904,179				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 SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning: 8/1/05

Ending: 7/31/06

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(727)	2		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	27,536	30		9
10	Interest and Other Investment Income	(11,093)	32		10
11	Discounts, Allowances, Rebates & Refunds	(502)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,598)	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	(7,410)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,414)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,581)	27		24
25	Fund Raising, Advertising and Promotional	(11,417)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(298)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(86)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,590)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(172,639)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (172,639)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (190,229)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39	<u>THERAPY</u>	X		258,573	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		11,097	10	42
43	Prescription Drugs	X		80,518	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>OXYGEN</u>	X		12,136	10	45
46	Other-Attach Schedule <u>Supp, Other</u>	X		4,673	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 366,997		47

BHF USE ONLY						
48		49		50		52

STATE OF ILLINOIS
 SUNRISE MANOR OF VIRDEN

Report Period Beginning: 0025841
 8/1/05
 Ending: 7/31/06

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/05

Ending:

7/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(727)	0	0	0	0	0	0	0	0	0	0	(727)	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	(727)	0	0	0	0	0	0	0	0	0	0	(727)	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	293	0	0	0	0	0	0	0	0	0	293	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,414)	(125,589)	0	0	0	0	0	0	0	0	0	(127,003)	19
20	Fees, Subscriptions & Promotions	(11,715)	0	0	0	0	0	0	0	0	0	0	(11,715)	20
21	Clerical & General Office Expenses	(502)	0	0	0	0	0	0	0	0	0	0	(502)	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	(293)	0	0	0	0	0	0	0	0	0	(293)	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):*	(19,589)	0	0	0	0	0	0	0	0	0	0	(19,589)	27
28	TOTAL General Administration	(33,220)	(125,589)	0	(158,809)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,947)	(125,589)	0	(159,536)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/05

Ending:

7/31/06

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	27,536	1,276	0	0	0	0	0	0	0	0	0	28,812	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,093)	333	0	0	0	0	0	0	0	0	0	(10,760)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(144,000)	0	0	0	0	0	0	0	0	0	(144,000)	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	16,443	(142,391)	0	(125,948)	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)	(17,504)	(267,980)	0	(285,484)	45								

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/05

Ending:

7/31/06

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	41.00	HILLTOP NURSING HOME, INC	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
H. RAYMOND KLEIN	36.50	JACKSONVILLE CONVALESCENT CENTER, INC	JACKSONVILLE	Sunrise Property	SPRINGFIELD	LEASOR
PHILIP KLEIN	4.5	MEADOW MANOR, INC.	TAYLORVILLE			
DANA KLEIN KAVY	4.5	MENARD CONVALESCENT CENTER, INC	PETERSBURG			
LISA KLEIN GILDAR	4.5					
DAVID & RAQUEL KLEIN	4.5					
JERRY & PAULA JENNINGS	4.5					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 144,000	SUNRISE PROPERTY	100.00%	\$	\$ (144,000)	1
2	V	30 DEPRECIATION		SUNRISE PROPERTY	100.00%	1,276	1,276	2
3	V	32 INTEREST		SUNRISE PROPERTY	100.00%	333	333	3
4	V							4
5	V	19 MANAGEMENT FEE	134,295	NURSING HOME MANAGERS, INC	77.50%		(134,295)	5
6	V	Var SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC	77.50%	95,341	95,341	6
7	V	19 ACCOUNTING		NURSING HOME MANAGERS, INC DIRECT ALLOCATION	77.50%	8,706	8,706	7
8	V	24 TRAVEL	293	TO TRANSFER 31% OF HOME OFFICE TRAVEL	77.50%		(293)	8
9	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE PER DESK REVIEW	77.50%	293	293	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 278,588			\$ 105,949	\$ * (172,639)	14

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

Facility Name & ID Number SUNRISE MANOR OF VIRDEN # 0025841 Report Period Beginning: 8/1/05 Ending: 7/31/06

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	H. RAYMOND KLEIN	OWNER	MANAGEMENT	36.50					\$ 2,003	17-7	1
2	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.50					15,652	17-7	2
3											3
4	H. RAYMOND KLEIN AND JERRY JENNINGS WERE PAID BY NURSING HOME										4
5	MANAGERS, INC., A RELATED ORGANIZATION. TOTAL COMPENSATION OF										5
6	\$10,010 FOR H. RAYMOND KLEIN WAS ALLOCATED AMONG THE FIVE RELATED										6
7	NURSING HOMES BASED UPON 10 HOURS PER WEEK. COMPENSATION OF										7
8	\$78,175 FOR JERRY JENNINGS WAS ALLOCATED AMONG THE FIVE RELATED										8
9	NURSING HOMES BASED UPON 35 HOURS PER WEEK.										9
10											10
11											11
12											12
13								TOTAL	\$ 17,655		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 SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/05

Ending: 7/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization NURSING HOME MANAGERS, INC
 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

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	OWNERS	X		ACQUISITION	VARIES	10/1/85	\$ 800,000	\$ 5,550	DEMAND	6.0000	\$ 333	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	SUNRISE PROPERTY	X		WORKING CAPITAL		9/20/04	75,000	418,760	DEMAND	4.0000	10,760	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 875,000	\$ 424,310			\$ 11,093	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 875,000	\$ 424,310			\$ 11,093	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 SUNRISE MANOR OF VIRDEN

0025841 Report Period Beginning: 8/1/05

Ending: 7/31/06

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 2005 report.	\$	35,911	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.)	\$	22,680	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(13,231)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		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.)	\$	37,813	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.	\$	24,582	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	19,023	8
	2002	20,851	9
	2003	21,199	10
	2004	22,680	11
	2005	23,881	12

LINE 2: BOTH INSTALLMENTS 2004 TAXES	\$22680	LINE 4: 2005 TAXES	\$23881
		7/12 OF \$23881	13932
			\$37,813

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNRISE MANOR OF VIRDEN COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0025841

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-000-148-01</u>	<u>SUNRISE MANOR</u>	\$ <u>23,881.36</u>	\$ <u>22,881.36</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>23,881.36</u>	\$ <u>22,881.36</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 SUNRISE MANOR OF VIRDEN

0025841 Report Period Beginning:

8/1/05 Ending:

7/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,444 B. General Construction Type: Exterior MASONRY Frame WOOD & STEEL Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>1985</u>	\$ <u>5,000</u>	1
2					2
3	TOTALS			\$ 5,000	3

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/05

Ending:

7/31/06

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	99		1985	1970	\$ 885,000	\$ 1,106	30	\$ 29,500	\$ 28,394	\$ 619,500	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		AIR CONDITIONING		1981	2,179		8			2,179	9
10		IMPROVEMENT		1981	5,664		15			5,664	10
11		AIR CONDITIONING		1983	1,734		10			1,734	11
12		EXHAUST FAN & IMPROVEMENT		1984	2,064		15			2,064	12
13		ROOF		1985	29,004		15			29,004	13
14		BLACKTOP		1985	16,000		15			16,000	14
15		LANDSCAPING		1985	2,400		10			2,400	15
16		TILE		1986	2,508	24	15		(24)	2,508	16
17		AIR CONDITIONING		1986	573	9	8		(9)	573	17
18		CIRCULATING PUMPS		1986	918	16	15		(16)	918	18
19		WATER HEATER		1987	1,705	54	15		(54)	1,705	19
20		SEWER & MANHOLE		1988	4,843	154	15		(154)	4,843	20
21		FIRE ALARM ADJUSTMENT		1989	1,388	44	15		(44)	1,388	21
22		SPRINKLER MAINTENANCE		1990	735	23	10		(23)	735	22
23		ROOF		1990	11,247	357	15	373	16	11,247	23
24		SPRINKLER & DETECTORS		1991	2,684	85	15	89	4	2,684	24
25		DOOR ALARM, TOILET, ETC		1993	2,867	91	15	191	100	2,580	25
26		ROOF, AIR CONDITIONING, KITCHEN		1995	16,554	424	15	1,105	681	12,693	26
27		SMOKE DOORS		1997	4,043	104	15	270	166	2,292	27
28		ROOF		1998	10,655	273	15	711	438	6,037	28
29		DOOR FRAMES		1998	4,379	112	15	291	179	2,481	29
30		GUTTERS		1999	800	21	15	53	32	400	30
31		AIR CONDITIONING		1999	17,091	438	10	1,710	1,272	12,819	31
32		WATER HEATER, DOOR, PLUMBING		2000	13,377	343	15	891	548	5,818	32
33		AIR CONDITIONING		2001	2,606	67	15	173	106	854	33
34		AIR CONDITIONING		2004	4,707	121	10	471	350	981	34
35		ROOF		2004	3,836	98	15	256	158	490	35
36		BOILER MAINTENANCE		2004	8,893	228	15	592	364	1,037	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 SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning:

8/1/05

Ending:

7/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	SMOKE DETECTORS & SPRINKLER SYSTEM	2005	\$ 9,831	\$ 252	15	\$ 656	\$ 404	\$ 899	37
38	DRY PIPE VALVE REPLACEMENT	2005	2,144	53	15	143	90	143	38
39	FIRE ALARM SYSTEM	2005	6,127	111	15	272	161	272	39
40	GREASE TRAP	2006	1,879	6	10	16	10	16	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,080,435	\$ 4,614		\$ 37,763	\$ 33,149	\$ 754,958	70

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

Facility Name & ID Number SUNRISE MANOR OF VIRDEN # 0025841 Report Period Beginning: 8/1/05 Ending: 7/31/06

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	\$ 281,853	\$ 31,074	\$ 27,065	\$ (4,009)	VARIOUS	\$ 141,651	71
72	Current Year Purchases	15,022	2,208	604	(1,604)	VARIOUS	604	72
73	Fully Depreciated Assets	228,580					228,580	73
74								74
75	TOTALS	\$ 525,455	\$ 33,282	\$ 27,669	\$ (5,613)		\$ 370,835	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)	\$	1,610,890	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	37,896	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	65,432	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	27,536	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,125,793	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: SUNRISE PROPERTY

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:	<u>1970</u>	<u>99</u>	<u>8/1/85</u>	\$ <u>144,000</u>	<u>1</u>	<u>N/A</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 144,000			7

10. Effective dates of current rental agreement:

Beginning 8/1/05

Ending 7/31/06

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

Fiscal Year Ending Annual Rent

12.	<u>7/31/2007</u>	\$ <u>144,000</u>
13.	<u>7/31/2008</u>	\$ <u>144,000</u>
14.	<u>7/31/2009</u>	\$ <u>144,000</u>

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: INCLUDED IN ABOVE AMOUNT

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	2,032	\$ 105,746	\$	2,032	\$ 105,746	1
2	Licensed Speech and Language Development Therapist		hrs		769	50,576		769	50,576	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,061	102,251		2,061	102,251	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				80,518		80,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen, Labs, Xray, Supp						27,906		27,906	13
14	TOTAL			\$	4,862	\$ 258,573	\$ 108,424	4,862	\$ 366,997	14

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

Facility Name & ID Number SUNRISE MANOR OF VIRDEN# 0025841Report Period Beginning: 8/1/05

Ending:

7/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 7/31/06

(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	\$ 55,832	\$ 59,299	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	482,023	482,023	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,025	4,025	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 541,880	\$ 545,347	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		5,000	13
14	Buildings, at Historical Cost		892,827	14
15	Leasehold Improvements, at Historical Cost	187,608	187,608	15
16	Equipment, at Historical Cost	375,554	524,054	16
17	Accumulated Depreciation (book methods)	(383,198)	(1,422,890)	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)	\$ 179,964	\$ 186,599	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 721,844	\$ 731,946	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 187,637	\$ 187,637	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	448,760	35,550	29
30	Accrued Salaries Payable	62,042	62,042	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,824	6,824	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,812	37,812	32
33	Accrued Interest Payable		28	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)	\$ 743,075	\$ 329,893	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)	\$ 743,075	\$ 329,893	46
47	TOTAL EQUITY(page 18, line 24)	\$ (21,231)	\$ 402,053	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 721,844	\$ 731,946	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 320,293	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 320,293	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(341,524)	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)	\$ (341,524)	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)	\$ (21,231)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SUNRISE MANOR OF VIRDEN# 0025841Report Period Beginning: 8/1/05Ending: 7/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,704,006	1
2	Discounts and Allowances for all Levels	(18,108)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,685,898	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,806	6
7	Oxygen	5,147	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 59,953	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,185	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	727	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	714	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,626	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,819	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,819	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	86	28
28a	W/A 52 ADMIT FEE 450	502	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 588	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,752,884	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	544,391	31
32	Health Care	1,623,237	32
33	General Administration	656,615	33
B. Capital Expense			
34	Ownership	215,962	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,094,408	40
41	Income before Income Taxes (line 30 minus line 40)**	(341,524)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (341,524)	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 **SUNRISE MANOR OF VIRDEN**

0025841

Report Period Beginning:

8/1/05

Ending:

7/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 48,199	\$ 23.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,433	8,839	189,602	21.45	3
4	Licensed Practical Nurses	13,610	14,811	233,944	15.80	4
5	CNAs & Orderlies	46,046	47,294	473,386	10.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,463	3,540	39,060	11.03	8
9	Activity Director	1,675	1,843	17,973	9.75	9
10	Activity Assistants	3,238	3,305	23,934	7.24	10
11	Social Service Workers	3,129	3,316	32,286	9.74	11
12	Dietician					12
13	Food Service Supervisor	1,875	2,038	26,525	13.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,146	10,406	80,273	7.71	15
16	Dishwashers					16
17	Maintenance Workers	3,599	3,704	38,746	10.46	17
18	Housekeepers	5,567	5,893	45,277	7.68	18
19	Laundry	2,554	2,753	25,706	9.34	19
20	Administrator	2,000	2,080	65,236	31.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,714	4,106	46,387	11.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Utility Workers</u>	4,220	4,332	31,461	7.26	33
34	TOTAL (lines 1 - 33)	115,269	120,340	\$ 1,417,995 *	\$ 11.78	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	248	\$ 7,883	1-3	35
36	Medical Director	120	9,000	9-3	36
37	Medical Records Consultant	7	193	10-3	37
38	Nurse Consultant	657	30,391	10-3	38
39	Pharmacist Consultant	96	3,475	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	87	5,241	12-3	45
46	Other(specify) <u>See Attached Sched</u>	423	24,670	VAR	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,638	\$ 80,853		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	946	28,703	10-3	51
52	Certified Nurse Assistants/Aides	1,643	32,936	10-3	52
53	TOTAL (lines 50 - 52)	2,589	\$ 61,639		53

Facility Name & ID Number SUNRISE MANOR OF VIRDEN

0025841

Report Period Beginning: 8/1/05

Ending: 7/31/06

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	
PATRICIA BARNES	ADMINISTRATOR	0	\$ 65,236	Workers' Compensation Insurance	\$ 61,033	IDPH License Fee	\$	
				Unemployment Compensation Insurance	24,697	Advertising: Employee Recruitment	5,744	
				FICA Taxes	106,805	Health Care Worker Background Check	2,018	
				Employee Health Insurance		(Indicate # of checks performed <u>46</u>)		
				Employee Meals		Patient Background Checks	80	
				Illinois Municipal Retirement Fund (IMRF)*		YELLOW PAGES & PUBLIC RELATION	11,715	
				EMPLOYEE CAFETERIA PLAN	54,153	CLIA LAB FEE 150 + FRANCHISE FEE 32:	475	
				EMPLOYEE LIFE INSURANCE	4,513	DUES & SUBSCRIPTIONS	205	
				GIFT CERTIFICATES	935	ADMINISTRATOR LICENSE	100	
				EMPLOYEE VACCINES & LABS	403	NHM ALLOCATION	226	
						Less: Public Relations Expense	(11,417)	
						Non-allowable advertising	()	
						Yellow page advertising	(298)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
			\$ 65,236		\$ 269,721		\$ 8,768	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
ADMINISTRATIVE CONSULTANT			\$ 10,929	GIFT CERTIFICATES	22	\$ 935	Out-of-State Travel	\$
				EMPLOYEE VACCINES & LABS	22	403		
							In-State Travel	
							SEE ATTACHED SCHEDULE	2,220
							NHM ALLOCATION	946
							TRANSFER 31% TO ADMINISTRATIVE	(293)
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL	
			\$ 10,929			\$ 1,338		\$ 2,873
C. Professional Services								
Vendor/Payee	Type		Amount					
NURSING HOME MNGRS	MANAGEMENT FEE		\$ 134,295					
FELDMAN, WASSER, ET AL	LEGAL		1,414					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
			\$ 135,709					

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 210 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. \$ 54,203
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. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 727
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, 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.

PAGE 2 - SCHEDULE III - QUESTION J

FACILITY WAS LEASED 10/01/80 FROM NON-RELATED PARTY
 FACILITY WAS PURCHASED 07/23/85

PAGE 3 & 4 - SCHEDULE V

LINE 27 - OTHER - GENERAL AND ADMINISTRATION	
FINES	\$ 7,410
SALES TAX	2,598
BAD DEBTS	9,581
LINE 27 - COLUMN 3	<u>\$ 19,589</u>

LINE 23 - INSERVICE TRAINING & EDUCATION	
QUALITY SAFETY WORKSHOP	\$ 345
MEDICAID REIMBURSEMENT WORKSHOP	435
ORTHOPAEDIC SEMINAR	45
MEDICARE SEMINAR	489
DIETARY WORKSHOP	175
SOCIAL SERVICE & ACTIVITY WORKSHOP	179
INHAA CONFERENCE	190
ALZHEIMER SEMINAR	100
PRESSURE ULCER/INCONTINANCE SEMINAR	525
INSERVICES BY HOME OFFICE	990
NURSING HOME MANAGERS ALLOCATION	1,580
LINE 23 - COLUMN 8	<u>\$ 5,053</u>

PAGE 3 & 4 - SCHEDULE V

COLUMN 5 - RECLASSIFICATION

TRANSFER FROM:		LINE #
OTHER MEDICARE ANCILLARY SERVICE	\$ (3,791)	10
MEDICARE X -RAYS	(3,127)	10
MEDICARE SUPPLIES	(882)	10
MEDICARE LABS	(7,970)	10
MEDICARE DRUGS & IV'S	(80,518)	10
OXYGEN	(12,136)	10
PHYSICAL THERAPY	(102,251)	10A
SPEECH THERAPY	(50,576)	10A
OCCUPATIONAL THERAPY	<u>(105,746)</u>	10A
TRANSFER TO: ANCILLARY SERVICES	<u>\$ 366,997</u>	39
TRANSFER TO:		
NURSING CONSULTANT TRAVEL	\$ 1,333	10
ADMINISTRATIVE CONSULTANT TRAVEL	<u>1,690</u>	17
TRANSFER FROM : TRAVEL	<u>\$ (3,023)</u>	24

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 65,432
NURSING HOME MANAGERS ALLOCATION	<u>1,797</u>
SCHEDULE V- LINE 30 - COLUMN 8	<u>\$ 67,229</u>

PAGE 20 - SCHEDULE XVIII - SECTION B - CONSULTANT SERVICES

	HOURS	CONSULTANT COST	SCH V LINE & COLUMN
PSYCHIATRIC CONSULTANT	28	\$ 3,500	10 - 3
MEDICARE CONSULTANT	48	8,341	10 - 3
ADMINISTRATIVE CONSULTANT	328	10,929	17-3
UTILIZATION REVIEW	<u>19</u>	<u>1,900</u>	10 - 3
SCHEDULE XVIII -LINE 47	<u>423</u>	<u>\$ 24,670</u>	

PAGE 23 - SCHEDULE XX - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENT WORKED BASED UPON TIME CARDS.

PAGE 19 - SCHEDULE XVII - LINE 41

RECONCILIATION OF INCOME

LINE 41 - NET INCOME	\$ (341,524)
* ACCRUED MANAGEMENT FEE - 07/31/05	(13,224)
* ACCRUED MANAGEMENT FEE - 07/31/06	12,868
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(1,819)
TAXABLE INCOME	<u>\$ (343,699)</u>

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

CENTRAL OFFICE COST ALLOCATION
 SUNRISE
 2005

	AUG 05	SEPT	OCT	NOV	DEC	JAN 06	FEB	MARCH	APRIL	MAY	JUNE	JULY	TOTAL	LINE #
SALARIES-ADMIN	\$2,847	\$2,867	\$2,927	\$2,892	\$2,800	\$2,529	\$2,533	\$2,453	\$2,354	\$2,392	\$2,435	\$2,379	\$31,409	17
SALARIES-CLERIC	2,234	2,250	2,297	2,270	2,198	1,995	1,998	1,935	1,857	1,887	1,921	1,877	24,721	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	11
SALARIES-NURSE	778	783	800	790	765	372	373	361	347	352	358	350	6,430	10
ACCOUNTING	16	16	16	16	16	9	9	9	8	9	9	9	141	19
WORK COMP INS	53	53	54	54	52	18	18	18	17	17	18	17	389	22
SUPPLIES	62	62	63	63	61	85	85	82	79	80	82	80	883	21
TELEPHONE	126	127	130	128	124	121	121	117	113	115	117	114	1,453	21
EMPL BENEFITS	1,123	1,131	1,154	1,141	1,104	969	971	940	902	917	933	912	12,196	22
PAYROLL TAXES	391	394	402	397	385	389	390	378	362	368	375	366	4,597	22
TRAVEL	109	110	112	111	107	59	59	57	55	56	57	56	946	24
IN SERVICE	99	100	102	101	97	160	160	155	149	151	154	151	1,580	23
MEDICAL CONSULT	0	0	0	0	0	89	89	86	82	84	85	83	598	9
MACHINE RENTAL	35	35	36	35	34	18	18	18	17	17	18	17	298	6
OWNERS COMP	180	182	185	183	177	162	163	157	151	154	156	153	2,003	17
INS-PROP,LIAB,WC	(33)	(33)	(34)	(33)	(32)	26	26	25	24	25	25	25	12	26
DEPRECIATION	160	161	164	162	157	147	147	143	137	139	142	138	1,797	30
RENT	395	398	406	401	389	375	375	363	349	354	361	352	4,519	34
MAINTENANCE	114	115	117	116	112	84	84	82	79	80	81	79	1,143	6
FEES & PUBLICAT	30	31	31	31	30	11	11	10	10	10	10	10	226	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	\$8,718	\$8,780	\$8,962	\$8,857	\$8,575	\$7,620	\$7,632	\$7,391	\$7,093	\$7,207	\$7,336	\$7,169	\$95,341	
FIXED ASSETS													95,341	
EQUIP - PRIOR	8,826	8,890	9,074	8,968	8,682	12,680	12,701	12,298	11,803	11,993	12,207	11,929	10,838	
EQUIP - CURR	4,888	4,923	5,025	4,966	4,808	0	0	114	110	112	191	186	2,110	
EQUIP - FULLY DEP	4,062	4,092	4,176	4,127	3,996	3,756	3,762	3,643	3,496	3,552	3,616	3,534	3,818	
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	1,431	1,441	1,471	1,454	1,408	1,323	1,325	1,283	1,232	1,251	1,274	1,245	1,345	

OCCUPIED DAYS 2005								
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,230	2,499	1,744		1,682	1,970	10,125
FEBRUARY		1,998	2,290	1,533		1,485	1,797	9,103
MARCH		2,199	2,453	1,727		1,679	1,945	10,003
APRIL		2,085	2,215	1,594		1,566	1,994	9,454
MAY		2,095	2,132	1,655		1,500	2,054	9,436
JUNE		1,942	2,069	1,677		1,402	1,975	9,065
JULY		2,118	2,026	1,781		1,315	1,994	9,234
AUGUST		2,091	2,047	1,833		1,280	1,960	9,211
SEPTEMBER		2,059	1,881	1,778		1,163	1,877	8,758
OCTOBER		2,210	1,902	1,854		1,173	1,999	9,138
NOVEMBER		2,175	1,844	1,936		1,216	1,978	9,149
DECEMBER		2,329	2,001	2,007		1,332	2,030	9,699
TOTAL	0	25,531	25,359	21,119	0	16,793	23,573	112,375

OCCUPIED DAYS 2006							
DAYS	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,331	2,170	2,010		1,459	1,952	9,922
FEBRUARY	2,071	1,914	1,868		1,302	1,756	8,911
MARCH	2,411	2,193	2,142		1,383	1,917	10,046
APRIL	2,269	2,014	2,034		1,346	1,718	9,381
MAY	2,177	1,972	2,041		1,447	1,746	9,383
JUNE	2,081	1,987	2,014		1,386	1,745	9,213
JULY	2,181	2,119	2,133		1,338	1,765	9,536
AUGUST							
SEPTEMBER							
OCTOBER							
NOVEMBER							
DECEMBER							
TOTAL	15,521	14,369	14,242	0	9,661	12,599	66,392

ALLOCATION PERCENTAGE 2005							
DAYS	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
FEBRUARY	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
MARCH	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
APRIL	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
MAY	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
JUNE	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%
JULY	0.00%	22.94%	21.94%	19.29%	14.24%	21.59%	100.00%
AUGUST	0.00%	22.70%	22.22%	19.90%	13.90%	21.28%	100.00%
SEPTEMBER	0.00%	23.51%	21.48%	20.30%	13.28%	21.43%	100.00%
OCTOBER	0.00%	24.18%	20.81%	20.29%	12.84%	21.88%	100.00%
NOVEMBER	0.00%	23.77%	20.16%	21.16%	13.29%	21.62%	100.00%
DECEMBER	0.00%	24.01%	20.63%	20.69%	13.73%	20.93%	100.00%

ALLOCATION PERCENTAGE 2006							
DAYS	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL	
JANUARY	23.49%	21.87%	20.26%	14.70%	19.67%	100.00%	
FEBRUARY	23.24%	21.48%	20.96%	14.61%	19.71%	100.00%	
MARCH	24.00%	21.83%	21.32%	13.77%	19.08%	100.00%	
APRIL	24.19%	21.47%	21.68%	14.35%	18.31%	100.00%	
MAY	23.20%	21.02%	21.75%	15.42%	18.61%	100.00%	
JUNE	22.59%	21.57%	21.86%	15.04%	18.94%	100.00%	
JULY	22.87%	22.22%	22.37%	14.03%	18.51%	100.00%	