

Facility Name & ID Number MEADOW MANOR# 0011528 Report Period Beginning: 05/01/07 Ending: 04/30/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,568	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,136	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			4,384	4,384	8
9	SNF/PED					9
10	ICF	15,158	9,073		24,231	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,158	9,073	4,384	28,615	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.44%

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)

MEALS ON WHEELSF. 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 1963

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 22 and days of care provided 4,384Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 04/30/08 Fiscal Year: 04/30/08

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

Facility Name & ID Number **MEADOW MANOR** # **0011528** Report Period Beginning: **05/01/07** Ending: **04/30/08**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	128,069	20,393	9,290	157,752		157,752	(16,465)	141,287		1
2	Food Purchase		199,429		199,429		199,429	(29,587)	169,842		2
3	Housekeeping	42,468	9,789		52,257		52,257		52,257		3
4	Laundry	25,631	14,417		40,048		40,048		40,048		4
5	Heat and Other Utilities			94,302	94,302		94,302	(400)	93,902		5
6	Maintenance	44,767	48,692	65,227	158,686		158,686	11,962	170,648		6
7	Other (specify):* Utility Workers	38,877			38,877		38,877		38,877		7
8	TOTAL General Services	279,812	292,720	168,819	741,351		741,351	(34,490)	706,861		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	1,488	13,488		9
10	Nursing and Medical Records	1,207,425	342,056	33,911	1,583,392	(244,592)	1,338,800	7,124	1,345,924		10
10a	Therapy	53,646	11,078	564,931	629,655	(564,931)	64,724		64,724		10a
11	Activities	55,328	2,551		57,879		57,879		57,879		11
12	Social Services	32,599		6,251	38,850		38,850		38,850		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,348,998	355,685	617,093	2,321,776	(809,523)	1,512,253	8,612	1,520,865		16
	C. General Administration										
17	Administrative	62,178		11,081	73,259	2,801	76,060	42,370	118,430		17
18	Directors Fees										18
19	Professional Services			206,856	206,856		206,856	(193,274)	13,582		19
20	Dues, Fees, Subscriptions & Promotions			57,011	57,011		57,011	(53,652)	3,359		20
21	Clerical & General Office Expenses	93,891	13,954	7,018	114,863		114,863	31,823	146,686		21
22	Employee Benefits & Payroll Taxes			353,878	353,878		353,878	656	354,534		22
23	Inservice Training & Education			9,629	9,629		9,629	1,913	11,542		23
24	Travel and Seminar			6,854	6,854	(3,999)	2,855	809	3,664		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			56,020	56,020		56,020	430	56,450		26
27	Other (specify):* Per Desk Review			107,654	107,654		107,654	(85,676)	21,978		27
28	TOTAL General Administration	156,069	13,954	816,001	986,024	(1,198)	984,826	(254,601)	730,225		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,784,879	662,359	1,601,913	4,049,151	(810,721)	3,238,430	(280,479)	2,957,951		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.

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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			29,039	29,039		29,039	5,727	34,766			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,584	50,584		50,584	(1,117)	49,467			32
33	Real Estate Taxes			24,455	24,455		24,455		24,455			33
34	Rent-Facility & Grounds							5,464	5,464			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			104,078	104,078		104,078	10,074	114,152			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					810,721	810,721		810,721			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,704	52,704		52,704		52,704			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			52,704	52,704	810,721	863,425		863,425			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,784,879	662,359	1,758,695	4,205,933		4,205,933	(270,405)	3,935,528			45

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

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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	\$ (4,120)	21	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(348)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(400)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,470	30		9
10	Interest and Other Investment Income	(1,117)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,884)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,452)	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	(672)	20		17
18	Fines and Penalties	(8,250)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,059)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(92,952)	27		24
25	Fund Raising, Advertising and Promotional	(51,112)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,231)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(46,232)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (214,359)		\$	30

BHF USE ONLY						
48		49		50		52

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

		1	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)	(56,046)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (56,046)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (270,405)		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	Therapy	X		564,931	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		22,217	10	42
43	Prescription Drugs	X		164,351	10	43
44	Ambulance & Other Ancillary	X		26,699	10	44
45	Other-Attach Schedule Supplies	X		10,408	10	45
46	Other-Attach Schedule Oxygen	X		22,115	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 810,721		47

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Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MEALS ON WHEELS - EXP. REIMB - FOOD	\$ (26,968)	2	1
2	MEALS ON WHEELS - EXP. REIMB - SALARY	(16,465)	1	2
3	VENDING	(2,271)	2	3
4	EXPENSE REIMBURSEMENT - R.N.	(528)	10	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	(46,232)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/07

Ending:

04/30/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(16,465)	0	0	0	0	0	0	0	0	0	0	(16,465)	1
2	Food Purchase	(29,587)	0	0	0	0	0	0	0	0	0	0	(29,587)	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	(400)	0	0	0	0	0	0	0	0	0	0	(400)	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	(46,452)	0	0	0	0	0	0	0	0	0	0	(46,452)	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	(528)	0	0	0	0	0	0	0	0	0	0	(528)	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	(528)	0	0	0	0	0	0	0	0	0	0	(528)	16
	C. General Administration													
17	Administrative	0	364	0	0	0	0	0	0	0	0	0	364	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,059)	(193,511)	0	0	0	0	0	0	0	0	0	(194,570)	19
20	Fees, Subscriptions & Promotions	(54,015)	0	0	0	0	0	0	0	0	0	0	(54,015)	20
21	Clerical & General Office Expenses	(7,004)	0	0	0	0	0	0	0	0	0	0	(7,004)	21
22	Employee Benefits & Payroll Taxes	0	(21,978)	0	0	0	0	0	0	0	0	0	(21,978)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(364)	0	0	0	0	0	0	0	0	0	(364)	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):*	(107,654)	21,978	0	0	0	0	0	0	0	0	0	(85,676)	27
28	TOTAL General Administration	(169,732)	(193,511)	0	(363,243)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(216,712)	(193,511)	0	(410,223)	29								

STATE OF ILLINOIS

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Summary B

04/30/08

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,470	0	0	0	0	0	0	0	0	0	0	3,470	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,117)	0	0	0	0	0	0	0	0	0	0	(1,117)	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	2,353	0	0	0	0	0	0	0	0	0	0	2,353	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)	(214,359)	(193,511)	0	(407,870)	45								

Facility Name & ID Number MEADOW MANOR

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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	95%	HILLTOP NURSING HOME, INC	CHARLESTON	Nrsg Home Managers	SPRINGFIELD	MANGEMENT
IGNACIO DELVALLE	5%	JACKSONVILLE CONV. CENTER INC.	JACKSONVILLE	Meadow Manor West	TAYLORVILLE	RENTAL
		MENARD CONVALESCENT CENTER, INC.	PETERSBURG			
		SUNRISE MANOR OF VIRDEN, INC.	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 MANAGEMENT FEE	\$ 203,966	NURSING HOME MANAGERS, INC.	95.00%	\$	\$ (203,966)	1
2	V	VAR SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	95.00%	137,465	137,465	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS - DIRECT ALLOCATION	95.00%	10,455	10,455	3
4	V	24 TRAVEL	364	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(364)	4
5	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW		364	364	5
6	V	22 EMPL. BENEFITS & PR TAXES	21,978	TO TRANSFER HOME OFFICE EMPLOYEE BENEFITS			(21,978)	6
7	V	27 OTHER - GENERAL ADMIN.		AND PAYROLL TAXES TO OTHER - PER DESK REVIEW		21,978	21,978	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 226,308			\$ 170,262	\$ * (56,046)	14

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

Facility Name & ID Number

MEADOW MANOR

#

0011528

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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									\$		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	\$ 0		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.

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization NURSING HOME MANAGERS, INC.
 Street Address 2653 WEST 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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	STOCKHOLDERS	X		WORKING CAPITAL	6/26/00	289,726	834,486	DEMAND	6.0000	50,584	6									
7										7										
8										8										
9	TOTAL Facility Related					\$ 289,726	\$ 834,486			\$ 50,584	9									
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 289,726	\$ 834,486			\$ 50,584	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 **MEADOW MANOR**

0011528 Report Period Beginning: **05/01/07**

Ending: **04/30/08**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2007 report.		\$ 32,074	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.)		\$ 24,055	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$ (8,019)	3																								
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 32,474	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.		\$ 24,455	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td><u>30,883</u></td><td><u>8</u></td></tr> <tr><td>2004</td><td><u>32,509</u></td><td><u>9</u></td></tr> <tr><td>2005</td><td><u>33,888</u></td><td><u>10</u></td></tr> <tr><td>2006</td><td><u>35,376</u></td><td><u>11</u></td></tr> <tr><td>2007</td><td><u>35,817</u></td><td><u>12</u></td></tr> </table>	2003	<u>30,883</u>	<u>8</u>	2004	<u>32,509</u>	<u>9</u>	2005	<u>33,888</u>	<u>10</u>	2006	<u>35,376</u>	<u>11</u>	2007	<u>35,817</u>	<u>12</u>	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2007 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
2003	<u>30,883</u>	<u>8</u>																									
2004	<u>32,509</u>	<u>9</u>																									
2005	<u>33,888</u>	<u>10</u>																									
2006	<u>35,376</u>	<u>11</u>																									
2007	<u>35,817</u>	<u>12</u>																									
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2007 \$																										
14	PLUS APPEAL COST FROM LINE 5 \$																										
15	LESS REFUND FROM LINE 6 \$																										
16	AMOUNT TO USE FOR RATE CALCULATION \$																										
SEE PAGE 10A LONG TERM CARE REAL ESTATE TAX STATEMENT FOR TAX APPLICABLE TO NURSING HOME																											
LINE 4 16/12 OF \$24,355 = \$32,474																											

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MEADOW MANOR COUNTY CHRISTIAN

FACILITY IDPH LICENSE NUMBER 0011528

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-13-23-402-002-00</u>	<u>MEADOW MANOR</u>	\$ <u>35,816.78</u>	\$ <u>24,355.41</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>35,816.78</u>	\$ <u>24,355.41</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? X YES NO

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number MEADOW MANOR

0011528 Report Period Beginning:

05/01/07 Ending:

04/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,061 B. General Construction Type: Exterior MASONRY Frame STEEL & WOOD 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>25,061</u>	<u>1963</u>	<u>\$ 3,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	25,061		\$ 3,000	3

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/07

Ending:

04/30/08

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	48		1963	1958	\$ 226,688	\$	25	\$	\$	\$ 226,688	4
5	48			1967	289,148		30			289,148	5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENT		1979		5,775		15			5,775	9
10	IMPROVEMENT		1980		5,207		VARIOUS			5,207	10
11	IMPROVEMENT		1981		635		10			635	11
12	IMPROVEMENT		1982		36,795		15			36,795	12
13	IMPROVEMENT		1984		44,410		15			44,410	13
14	IMPROVEMENT		1986		13,401		15			13,401	14
15	AIR CONDITIONER		1987		3,749	55	15		(55)	3,749	15
16	IMPROVEMENT		1987		6,721	213	15		(213)	6,721	16
17	IMPROVEMENT		1987		2,539	81	15		(81)	2,539	17
18	SPRINKLER		1989		890	28	15		(28)	890	18
19	IMPROVEMENT		1989		16,132	512	15		(512)	16,132	19
20	IMPROVEMENT		1990		4,004	127	15		(127)	4,004	20
21	IMPROVEMENT		1990		22,907	727	VARIOUS	810	83	16,425	21
22	IMPROVEMENT		1993		2,576	82	VARIOUS	83	1	2,576	22
23	IMPROVEMENT		1994		1,475	47	15	99	52	1,423	23
24	IMPROVEMENT		1995		42,600	1,092	20	2,130	1,038	28,755	24
25	AIR CONDITIONER		1996		6,844	175	15	457	282	5,702	25
26	SMOKE DETECTORS		1996		981	25	15	65	40	817	26
27	SINKS & FAUCETS		1996		2,698	69	15	179	110	2,249	27
28	WINDOWS		1996		3,859	99	15	258	159	3,214	28
29	FIRE DOORS		1996		784	20	15	56	36	654	29
30	NEW DOOR FRAMES		1997		10,035	257	15	669	412	7,024	30
31	SPRINKLER REPAIRS		1997		1,127	29	15	76	47	789	31
32	FIRE DOORS		1998		808	21	15	54	33	513	32
33	AIR CONDITIONER		1998		1,820	47	15	123	76	1,152	33
34	FIRE ALARM SYSTEM		1999		8,250	212	20	410	198	3,919	34
35	WATER HEATER		2000		3,813	98	15	254	156	2,117	35
36	BACKFLOW VALVE		2000		3,998	103	15	266	163	2,156	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 MEADOW MANOR

0011528

Report Period Beginning:

05/01/07

Ending:

04/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	AIR CONDITIONER	1999	\$ 2,985	\$ 77	15	\$ 199	\$ 122	\$ 1,774	37
38	DOORS	2001	4,450	114	15	295	181	2,102	38
39	5 TON AIR CONDITIONER	2001	1,613	41	10	162	121	1,102	39
40	ROOFTOP A/C & HEAT	2001	3,165	81	15	211	130	1,389	40
41	2 ROOMS & BATHROOMS RENOVATED FOR MEDICARE	2002	56,051	1,437	20	2,802	1,365	15,181	41
42	ROOFTOP A/C & HEAT	2002	3,396	87	10	339	252	1,868	42
43	AIR CONDITIONER	2003	1,985	51	10	198	147	959	43
44	SMOKE DETECTORS & EXHAUST SYSTEM	2004	4,838	124	15	322	198	1,356	44
45	ROOF	2004	162,600	4,169	20	8,130	3,961	27,778	45
46	FIRE SUPPRESSION SYSTEM & ELECTRICAL WIRING	2005	6,420	164	20	321	157	928	46
47	HEAT EXCHANGER	2005	1,181	30	15	79	49	191	47
48	FLOOR - BEAUTY SHOP	2007	14,365	354	20	659	305	659	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)		\$ 1,033,718	\$ 10,848		\$ 19,706	\$ 8,858	\$ 790,866	70

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

Facility Name & ID Number MEADOW MANOR # 0011528 Report Period Beginning: 05/01/07 Ending: 04/30/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 118,994	\$ 9,243	\$ 10,893	\$ 1,650	Various	\$ 57,445	71
72	Current Year Purchases	31,017	8,948	1,910	(7,038)	Various	1,910	72
73	Fully Depreciated Assets	386,794				Various	386,794	73
74	Assets No Longer in Service (Includes MM West)	(160,147)					(160,147)	74
75	TOTALS	\$ 376,658	\$ 18,191	\$ 12,803	\$ (5,388)		\$ 286,002	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)	\$ 1,413,376	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,039	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,509	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,470	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,076,868	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	MM WEST CLOSED 9/6/01	\$ 310,256	\$	\$	86
87	PER 4/30/04 - DESK REVIEW				87
88					88
89					89
90					90
91	TOTALS	\$ 310,256	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning: 05/01/07

Ending: 04/30/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>2009</u>	\$ _____
13.	<u>2010</u>	\$ _____
14.	<u>2011</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: _____

(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	39 - 8	hrs	\$	4,096	\$ 265,569	\$	4,096	\$ 265,569	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		696	63,609		696	63,609	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		4,281	235,753		4,281	235,753	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 8	# of prescripts				164,351		164,351	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Labs,Xray, Oxygen</u>	39 - 8					44,332		44,332	12
13	Other (specify): <u>Ambul,Supplies,Other</u>	39 - 8					37,107		37,107	13
14	TOTAL			\$	9,073	\$ 564,931	\$ 245,790	9,073	\$ 810,721	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 MEADOW MANOR# 0011528Report Period Beginning: 05/01/07

Ending:

04/30/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 04/30/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,912	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,455,837		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,876		6
7	Other Prepaid Expenses	53,867		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,572,492	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,000		13
14	Buildings, at Historical Cost	1,033,718		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	440,940		16
17	Accumulated Depreciation (book methods)	(1,108,857)		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)	\$ 368,801	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,941,293	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 490,992	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	227,630		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,280		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,474		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)	\$ 758,376	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	834,486		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)	\$ 834,486	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,592,862	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 348,431	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,941,293	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 161,835	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 161,835	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	186,596	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)	\$ 186,596	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)	\$ 348,431	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MEADOW MANOR# 0011528Report Period Beginning: 05/01/07Ending: 04/30/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,231,097	1
2	Discounts and Allowances for all Levels	(151,781)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,079,316	3
B. Ancillary Revenue			
4	Day Care	4,120	4
5	Other Care for Outpatients		5
6	Therapy	245,383	6
7	Oxygen	8,634	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 258,137	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	43,781	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	400	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	4,095	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 48,276	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,117	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,117	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending \$2,271 W/A \$36 Old Checks \$2,398	4,705	28
28a	Expense Reimb - RN \$528 Admit Fee \$450	978	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,683	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,392,529	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	741,351	31
32	Health Care	2,321,776	32
33	General Administration	986,024	33
B. Capital Expense			
34	Ownership	104,078	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	52,704	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,205,933	40
41	Income before Income Taxes (line 30 minus line 40)**	186,596	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 186,596	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 **MEADOW MANOR**

0011528

Report Period Beginning: **05/01/07**

Ending:

04/30/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 55,441	\$ 26.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,410	5,904	127,938	21.67	3
4	Licensed Practical Nurses	27,224	28,397	455,849	16.05	4
5	CNAs & Orderlies	56,197	57,686	568,197	9.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,003	5,237	53,646	10.24	8
9	Activity Director	2,020	2,086	18,432	8.84	9
10	Activity Assistants	4,585	4,780	36,896	7.72	10
11	Social Service Workers	2,090	2,231	32,599	14.61	11
12	Dietician					12
13	Food Service Supervisor	2,138	2,258	25,103	11.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,798	11,038	86,501	7.84	15
16	Dishwashers					16
17	Maintenance Workers	4,263	4,385	44,767	10.21	17
18	Housekeepers	5,436	5,549	42,468	7.65	18
19	Laundry	2,959	3,089	25,631	8.30	19
20	Administrator	2,000	2,080	62,178	29.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,137	7,544	93,891	12.45	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 Utility Workers	3,897	4,138	38,877	9.40	32
33	Other(specify) M-O-W Coordinat	1,654	1,722	16,465	9.56	33
34	TOTAL (lines 1 - 33)	144,811	150,204	\$ 1,784,879 *	\$ 11.88	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	306	\$ 9,290	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	17	513	10 - 3	37
38	Nurse Consultant	426	24,398	10 - 3	38
39	Pharmacist Consultant	96	3,000	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	100	6,251	12 - 3	45
46	Other(specify)				46
47	Psychiatric Consultant	24	6,000	10 - 3	47
48	Administrative Consultant	432	11,081	17 - 3	48
49	TOTAL (lines 35 - 48)	1,521	\$ 72,533		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$ 0	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? 9 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,038 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. \$ 52,704
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? YES Indicate the amount. \$ 348
- (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.

DUE TO THE CLOSING OF THE MEADOW MANOR WEST BUILDING (SEPTEMBER 6, 2001) WE ARE NO LONGER COMBINING MEADOW MANOR AND MEADOW MANOR WEST ON COST REPORTS. ADJUSTMENTS TO DEPRECIATION, REAL ESTATE TAXES, ETC. HAVE BEEN NOTED ON THE COST REPORT WHERE APPLICABLE.

PAGE 3 & 4 - SCHEDULE V

LINE 27 - OTHER GENERAL ADMINISTRATION		
BAD DEBTS	\$ 92,952	
SALES TAX	6,452	
PENALTY	8,250	
SCHEDULE V - LINE 27 - COLUMN 3	<u>\$ 107,654</u>	

COLUMN 5 - DETAIL OF RECLASSIFICATIONS

FROM:	AMOUNT	LINE #
MEDICARE X-RAYS	\$ (8,037)	10
MEDICARE AMBULANCE	(26524)	10
MEDICARE IV	(19,068)	10
MEDICARE DRUGS	(145,283)	10
MEDICARE LABS	(14,180)	10
MEDICARE SUPPLIES	(10,408)	10
MEDICARE OTHER ANCILLARY	(175)	10
OXYGEN	(22,115)	10
PHYSICAL THERAPY	(235,753)	10A
OCCUPATIONAL THERAPY	(265,569)	10A
SPEECH THERAPY	(63,609)	10A
TO: ANCILLARY SERVICES	<u>\$ 810,721</u>	39
TO: ADMINISTRATIVE CONS. MILEAGE	\$ 2,801	17
NURSE CONSULTANT MILEAGE	1,198	10
FROM: TRAVEL	<u>\$ (3,999)</u>	24

PAGE 3 - SCHEDULE V - LINE 23

DETAIL - INSERVICE TRAINING & EDUCATION	
NURSING MANUALS	\$ 64
EMPLOYEE TRAINING - ONLINE	2,448
ACTIVITY COURSE & LODGING	694
ACCUCARE TRAINING & LODGING	2,732
MEDICARE BILLING SEMINAR	175
LIFE SAFETY SEMINAR	150
IN HOUSE TRAINING	337
HOME OFFICE INSERVICES	3,029
NURSING HOME MANAGERS ALLOCATION	1,913
SCHEDULE V - LINE 23 - COLUMN 8	<u>\$ 11,542</u>

PAGE 10A - SECTION A - 2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

THE FOLLOWING ADJUSTMENTS ARE DUE TO THE CLOSING OF MEADOW MANOR WEST ON SEPTEMBER 6, 2001.

MEADOW MANOR PORTION: ALLOWABLE	\$ 24,355.41
68% OF THE \$35,816.78 TAX BILL	
MEADOW MANOR WEST PORTION: NON-ALLOWABLE	11,461.37
32% OF THE \$35,816.78 TAX BILL	
TOTAL 2007 REAL ESTATE TAX BILL	<u>\$ 35,816.78</u>

PAGE 13 - SCHEDULE XI - SECTION E
RECONCILIATION OF DEPRECIATION

SCHEDULE XI - SECTION E - LINE 83	\$ 32,509
NURSING HOME MANAGERS ALLOCATION	<u>2,257</u>
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 34,766</u>

PAGE 21 - SCHEDULE XIX - SECTION F
DUES, FEES, SUBSCRIPTIONS, AND PROMOTIONS

YELLOW PAGES	\$ 2231
INHAA DUES	100
PUBLIC RELATIONS	51,112
FRANCHISE FEES	178
CHAMBER OF COMMERCE	312
LTCNA	35
KIWANIS	360
COUNTY HEALTH FOOD SERVICE	150
ADMINISTRATOR LICENSE	100
CLIA LAB WAVER	<u>150</u>
SCHEDULE XIX - SECTION F	<u>\$ 54,728</u>

PAGE 19 - SCHEDULE XVII
RECONCILIATION OF INCOME

LINE 43 - NET INCOME	\$ 186,596
* MANAGEMENT FEE 4/07	(20,356)
INTEREST INCOME	(1,117)
RENTAL INCOME	(400)
ROUNDING	<u>2</u>
TAXABLE INCOME	<u>\$ 164,725</u>

PAGE 21 - SCHEDULE XIX - SECTION G
SCHEDULE OF TRAVEL & SEMINAR

ADMINISTRATOR MILEAGE	\$ 504
DON MILEAGE	230
MISCELLANEOUS MILEAGE	547
ACTIVITY MILEAGE	243
COMMUNITY RELATIONS MILEAGE	958
SEMINARS & WORKSHOP MILEAGE	<u>373</u>
SCHEDULE XIX - SECTION G	<u>\$ 2,855</u>

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

PAGE 23 - SCHEDULE XX - QUESTION 12

SALARY COSTS ARE ALLOCATED TO DEPARTMENT BASED UPON HOURS WORKED PER TIME CARDS.

CENTRAL OFFICE COST ALLOCATION
 MEADOW MANOR
 SCHEDULE VII PAGE 6 LINE 2

0011528

05/01/07 TO 04/30/08

CENTRAL OFFICE COST ALLOCATION
 MEADOW MANOR
 2007

	MAY 07	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN 08	FEB	MARCH	APRIL	2007 TOTAL	LINE #
SALARIES-ADMIN	\$2,098	1,998	1,990	1,805	1,841	1,773	1,824	1,869	\$2,041	\$1,979	\$1,980	\$2,040	\$23,238	17
SALARIES-CLERIC	2,808	2,674	2,665	2,793	2,849	2,744	2,822	2,891	3,297	3,197	3,199	3,294	35,232	21
SALARIES-CONTR	1,554	1,480	1,475	1,546	1,577	1,519	1,562	1,600	1,639	1,589	1,590	1,637	18,768	17
SALARIES-NURSE	681	648	646	389	397	382	393	403	943	914	915	942	7,652	10
ACCOUNTING	115	110	109	73	74	72	74	75	151	146	146	151	1,296	19
WORK COMP INS	71	68	67	34	35	34	35	35	70	68	68	70	656	22
SUPPLIES	91	87	86	114	116	112	115	118	169	163	164	168	1,503	21
TELEPHONE	140	133	133	131	134	129	132	136	260	252	252	260	2,092	21
EMPL BENEFITS	1,304	1,242	1,237	1,325	1,352	1,302	1,339	1,372	1,205	1,168	1,169	1,204	15,217	22
PAYROLL TAXES	491	468	466	593	605	583	599	614	594	576	577	594	6,761	22
TRAVEL	65	62	62	77	79	76	78	80	151	147	147	151	1,173	24
IN SERVICE	98	93	93	225	229	221	227	233	126	122	122	126	1,913	23
MEDICAL CONSULT	255	243	242	291	297	286	294	301	252	244	245	252	3,201	9
MACHINE RENTAL	22	21	21	618	631	608	625	640	835	810	810	835	6,476	6
OWNERS COMP	0	0	0	0	0	0	0	0	0	0	0	0	0	17
INS-PROP,LIAB,WC	(97)	(92)	(92)	136	139	134	138	141	6	5	5	6	430	26
DEPRECIATION	184	176	175	180	183	176	181	186	207	201	201	207	2,257	30
RENT	462	440	439	440	448	432	444	455	483	468	469	483	5,464	34
MAINTENANCE	135	129	128	393	401	386	397	407	789	765	766	789	5,486	6
FEES & PUBLICAT	14	13	13	55	56	54	55	57	12	11	11	12	363	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
MEDICAL CONSULT	0	0	0	(339)	(346)	(333)	(343)	(351)	0	0	0	0	(1,713)	9
TOTAL	10,493	9,992	9,956	10,879	11,097	10,688	10,990	11,261	\$13,229	\$12,827	\$12,835	\$13,219	137,465	
FIXED ASSETS	0	0	0	0	0	0	0	0	0	0	0	0	137,465	
EQUIP - PRIOR	15,329	14,598	14,546	14,575	14,868	14,319	14,724	15,087	15,152	14,692	14,702	15,141	14,811	
EQUIP - CURR	262	250	918	920	939	1,179	1,540	1,969	0	0	252	259	707	
EQUIP - FULLY DEP	5,517	5,253	5,235	5,245	5,351	5,153	5,299	5,430	5,453	5,287	5,291	5,449	5,330	
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	1,633	1,555	1,549	1,553	1,584	1,525	1,568	1,607	1,614	1,565	1,566	1,613	1,578	

Year	1990	1991	1992	1993	1994
Population	100	100	100	100	100
Urban	30	30	30	30	30
Rural	70	70	70	70	70
Male	50	50	50	50	50
Female	50	50	50	50	50

ALLOCATION PERCENTAGES USED ON PAGE 27
MEADOW MANOR

0011528

05/01/07 TO 04/30/08

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

OCCUPIED DAYS 2008	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,239	2,512	2,573		1,460	1,936	10,720
FEBRUARY	2,140	2,453	2,399		1,407	1,909	10,308
MARCH	2,260	2,436	2,476		1,475	1,985	10,632
APRIL	2,248	2,186	2,456		1,483	1,867	10,240
MAY	2,356	2,118	2,479		1,731	2,002	10,686
JUNE	2,283	2,143	2,410		1,661	1,881	10,378
JULY	2,369	2,288	2,429		1,632	1,992	10,710
AUGUST							0
SEPTEMBER							0
OCTOBER							0
NOVEMBER							0
DECEMBER							0
TOTAL	15,895	16,136	17,222	0	10,849	13,572	73,674 73,674

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%

ALLOCATION PERCENTAGE 2008	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	20.89%	23.43%	24.00%	13.62%	18.06%	100.00%
FEBRUARY	20.76%	23.80%	23.27%	13.65%	18.52%	100.00%
MARCH	21.26%	22.91%	23.29%	13.87%	18.67%	100.00%
APRIL	21.95%	21.35%	23.98%	14.48%	18.23%	100.00%
MAY	22.05%	19.82%	23.20%	16.20%	18.73%	100.00%
JUNE	22.00%	20.65%	23.22%	16.01%	18.12%	100.00%
JULY	22.12%	21.36%	22.68%	15.24%	18.60%	100.00%