

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0003020

Facility Name: MENARD CONVALESCENT CENTER

Address: 120 ANTLE STREET PETERSBURG 62675
 Number City Zip Code

County: MENARD

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

HFS ID Number: 37-0856151001

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

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 12/1/06 to 11/30/07 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 MENARD CONVALESCENT CENTER# 0003020 Report Period Beginning: 12/1/06 Ending: 11/30/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>59</u>	Skilled (SNF)	<u>59</u>	<u>21,535</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>27</u>	Intermediate (ICF)	<u>27</u>	<u>9,855</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>86</u>	TOTALS	<u>86</u>	<u>31,390</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>2,601</u>	<u>2,601</u>	8
9	SNF/PED					9
10	ICF	<u>8,555</u>	<u>6,759</u>		<u>15,314</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,555</u>	<u>6,759</u>	<u>2,601</u>	<u>17,915</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.07%

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

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

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

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

NONE

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

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

YES NO

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

YES NO

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

Date started / / 66

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

YES Date _____ NO

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

YES NO If YES, enter numberof beds certified 30 and days of care provided 2,601Medicare Intermediary NATIONAL GOVERNMENT SERVICES OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 11/30/07 Fiscal Year: 11/30/07

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/06 Ending: 11/30/07

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	116,719	9,393	5,766	131,878		131,878		131,878		1
2	Food Purchase		84,873		84,873		84,873	(1,790)	83,083		2
3	Housekeeping	41,574	9,270		50,844		50,844		50,844		3
4	Laundry	26,066	6,736		32,802		32,802		32,802		4
5	Heat and Other Utilities			85,855	85,855		85,855		85,855		5
6	Maintenance	34,205	20,276	35,958	90,439		90,439	3,459	93,898		6
7	Other (specify):* UTILITY WORKERS	18,720			18,720		18,720		18,720		7
8	TOTAL General Services	237,284	130,548	127,579	495,411		495,411	1,669	497,080		8
	B. Health Care and Programs										
9	Medical Director	12,033		12,000	24,033		24,033		24,033		9
10	Nursing and Medical Records	809,817	198,999	47,695	1,056,511	(151,222)	905,289	5,483	910,772		10
10a	Therapy	31,289	4,585	229,696	265,570	(229,696)	35,874		35,874		10a
11	Activities	55,122	4,725		59,847		59,847		59,847		11
12	Social Services	25,304		5,285	30,589		30,589		30,589		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	933,565	208,309	294,676	1,436,550	(380,918)	1,055,632	5,483	1,061,115		16
	C. General Administration										
17	Administrative	48,959		4,800	53,759	1,029	54,788	27,336	82,124		17
18	Directors Fees										18
19	Professional Services			123,489	123,489		123,489	(112,843)	10,646		19
20	Dues, Fees, Subscriptions & Promotions			21,393	21,393		21,393	(12,954)	8,439		20
21	Clerical & General Office Expenses	51,616	13,927	4,061	69,604		69,604	22,638	92,242		21
22	Employee Benefits & Payroll Taxes			229,113	229,113		229,113	435	229,548		22
23	Inservice Training & Education			5,711	5,711		5,711	1,196	6,907		23
24	Travel and Seminar			7,229	7,229	(2,674)	4,555	382	4,937		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			57,619	57,619		57,619	(6)	57,613		26
27	Other (specify):*			30,808	30,808		30,808	(16,677)	14,131		27
28	TOTAL General Administration	100,575	13,927	484,223	598,725	(1,645)	597,080	(90,493)	506,587		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,271,424	352,784	906,478	2,530,686	(382,563)	2,148,123	(83,341)	2,064,782		29

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER #0003020 Report Period Beginning: 12/1/06 Ending: 11/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			16,058	16,058		16,058	5,631	21,689		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			29,766	29,766		29,766		29,766		33
34	Rent-Facility & Grounds							3,482	3,482		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			45,824	45,824		45,824	9,113	54,937		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					382,563	382,563		382,563		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			47,085	47,085		47,085		47,085		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			47,085	47,085	382,563	429,648		429,648		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,271,424	352,784	999,387	2,623,595		2,623,595	(74,228)	2,549,367		45

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

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning: 12/1/06

Ending: 11/30/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(577)	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	4,233	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(646)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,934)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(204)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,874)	27		24
25	Fund Raising, Advertising and Promotional	(12,333)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(840)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(1,213)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,388)		\$	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)	(31,840)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31,840)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (74,228)		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		229,696	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		23,525	10	42
43	Prescription Drugs	X		90,842	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>Amb, Supp</u>	X		16,069	10	45
46	Other-Attach Schedule <u>Oxygen, IV</u>	X		22,431	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 382,563		47

BHF USE ONLY						
48		49		50		52

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/1/06

Ending: 11/30/07

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/06

Ending:

11/30/07

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	(577)	0	0	0	0	0	0	0	0	0	0	(577)	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	(577)	0	0	0	0	0	0	0	0	0	0	(577)	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	171	0	0	0	0	0	0	0	0	0	171	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(204)	(113,375)	0	0	0	0	0	0	0	0	0	(113,579)	19
20	Fees, Subscriptions & Promotions	(13,173)	0	0	0	0	0	0	0	0	0	0	(13,173)	20
21	Clerical & General Office Expenses	(646)	0	0	0	0	0	0	0	0	0	0	(646)	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	(171)	0	0	0	0	0	0	0	0	0	(171)	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):*	(30,808)	0	0	0	0	0	0	0	0	0	0	(30,808)	27
28	TOTAL General Administration	(44,831)	(113,375)	0	(158,206)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,408)	(113,375)	0	(158,783)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/06

Ending:

11/30/07

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	4,233	0	0	0	0	0	0	0	0	0	0	4,233	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,233	0	0	0	0	0	0	0	0	0	0	4,233	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(41,175)	(113,375)	0	(154,550)	45								

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/06

Ending:

11/30/07

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 MANAGEMENT FEE	\$ 121,366	NURSING HOME MANAGERS		\$	\$ (121,366)	1
2	V	VAR SEE ATTACHED		NURSING HOME MANAGERS		81,535	81,535	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		7,991	7,991	3
4	V	24 TRAVEL	171	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(171)	4
5	V	17 ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		171	171	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		\$ 121,537			\$ 89,697	\$ * (31,840)	14

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/06 Ending: 11/30/07

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/06

Ending: 11/30/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/06 Ending: 11/30/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

0003020 Report Period Beginning: **12/1/06**

Ending: **11/30/07**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 27,843	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 30,057	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 2,214	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 27,552	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.		\$ 29,766	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	13,606	8
	2003	13,917	9
	2004	29,600	10
	2005	30,375	11
	2006	30,057	12
LINE 4 ACCRUAL: 11/12 OF \$30,057 = \$27,552			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MENARD CONVALESCENT CENTER COUNTY MENARD

FACILITY IDPH LICENSE NUMBER 0003020

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-14-219-006</u>	<u>NURSING HOME</u>	\$ <u>307.82</u>	\$ <u>307.82</u>
2. <u>11-14-219-009</u>	<u>NURSING HOME</u>	\$ <u>1,316.02</u>	\$ <u>1,316.02</u>
3. <u>11-14-227-001</u>	<u>NURSING HOME</u>	\$ <u>2,462.38</u>	\$ <u>2,462.38</u>
4. <u>11-14-228-001</u>	<u>NURSING HOME</u>	\$ <u>24,788.18</u>	\$ <u>24,788.48</u>
5. <u>11-14-228-002</u>	<u>NURSING HOME</u>	\$ <u>874.80</u>	\$ <u>874.80</u>
6. <u>11-14-229-001</u>	<u>NURSING HOME</u>	\$ <u>307.82</u>	\$ <u>307.82</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>30,057.02</u>	\$ <u>30,057.32</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020 Report Period Beginning:

12/1/06 Ending:

11/30/07

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

Report Period Beginning:

12/1/06

Ending:

11/30/07**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1966	1966	\$ 172,985	\$	30	\$	\$	\$ 172,985	4
5	32		1974	1974	148,705		30			148,705	5
6											6
7											7
8											8
	Improvement Type**										
9		LANDSCAPING		1966	5,308					5,308	9
10		FIRE DOORS		1979	1,433					1,433	10
11		FIRE DOORS		1981	8,340					8,340	11
12		BATHROOM		1984	7,335		30	244	244	5,753	12
13		AIR CONDITIONER		1984	1,100		8			1,100	13
14		ELECTRICAL & PLUMBING		1985	11,117		15			11,117	14
15		PLUMBING		1986	4,921		15			4,921	15
16		SMOKE DETECTORS		1986	10,445		25	418	418	8,986	16
17		AIR CONDITIONER		1986	2,235		10			2,235	17
18		PLUMBING		1986	1,145		20			1,145	18
19		ROOF		1987	6,362	257	20	126	(131)	6,327	19
20		WATER HEATER & WINDOWS		1988	6,530	207	15		(207)	6,530	20
21		NURSE CALL		1988	1,674	53	10		(53)	1,674	21
22		ROOF		1989	30,672	974	20	1,534	560	28,377	22
23		WATER HEATER & PARKING LOT		1989	11,502	365	15		(365)	11,502	23
24		FURNACE & FLOORING		1990	19,165	608	15		(608)	19,165	24
25		AIR CONDITIONER		1991	2,633	84	15		(84)	2,633	25
26		PLUMBING FAUCETS		1992	8,909	283	15	162	(121)	8,775	26
27		DOOR ALARM		1992	1,572	50	20	78	28	1,338	27
28		WATER HEATER & GARAGE DOOR		1993	4,348	138	15	290	152	4,204	28
29		WATER HEATER & PLUMBING		1994	5,074	130	15	339	209	4,566	29
30		LANDSCAPING		1994	3,900	260	15	260		3,445	30
31		AIR CONDITIONER & ROOF		1995	7,049	181	15	470	289	5,874	31
32		REMODEL BATHROOMS - TILE, CEILING, FIXTURES		1996	19,751	506	15	1,317	811	15,143	32
33		AIR CONDITIONER		1997	1,710	44	15	114	70	1,197	33
34		FIRE DAMPERS		1998	4,076	105	15	272	167	2,582	34
35		FURNACE		1998	2,200	56	15	147	91	1,395	35
36		GREASE TRAP		1999	2,824	72	15	188	116	1,600	36

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

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

See Page 12A, Line 70 for total

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

0003020

Report Period Beginning:

12/1/06

Ending:

11/30/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	CEILING REPAIR	2002	\$ 4,935	\$ 127	15	\$ 329	\$ 202	\$ 1,947	37
38	AIR CONDITIONING	2002	2,102	54	15	140	86	724	38
39	AIR CONDITIONING & VENTILATION	2004	4,935	127	10	494	367	1,892	39
40	WATER HEATER	2004	1,675	43	15	112	69	345	40
41	DOORS & CONCRETE	2005	33,052	847	20	1,652	805	4,957	41
42	SMOKE DAMPERS	2006	4,504	115	15	300	185	575	42
43	SIDEWALKS	2006	2,480	64	20	124	60	217	43
44	SECURITY DOORS	2006	4,897	126	20	245	119	429	44
45	FIRE SUPPRESSION SYSTEM	2006	1,879	48	25	75	27	113	45
46	AIR CONDITIONING	2007	2,260	26	15	63	37	63	46
47	FLOORING	2007	2,098	11	10	35	24	35	47
48	LANDSCAPING	2007	888	127	15	44	(83)	44	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)		\$ 580,725	\$ 6,088		\$ 9,572	\$ 3,484	\$ 509,696	70

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

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/06 Ending: 11/30/07

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	\$ 125,083	\$ 9,431	\$ 10,634	\$ 1,203	VAR	\$ 79,148	71
72	Current Year Purchases	3,775	539	85	(454)	VAR	85	72
73	Fully Depreciated Assets	191,108					191,108	73
74	ASSETS NO LONGER IN SERVICE	(73,230)					(73,230)	74
75	TOTALS	\$ 246,736	\$ 9,970	\$ 10,719	\$ 749		\$ 197,111	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)	\$ 837,380	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,058	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,291	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,233	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 706,807	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	1,500	\$ 104,696	\$	1,500	\$ 104,696	1
2	Licensed Speech and Language Development Therapist		hrs		167	9,617		167	9,617	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,379	115,383		2,379	115,383	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				98,486		98,486	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, Lab, Xray, Supp, Amb						54,381		54,381	13
14	TOTAL			\$	4,046	\$ 229,696	\$ 152,867	4,046	\$ 382,563	14

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

Facility Name & ID Number MENARD CONVALESCENT CENTER# 0003020Report Period Beginning: 12/1/06

Ending:

11/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 11/30/07

(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	\$ 9,214	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	418,410		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,957		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,847		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 436,428	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	580,726		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	315,512		16
17	Accumulated Depreciation (book methods)	(748,753)		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)	\$ 157,404	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 593,832	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 618,123	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,847		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,766		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,552		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 691,288	\$	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)	\$ 691,288	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (97,456)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 593,832	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,072,386)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,072,386)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(106,817)	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) ADDITIONAL CONTRIBUTED CAPITAL	1,081,747	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 974,930	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)	\$ (97,456)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning: 12/1/06

Ending: 11/30/07

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	\$ 2,427,311	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,427,311	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	75,712	6
7	Oxygen	9,581	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 85,293	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	577	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	894	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,471	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	38	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING 1213 ADM FEE 600 W/A 24	1,837	28
28a	JURY DUTY 22 BAD DEBT RECOVERY 806	828	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,665	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,516,778	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	495,411	31
32	Health Care	1,436,550	32
33	General Administration	598,725	33
B. Capital Expense			
34	Ownership	45,824	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	47,085	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,623,595	40
41	Income before Income Taxes (line 30 minus line 40)**	(106,817)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (106,817)	43

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

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

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

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

Facility Name & ID Number MENARD CONVALESCENT CENTER

0003020

Report Period Beginning:

12/1/06

Ending:

11/30/07

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	2,040	2,120	\$ 53,125	\$ 25.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,167	3,399	87,724	25.81	3
4	Licensed Practical Nurses	15,447	16,483	268,994	16.32	4
5	CNAs & Orderlies	38,344	39,480	399,974	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,998	3,161	31,289	9.90	8
9	Activity Director	1,825	1,948	23,767	12.20	9
10	Activity Assistants	3,101	3,228	31,355	9.71	10
11	Social Service Workers	2,483	2,572	25,304	9.84	11
12	Dietician					12
13	Food Service Supervisor	2,138	2,344	25,474	10.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,730	10,110	91,245	9.03	15
16	Dishwashers					16
17	Maintenance Workers	3,637	3,735	34,205	9.16	17
18	Housekeepers	5,139	5,344	41,574	7.78	18
19	Laundry	3,061	3,254	26,066	8.01	19
20	Administrator	1,840	2,080	48,959	23.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,945	4,296	51,616	12.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	300	300	12,033	40.11	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Utility Workers</u>	1,796	1,976	18,750	9.49	33
34	TOTAL (lines 1 - 33)	100,991	105,830	\$ 1,271,454 *	\$ 12.01	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	159	\$ 5,766	1-3	35
36	Medical Director	100	12,000	9-3	36
37	Medical Records Consultant	21	657	10-3	37
38	Nurse Consultant	581	31,677	10-3	38
39	Pharmacist Consultant	84	2,183	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	86	5,285	12-3	45
46	Other(specify) <u>Psych Consultant</u>	24	6,000	10-3	46
47	<u>ADMINISTRATIVE CONSULTANT</u>	184	4,800	17-3	47
48					48
49	TOTAL (lines 35 - 48)	1,239	\$ 68,368		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	191	6,690	10-3	51
52	Certified Nurse Assistants/Aides	30	488	10-3	52
53	TOTAL (lines 50 - 52)	221	\$ 7,178		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 69 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 _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 47,085
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V - PAGES 3 & 4

SCHEDULE V - PAGE 3 - LINE 24 - COLUMN 8

OTHER GENERAL ADMINISTRATION
PAGE 3 - LINE 27 - COLUMN 3

SALES TAX	\$ 2,934
BAD DEBT	27,874
	<u>\$ 30,808</u>

PAGE 3 - LINE 27 - COLUMN 8

NHM ALLOCATION - PER 2004 DESK REVIEW	\$ <u>14131</u>
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COLUMN 5 - RECLASSIFICATIONS

RECLASS FROM:

		LINE #
AMBULANCE	\$ (15,609)	10
X - RAYS	(11,150)	10
LABS	(12,375)	10
MEDICARE DRUGS	(90,842)	10
IV'S	(7,644)	10
MEDICARE SUPPLIES	(460)	10
OXYGEN	(14,787)	10
PHYSICAL THERAPY	(115,383)	10A
SPEECH THERAPY	(9,617)	10A
OCCUPATIONAL THERAPY	<u>(104,696)</u>	10A

RECLASS TO:

ANCILLARY	\$ <u>382,563</u>	39
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RECLASS TO:

NURSE CONSULTANT TRAVEL	\$ 1,645	10
ADMINISTRATIVE CONS. TRAVEL	<u>1,029</u>	17

RECLASS FROM:

TRAVEL	\$ <u>(2,674)</u>	24
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DETAIL - TRAVEL

ADMINISTRATOR REIMBURSEMENT	\$ 2,118
ACTIVITY TRAVEL	797
MAINTANANCE TRAVEL	428
PATIENT SCREENING TRAVEL	491
MISCELLANEOUS MILEAGE	28
TRAVEL TO MEETINGS / SEMINARS	693
NHM ALLOCATION	382
	<u>\$ 4,937</u>

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 20,291
NURSING HOME MANAGERS ALLOCATION	<u>1,398</u>

SCHEDULE V - LINE 30 - COLUMN 8

	\$ <u>21,689</u>
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SCHEDULE XVII - PAGE 19

RECONCILIATION OF INCOME

LINE 41 - NET INCOME	\$ (106,817)
* ACCRUED MANAGEMENT FEE 11/04	(15,804)
* ACCRUED MANAGEMENT FEE 11/05	34,615
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	<u>(38)</u>
TAXABLE INCOME	<u>\$ (88,044)</u>

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

SCHEDULE V - PAGE 3 - LINE 23 - COLUMN 8

DETAIL - INSERVICE TRAINING & EDUCATION

DIETARY MEETINGS	\$ 686
NURSING SEMINARS	69
LIFE SAFETY SEMINAR	150
ALZHEIMER SEMINARS	315
HOME OFFICE INSERVICES	2213
CPR TRAINING	575
ADMINISTRATOR WORKSHOP	150
EMPLOYEE TRAINING	1478
NURSING HOME MANAGERS ALLOCATION	<u>1196</u>
	<u>\$ 6832</u>

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

FOOD SERVICE PERMIT	\$ 150
DUES & SUBSCRIPTIONS	260
SANITATION LICENSE	35
FRANCHISE FEE	190
	<u>\$ 635</u>

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS
WORKED BASED UPON TIME CARDS.

TIONS

SCHEDULE V - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION
 MENARD
 2006

	DEC 06	JAN 07	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2006 TOTAL	LINE #
SALARIES-ADMIN	2,154	\$1,289	\$1,357	\$1,346	\$1,297	\$1,314	\$1,377	\$1,373	\$1,235	\$1,177	\$1,135	\$1,124	\$16,178	17
SALARIES-CLERIC	1,749	1,725	1,816	1,802	1,736	1,759	1,843	1,838	1,912	1,821	1,757	1,740	21,498	21
SALARIES-CONTR	0	955	1,005	998	961	974	1,020	1,017	1,058	1,008	972	963	10,930	17
SALARIES-NURSE	284	418	440	437	421	426	447	446	266	254	245	242	4,326	10
ACCOUNTING	34	71	74	74	71	72	76	75	50	48	46	45	736	19
WORK COMP INS	29	44	46	46	44	45	47	47	23	22	22	21	435	22
SUPPLIES	42	56	59	58	56	57	60	60	78	74	72	71	742	21
TELEPHONE	80	86	91	90	87	88	92	92	90	85	82	82	1,044	21
EMPL BENEFITS	882	801	843	837	806	817	856	853	907	864	833	825	10,125	27
PAYROLL TAXES	281	302	318	315	304	308	322	322	406	387	373	369	4,006	27
TRAVEL	63	40	42	42	40	41	43	43	53	50	48	48	553	24
IN SERVICE	179	60	63	63	60	61	64	64	154	147	141	140	1,196	23
MEDICAL CONSULT	145	157	165	164	158	160	167	167	199	190	183	181	2,035	10
MACHINE RENTAL	16	14	14	14	14	14	15	15	423	403	389	385	1,716	6
OWNERS COMP	57	0	0	0	0	0	0	0	0	0	0	0	57	17
INS-PROP,LIAB,WC	73	(59)	(63)	(62)	(60)	(61)	(63)	(63)	93	89	86	85	(6)	26
DEPRECIATION	111	113	119	118	114	115	121	121	123	117	113	112	1,398	30
RENT	283	284	299	297	286	290	303	303	301	287	276	274	3,482	34
MAINTENANCE	122	83	88	87	84	85	89	89	269	256	247	245	1,743	6
FEES & PUBLICAT	14	9	9	9	9	9	9	9	37	36	34	34	219	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
MEDICAL DIRECTOR	0	0	0	0	0	0	0	0	(232)	(221)	(213)	(211)	(878)	10
TOTAL	6,598	\$6,445	\$6,787	\$6,735	\$6,487	\$6,573	\$6,888	\$6,868	\$7,446	\$7,092	\$6,841	\$6,776	\$81,535	
FIXED ASSETS	0												81,535	
EQUIP - PRIOR	9,567	9,416	9,915	9,839	9,477	9,602	10,062	10,034	9,975	9,501	9,166	9,078	9,636	
EQUIP - CURR	343	0	0	168	162	164	172	634	630	600	755	949	381	
EQUIP - FULLY DEP	2,834	3,389	3,568	3,541	3,411	3,456	3,621	3,611	3,590	3,419	3,298	3,267	3,417	
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	998	1,003	1,056	1,048	1,010	1,023	1,072	1,069	1,063	1,012	976	967	1,025	

ALLOCATION PERCENTAGES
USED ON MONTHLY ALLOCATIONS - PAGE 27

OCCUPIED DAYS 2006	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	2,154	2,036	2,111		1,269	1,703	9,273
SEPTEMBER	2,072	1,880	2,074		1,249	1,723	8,998
OCTOBER	1,974	2,055	2,267		1,418	1,951	9,665
NOVEMBER	1,830	1,947	2,126		1,414	1,948	9,265
DECEMBER	2,029	2,088	2,182		1,441	1,968	9,708
TOTAL	25,580	24,375	25,002	0	16,452	21,892	113,301 113,301

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

ALLOCATION PERCENTAGE 2006	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%
AUGUST	23.23%	21.96%	22.77%	13.68%	18.37%	100.00%
SEPTEMBER	23.03%	20.89%	23.05%	13.88%	19.15%	100.00%
OCTOBER	20.42%	21.26%	23.46%	14.67%	20.19%	100.00%
NOVEMBER	19.75%	21.01%	22.95%	15.26%	21.03%	100.00%
DECEMBER	20.90%	21.51%	22.48%	14.84%	20.27%	100.00%

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