



Facility Name & ID Number MEADOW MANOR

# 0011528 Report Period Beginning: 05/01/04 Ending: 04/30/05

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	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	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		8	2,994	3,002	8
9	SNF/PED					9
10	ICF	12,182	5,074		17,256	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,182	5,082	2,994	20,258	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.81%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
NONE

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

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

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 2,994

Medicare Intermediary ADMINASTAR FEDERAL OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 4/30/05 Fiscal Year: 4/30/05

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	90,156	12,033	5,341	107,530		107,530		107,530		1
2	Food Purchase		84,247		84,247		84,247	(1,616)	82,631		2
3	Housekeeping	33,217	10,532		43,749		43,749		43,749		3
4	Laundry	17,444	9,186		26,630		26,630		26,630		4
5	Heat and Other Utilities			57,100	57,100		57,100	(400)	56,700		5
6	Maintenance	31,966	17,265	33,218	82,449		82,449	1,044	83,493		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	172,783	133,263	95,659	401,705		401,705	(972)	400,733		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	895,936	185,274	107,075	1,188,285	(143,485)	1,044,800	6,369	1,051,169		10
10a	Therapy	25,495	5,117	202,646	233,258	(202,646)	30,612		30,612		10a
11	Activities	46,361	2,129		48,490		48,490		48,490		11
12	Social Services	32,592		4,351	36,943		36,943		36,943		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,000,384	192,520	326,072	1,518,976	(346,131)	1,172,845	6,369	1,179,214		16
	<b>C. General Administration</b>										
17	Administrative	50,322		13,630	63,952	3,172	67,124	30,286	97,410		17
18	Directors Fees										18
19	Professional Services			89,702	89,702		89,702	(80,962)	8,740		19
20	Dues, Fees, Subscriptions & Promotions			18,417	18,417		18,417	(12,876)	5,541		20
21	Clerical & General Office Expenses	38,932	12,006	7,534	58,472		58,472	21,991	80,463		21
22	Employee Benefits & Payroll Taxes			223,853	223,853		223,853	14,520	238,373		22
23	Inservice Training & Education			3,205	3,205		3,205	2,339	5,544		23
24	Travel and Seminar			7,253	7,253	(5,818)	1,435	433	1,868		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			81,307	81,307		81,307	310	81,617		26
27	Other (specify):*			15,356	15,356		15,356	(15,356)			27
28	<b>TOTAL General Administration</b>	89,254	12,006	460,257	561,517	(2,646)	558,871	(39,315)	519,556		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,262,421	337,789	881,988	2,482,198	(348,777)	2,133,421	(33,918)	2,099,503		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 MEADOW MANOR

#0011528

Report Period Beginning:

05/01/04

Ending:

04/30/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			21,490	21,490		21,490	7,092	28,582			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			869	869		869	(576)	293			32
33	Real Estate Taxes			22,475	22,475		22,475		22,475			33
34	Rent-Facility & Grounds							3,794	3,794			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			44,834	44,834		44,834	10,310	55,144			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					348,777	348,777		348,777			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			52,560	52,560	348,777	401,337		401,337			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,262,421	337,789	979,382	2,579,592		2,579,592	(23,608)	2,555,984			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 MEADOW MANOR

# 0011528

Report Period Beginning:

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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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(580)	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	5,613	30		9
10	Interest and Other Investment Income	(576)	32		10
11	Discounts, Allowances, Rebates & Refunds	(745)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,156)	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	(302)	20		17
18	Fines and Penalties	(3,347)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(196)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,853)	27		24
25	Fund Raising, Advertising and Promotional	(12,650)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>VENDING</u>	(1,036)	2		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (26,228)		\$	30

OHF USE ONLY						
48		49		50		51
						52

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

		1	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)	2,620	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 2,620		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (23,608)		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		202,646	10a	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		15,219	10	42
43	Prescription Drugs	X		108,200	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>Supp &amp; Oxy</u>	X		19,669	10	45
46	Other-Attach Schedule <u>Other Ancill</u>	X		3,043	10	46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 348,777		47

MEADOW MANOR

ID# 0011528

Report Period Beginning: 05/01/04

Ending: 04/30/05

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	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MEADOW MANOR

# 0011528

Report Period Beginning:

05/01/04

Ending:

04/30/05

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(580)	0	0	0	0	0	0	0	0	0	0	(580)	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	<b>TOTAL General Services</b>	<b>(980)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(980)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	195	0	0	0	0	0	0	0	0	0	195	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(196)	(80,893)	0	0	0	0	0	0	0	0	0	(81,089)	19
20	Fees, Subscriptions & Promotions	(12,952)	0	0	0	0	0	0	0	0	0	0	(12,952)	20
21	Clerical & General Office Expenses	(745)	0	0	0	0	0	0	0	0	0	0	(745)	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	(195)	0	0	0	0	0	0	0	0	0	(195)	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):*	(15,356)	0	0	0	0	0	0	0	0	0	0	(15,356)	27
28	<b>TOTAL General Administration</b>	<b>(29,249)</b>	<b>(80,893)</b>	<b>0</b>	<b>(110,142)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(30,229)</b>	<b>(80,893)</b>	<b>0</b>	<b>(111,122)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number MEADOW MANOR

# 0011528 Report Period Beginning:

05/01/04 Ending:

Summary B

04/30/05

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	5,613	0	0	0	0	0	0	0	0	0	0	5,613 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(576)	0	0	0	0	0	0	0	0	0	0	(576) 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	<b>TOTAL Ownership</b>	<b>5,037</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,037 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(25,192)</b>	<b>(80,893)</b>	<b>0</b>	<b>(106,085) 45</b>								

**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
H. RAYMOND KLEIN	47.50	HILLTOP NURSING HOME, INC.	CHARLESTON	Nrsg Home Managers	SPRINGFIELD	MANAGEMENT
SAM KLEIN	47.50	JACKSONVILLE CONV. CENTER, INC.	JACKSONVILLE	Meadow Manor West	TAYLORVILLE	
IGNACIO DELVALLE	5.00	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	\$ 89,207	NURSING HOME MANAGERS, INC.	95.00%	\$	\$ (89,207)	1
2	V	VAR SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	95.00%	83,513	83,513	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS, INC.-DIRECT ALLOCATION	95.00%	8,314	8,314	3
4	V	24 TRAVEL	195	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(195)	4
5	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW		195	195	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		\$ 89,402			\$ 92,022	\$ * 2,620	14

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

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

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	H. RAYMOND KLEIN	OWNER	MANAGEMENT	47.50					\$ 1,733	17 - 7	1	
2											2	
3											3	
4			H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC.,									4
5			A RELATED ORGANIZATION. TOTAL COMPENSATION OF \$10,010									5
6			WAS ALLOCATED AMONG THE FIVE RELATED NURSING HOMES									6
7			BASED UPON 10 HOURS PER WEEK FOR H. RAYMOND KLEIN.									7
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 1,733		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 MEADOW MANOR

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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

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

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

**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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	STOCKHOLDERS	X		WORKING CAPITAL		06/26/00	289,726	1,912,726	DEMAND	6.0000	869	6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 289,726	\$ 1,912,726			\$ 869	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 289,726	\$ 1,912,726			\$ 869	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: 05/01/04 Ending: 04/30/05

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>28,000</b>	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.)			\$	<b>21,000</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(7,000)</b>	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>29,475</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>22,475</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2000	<u>28,443</u>	<u>8</u>			
2001	<u>29,530</u>	<u>9</u>			
2002	<u>29,786</u>	<u>10</u>			
2003	<u>30,883</u>	<u>11</u>			
2004	<u>32,509</u>	<u>12</u>			
<b>SEE PAGE 10A LONG TERM CARE REAL ESTATE TAX STATEMENT FOR TAX APPLICABLE TO NURSING HOME</b>					
<b>LINE 4: 16/12 OF \$22,106 = \$29,475</b>					
			<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2004	\$			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:

- Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
- 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: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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,

**2004 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 Cos**

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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</u>	<u>MEADOW MANOR</u>	\$ <u>32,509.22</u>	\$ <u>22,106.27</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>32,509.22</u>	\$ <u>22,106.27</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

Facility Name & ID Number MEADOW MANOR

# 0011528 Report Period Beginning:

05/01/04 Ending:

04/30/05

**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).

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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:**

	1	2	3	4	
A. Land.	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>MMWEST NO LONGER USED</u>	<u>10,391</u>	<u>1984</u>		<u>2</u>
3	<b>TOTALS</b>	<b>35,452</b>		<b>\$ 3,000</b>	<b>3</b>

Facility Name &amp; ID Number MEADOW MANOR

# 0011528

Report Period Beginning:

05/01/04

Ending:

04/30/05

**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 OHF 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	CLOSED			1970	227,964		25			227,964	6
7											7
8											8
	<b>Improvement Type**</b>										
9	IMPROVEMENT			1979	5,775		15			5,775	9
10	IMPROVEMENT - MM WEST			1980	1,810		VARIOUS			1,810	10
11	IMPROVEMENT			1980	5,207		VARIOUS			5,207	11
12	IMPROVEMENT			1981	635		10			635	12
13	IMPROVEMENT			1982	36,795		15			36,795	13
14	ROOF - MM WEST			1984	3,000		15			3,000	14
15	IMPROVEMENT - MM WEST			1984	15,420		15			15,420	15
16	IMPROVEMENT			1984	44,410		15			44,410	16
17	IMPROVEMENT			1986	13,401	308	15		(308)	13,401	17
18	IMPROVEMENT - MM WEST			1985	2,016		15			2,016	18
19	BOILER - MM WEST			1986	966		15			962	19
20	ROOF - MM WEST			1987	1,878		15			1,812	20
21	AIR CONDITIONER			1987	3,749	160	15		(160)	3,749	21
22	IMPROVEMENT			1987	6,721	213	15		(213)	6,721	22
23	IMPROVEMENT			1987	2,539	81	15	170	89	2,368	23
24	IMPROVEMENT - MM WEST			1988	3,588		15			2,490	24
25	SPRINKLER			1989	890	28	15	60	32	828	25
26	IMPROVEMENT			1989	16,132	512	15	540	28	16,132	26
27	IMPROVEMENT			1990	4,004	127	15	267	140	3,738	27
28	IMPROVEMENT - MM WEST			1989	12,205		15			9,699	28
29	IMPROVEMENT - MM WEST			1989	842		15			583	29
30	IMPROVEMENT			1990	22,907	727	VARIOUS	987	260	13,994	30
31	IMPROVEMENT - MM WEST			1990	24,924		VARIOUS			14,410	31
32	IMPROVEMENT			1993	2,576	82	15	172	90	2,150	32
33	IMPROVEMENT - MM WEST			1993	3,604		15			2,140	33
34	IMPROVEMENT			1994	1,475	47	15	98	51	1,127	34
35	IMPROVEMENT			1995	42,600	1,092	20	2,130	1,038	22,365	35
36	IMPROVEMENT - MM WEST			1995	2,471		15			1,141	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number MEADOW MANOR

# 0011528

Report Period Beginning:

05/01/04 Ending:

04/30/05

## 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	1996	\$ 6,844	\$ 175	15	\$ 456	\$ 281	\$ 4,332	37
38	SMOKE DETECTORS	1996	981	25	15	65	40	621	38
39	SINKS & FAUCETS	1996	2,698	69	15	180	111	1,710	39
40	WINDOWS	1996	3,859	99	15	257	158	2,442	40
41	FIRE DOORS	1996	784	20	15	52	32	494	41
42	AIR CONDITIONER - MM WEST	1997	7,569		15			1,977	42
43	NEW DOOR FRAMES	1997	10,035	257	15	669	412	5,017	43
44	SPRINKLER REPAIRS	1997	1,127	29	15	75	46	563	44
45	FIRE DOORS	1998	808	21	15	54	33	351	45
46	AIR CONDITIONER	1998	1,820	47	15	121	74	787	46
47	FIRE ALARM SYSTEM	1999	8,250	212	20	413	201	2,684	47
48	BACKFLOW VALVE - MM WEST	2000	1,999		15			200	48
49	WATER HEATER	2000	3,813	98	15	254	156	1,355	49
50	BACKFLOW VALVE	2000	3,998	103	15	267	164	1,357	50
51	AIR CONDITIONER	1999	2,985	77	15	199	122	1,177	51
52	DOORS	2001	4,450	114	15	297	183	1,213	52
53	5 TON AIR CONDITIONER	2001	1,613	41	10	161	120	617	53
54	ROOFTOP A/C & HEAT	2001	3,165	81	15	211	130	756	54
55	MEADOW MANOR WEST BUILDING CLOSED 09/06/01	2001	(310,256)					(285,624)	55
56	2 ROOMS & BATHROOMS RENOVATED FOR MEDICARE	2002	56,051	1,437	20	2,803	1,366	6,774	56
57	ROOFTOP A/C & HEAT	2002	3,396	87	10	340	253	850	57
58	AIR CONDITIONER	2003	1,985	51	10	198	147	363	58
59	SMOKE DETECTORS & EXHAUST SYSTEM	2004	4,838	124	15	322	198	388	59
60	ROOF	2004	162,600	1,566	20	3,388	1,822	3,388	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)		\$ 1,011,752	\$ 8,110		\$ 15,206	\$ 7,096	\$ 732,470	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: 05/01/04 Ending: 04/30/05

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	\$ 119,321	\$ 9,100	\$ 10,720	\$ 1,620	Various	\$ 71,645	71
72	Current Year Purchases	21,962	4,280	1,177	(3,103)	Various	1,177	72
73	Fully Depreciated Assets	337,156				Various	337,156	73
74	Assets No Longer in Service (Includes MM West)	(160,147)					(160,147)	74
75	TOTALS	\$ 318,292	\$ 13,380	\$ 11,897	\$ (1,483)		\$ 249,831	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)	\$ 1,333,044	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,490	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,103	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,613	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 982,301	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:

**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	<b>TOTAL</b>				\$			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	<b>TOTAL</b>		\$	\$	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. \_\_\_\_\_/2006 \$ \_\_\_\_\_  
13. \_\_\_\_\_/2007 \$ \_\_\_\_\_  
14. \_\_\_\_\_/2008 \$ \_\_\_\_\_

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

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

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

**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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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)	
<b>TOTAL TRAINED</b>	

(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	\$	1,852	\$ 79,731	\$	1,852	\$ 79,731	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		620	29,430		620	29,430	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		1,497	93,485		1,497	93,485	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				108,200		108,200	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab,Xray,O2,Sup,Oth	39 - 8					37,931		37,931	13
14	TOTAL			\$	3,969	\$ 202,646	\$ 146,131	3,969	\$ 348,777	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: 05/01/04

Ending:

04/30/05**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 04/30/05

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 19,138	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	399,049		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,684		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	82,983		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 511,854	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,000		13
14	Buildings, at Historical Cost	1,011,752		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	382,574		16
17	Accumulated Depreciation (book methods)	(1,028,451)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 368,875	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 880,729	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 112,766	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,903		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,638		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,475		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 233,782	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,912,726		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,912,726	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,146,508	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,265,779)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 880,729	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(990,523)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(990,523)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(275,256)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(275,256)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,265,779)</b>	<b>24</b> *

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

Facility Name & ID Number MEADOW MANOR# 0011528Report Period Beginning: 05/01/04Ending: 04/30/05**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,338,908	1
2	Discounts and Allowances for all Levels	(108,733)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,230,175	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	60,051	6
7	Oxygen	10,473	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 70,524	8
<b>C. Other Operating Revenue</b>			
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	580	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	300	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,280	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	576	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 576	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	VENDING - \$1036 W/A - \$70	1,106	28
28a	ADMIT FEES - \$675	675	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,781	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,304,336	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	401,705	31
32	Health Care	1,518,976	32
33	General Administration	561,517	33
<b>B. Capital Expense</b>			
34	Ownership	44,834	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	52,560	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,579,592	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(275,256)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (275,256)	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:

**05/01/04**

Ending:

**04/30/05**

**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	\$ 46,490	\$ 22.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,304	4,482	102,101	22.78	3
4	Licensed Practical Nurses	15,893	16,632	259,950	15.63	4
5	CNAs & Orderlies	45,953	47,513	487,395	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,106	2,282	25,495	11.17	8
9	Activity Director	1,796	1,850	17,713	9.57	9
10	Activity Assistants	4,157	4,273	28,648	6.70	10
11	Social Service Workers	2,188	2,284	32,592	14.27	11
12	Dietician					12
13	Food Service Supervisor	1,879	2,013	22,484	11.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,595	9,881	67,672	6.85	15
16	Dishwashers					16
17	Maintenance Workers	3,895	4,104	31,966	7.79	17
18	Housekeepers	5,145	5,219	33,217	6.36	18
19	Laundry	2,703	2,716	17,444	6.42	19
20	Administrator	2,000	2,080	50,322	24.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,952	4,137	38,932	9.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,566	111,546	\$ 1,262,421 *	\$ 11.32	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	192	\$ 5,341	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	20	600	10 - 3	37
38	Nurse Consultant	748	38,262	10 - 3	38
39	Pharmacist Consultant	96	2,625	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	74	4,351	12 - 3	45
46	Other(specify) <u>Utilization Review</u>	27	2,750	10 - 3	46
47	<u>MEDICARE CONSULTANT</u>	96	22,655	10 - 3	47
48	<u>ADMINISTRATIVE CONSULTANT</u>	408	13,630	17 - 3	48
49	TOTAL (lines 35 - 48)	1,781	\$ 102,214		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	60	\$ 2,582	10 - 3	50
51	Licensed Practical Nurses	1,130	35,945	10 - 3	51
52	Certified Nurse Assistants/Aides	75	1,656	10 - 3	52
53	TOTAL (lines 50 - 52)	1,265	\$ 40,183		53





Facility Name &amp; ID Number MEADOW MANOR

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,840 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. \$ 52,560  
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. \$ 580
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

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, BALANCE SHEET , ETC. HAVE BEEN NOTED ON THE COST REPORT WHERE APPLICABLE.

PAGE 3 & 4 - SCHEDULE V

LINE 27 - OTHER GENERAL ADMINISTRATION		
FINES & PENALTIES	\$	3,347
BAD DEBTS		8,853
SALES TAX		<u>3,156</u>
SCHEDULE V - LINE 27 - COLUMN 3	\$	<u>15,356</u>

COLUMN 5 - DETAIL OF RECLASSIFICATIONS

FROM:	AMOUNT	LINE #
MEDICARE X-RAYS	\$ (2,648)	10
MEDICARE IV	(12,339)	10
MEDICARE DRUGS	(95,861)	10
MEDICARE LABS	(12,571)	10
MEDICARE SUPPLIES	(1,539)	10
MEDICARE OTHER ANCILLARY	(3,043)	10
OXYGEN	(18,130)	10
PHYSICAL THERAPY	(93,485)	10A
OCCUPATIONAL THERAPY	(79,731)	10A
SPEECH THERAPY	<u>(29,430)</u>	10A
TO: ANCILLARY SERVICES	\$ <u>348,777</u>	39
TO: ADMINISTRATIVE CONS. MILEAGE	\$ 3,172	17
NURSE CONSULTANT MILEAGE	<u>2,646</u>	10
FROM: TRAVEL	\$ <u>(5,818)</u>	24

PAGE 3 - SCHEDULE V - LINE 23

DETAIL - INSERVICE TRAINING & EDUCATION		
ACTIVITY COURSE	\$	400
DIETARY SEMINAR		169
FOOD SANITATION COURSE		410
SAFETY SEMINAR		90
I.V. NURSE CLASS		225
MDS CLASS AND TRAINING		874
CPR TRAINING		60
ALZHEIMER SEMINAR		120
HOME OFFICE INSERVICES		857
NURSING HOME MANAGERS ALLOCATION		<u>2,339</u>
SCHEDULE V - LINE 23 - COLUMN 8	\$	<u>5,544</u>

PAGE 10A - SECTION A - 2004 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	\$ 22,106.27
68% OF THE \$32,509.22 TAX BILL	
MEADOW MANOR WEST PORTION: NON-ALLOWABLE	
32% OF THE \$32,509.22 TAX BILL	<u>10,402.95</u>
TOTAL 2004 REAL ESTATE TAX BILL	\$ <u>32,509.22</u>

PAGE 13 - SCHEDULE XI - SECTION E  
 RECONCILIATION OF DEPRECIATION

SCHEDULE XI - SECTION E - LINE 83	\$ 27,103
NURSING HOME MANAGERS ALLOCATION	<u>1,479</u>
SCHEDULE V - LINE 30 - COLUMN 8	\$ <u>28,582</u>

PAGE 23 - SCHEDULE XX - QUESTION 12

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

PAGE 19 - SCHEDULE XVII  
 RECONCILIATION OF INCOME

LINE 43 - NET INCOME	\$ (275,256)
* MANAGEMENT FEE 4/04	(7,816)
* MANAGEMENT FEE 4/05	8,687
INTEREST INCOME	(576)
RENTAL INCOME	<u>(400)</u>
TAXABLE INCOME	\$ <u>(275,361)</u>

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

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

PUBLIC RELATIONS	\$ 12,650
FRANCHISE FEES	265
CHAMBER OF COMMERCE	302
FOOD SERV. SUPERVISOR LICENSE	35
BOILER LICENSE	<u>170</u>

PAGE 21 - SECTION F \$ 13,422



Item	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990	1989	1988	1987	1986	1985	1984	1983	1982	1981	1980	1979	1978	1977	1976	1975	1974	1973	1972	1971	1970	1969	1968	1967	1966	1965	1964	1963	1962	1961	1960	1959	1958	1957	1956	1955	1954	1953	1952	1951	1950	1949	1948	1947	1946	1945	1944	1943	1942	1941	1940	1939	1938	1937	1936	1935	1934	1933	1932	1931	1930	1929	1928	1927	1926	1925	1924	1923	1922	1921	1920	1919	1918	1917	1916	1915	1914	1913	1912	1911	1910	1909	1908	1907	1906	1905	1904	1903	1902	1901	1900	1899	1898	1897	1896	1895	1894	1893	1892	1891	1890	1889	1888	1887	1886	1885	1884	1883	1882	1881	1880	1879	1878	1877	1876	1875	1874	1873	1872	1871	1870	1869	1868	1867	1866	1865	1864	1863	1862	1861	1860	1859	1858	1857	1856	1855	1854	1853	1852	1851	1850	1849	1848	1847	1846	1845	1844	1843	1842	1841	1840	1839	1838	1837	1836	1835	1834	1833	1832	1831	1830	1829	1828	1827	1826	1825	1824	1823	1822	1821	1820	1819	1818	1817	1816	1815	1814	1813	1812	1811	1810	1809	1808	1807	1806	1805	1804	1803	1802	1801	1800	1799	1798	1797	1796	1795	1794	1793	1792	1791	1790	1789	1788	1787	1786	1785	1784	1783	1782	1781	1780	1779	1778	1777	1776	1775	1774	1773	1772	1771	1770	1769	1768	1767	1766	1765	1764	1763	1762	1761	1760	1759	1758	1757	1756	1755	1754	1753	1752	1751	1750	1749	1748	1747	1746	1745	1744	1743	1742	1741	1740	1739	1738	1737	1736	1735	1734	1733	1732	1731	1730	1729	1728	1727	1726	1725	1724	1723	1722	1721	1720	1719	1718	1717	1716	1715	1714	1713	1712	1711	1710	1709	1708	1707	1706	1705	1704	1703	1702	1701	1700	1699	1698	1697	1696	1695	1694	1693	1692	1691	1690	1689	1688	1687	1686	1685	1684	1683	1682	1681	1680	1679	1678	1677	1676	1675	1674	1673	1672	1671	1670	1669	1668	1667	1666	1665	1664	1663	1662	1661	1660	1659	1658	1657	1656	1655	1654	1653	1652	1651	1650	1649	1648	1647	1646	1645	1644	1643	1642	1641	1640	1639	1638	1637	1636	1635	1634	1633	1632	1631	1630	1629	1628	1627	1626	1625	1624	1623	1622	1621	1620	1619	1618	1617	1616	1615	1614	1613	1612	1611	1610	1609	1608	1607	1606	1605	1604	1603	1602	1601	1600	1599	1598	1597	1596	1595	1594	1593	1592	1591	1590	1589	1588	1587	1586	1585	1584	1583	1582	1581	1580	1579	1578	1577	1576	1575	1574	1573	1572	1571	1570	1569	1568	1567	1566	1565	1564	1563	1562	1561	1560	1559	1558	1557	1556	1555	1554	1553	1552	1551	1550	1549	1548	1547	1546	1545	1544	1543	1542	1541	1540	1539	1538	1537	1536	1535	1534	1533	1532	1531	1530	1529	1528	1527	1526	1525	1524	1523	1522	1521	1520	1519	1518	1517	1516	1515	1514	1513	1512	1511	1510	1509	1508	1507	1506	1505	1504	1503	1502	1501	1500	1499	1498	1497	1496	1495	1494	1493	1492	1491	1490	1489	1488	1487	1486	1485	1484	1483	1482	1481	1480	1479	1478	1477	1476	1475	1474	1473	1472	1471	1470	1469	1468	1467	1466	1465	1464	1463	1462	1461	1460	1459	1458	1457	1456	1455	1454	1453	1452	1451	1450	1449	1448	1447	1446	1445	1444	1443	1442	1441	1440	1439	1438	1437	1436	1435	1434	1433	1432	1431	1430	1429	1428	1427	1426	1425	1424	1423	1422	1421	1420	1419	1418	1417	1416	1415	1414	1413	1412	1411	1410	1409	1408	1407	1406	1405	1404	1403	1402	1401	1400	1399	1398	1397	1396	1395	1394	1393	1392	1391	1390	1389	1388	1387	1386	1385	1384	1383	1382	1381	1380	1379	1378	1377	1376	1375	1374	1373	1372	1371	1370	1369	1368	1367	1366	1365	1364	1363	1362	1361	1360	1359	1358	1357	1356	1355	1354	1353	1352	1351	1350	1349	1348	1347	1346	1345	1344	1343	1342	1341	1340	1339	1338	1337	1336	1335	1334	1333	1332	1331	1330	1329	1328	1327	1326	1325	1324	1323	1322	1321	1320	1319	1318	1317	1316	1315	1314	1313	1312	1311	1310	1309	1308	1307	1306	1305	1304	1303	1302	1301	1300	1299	1298	1297	1296	1295	1294	1293	1292	1291	1290	1289	1288	1287	1286	1285	1284	1283	1282	1281	1280	1279	1278	1277	1276	1275	1274	1273	1272	1271	1270	1269	1268	1267	1266	1265	1264	1263	1262	1261	1260	1259	1258	1257	1256	1255	1254	1253	1252	1251	1250	1249	1248	1247	1246	1245	1244	1243	1242	1241	1240	1239	1238	1237	1236	1235	1234	1233	1232	1231	1230	1229	1228	1227	1226	1225	1224	1223	1222	1221	1220	1219	1218	1217	1216	1215	1214	1213	1212	1211	1210	1209	1208	1207	1206	1205	1204	1203	1202	1201	1200	1199	1198	1197	1196	1195	1194	1193	1192	1191	1190	1189	1188	1187	1186	1185	1184	1183	1182	1181	1180	1179	1178	1177	1176	1175	1174	1173	1172	1171	1170	1169	1168	1167	1166	1165	1164	1163	1162	1161	1160	1159	1158	1157	1156	1155	1154	1153	1152	1151	1150	1149	1148	1147	1146	1145	1144	1143	1142	1141	1140	1139	1138	1137	1136	1135	1134	1133	1132	1131	1130	1129	1128	1127	1126	1125	1124	1123	1122	1121	1120	1119	1118	1117	1116	1115	1114	1113	1112	1111	1110	1109	1108	1107	1106	1105	1104	1103	1102	1101	1100	1099	1098	1097	1096	1095	1094	1093	1092	1091	1090	1089	1088	1087	1086	1085	1084	1083	1082	1081	1080	1079	1078	1077	1076	1075	1074	1073	1072	1071	1070	1069	1068	1067	1066	1065	1064	1063	1062	1061	1060	1059	1058	1057	1056	1055	1054	1053	1052	1051	1050	1049	1048	1047	1046	1045	1044	1043	1042	1041	1040	1039	1038	1037	1036	1035	1034	1033	1032	1031	1030	1029	1028	1027	1026	1025	1024	1023	1022	1021	1020	1019	1018	1017	1016	1015	1014	1013	1012	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ALLOCATION PERCENTAGES USED ON PAGE 28

MEADOW MANOR

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PAGE 28

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OCCUPIED

DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
2004								
JANUARY		2,030	2,537	1,662		1,422	2,071	9,722
FEBRUARY		1,886	2,419	1,579		1,304	1,901	9,089
MARCH		1,904	2,594	1,733		1,438	2,148	9,817
APRIL		1,814	2,437	1,647		1,496	2,206	9,600
MAY		1,838	2,364	1,665		1,591	2,159	9,617
JUNE		1,847	2,285	1,683		1,547	2,088	9,450
JULY		1,881	2,437	1,679		1,617	2,176	9,790
AUGUST		1,861	2,363	1,738		1,763	2,236	9,961
SEPTEMBER		1,815	2,198	1,704		1,775	2,166	9,658
OCTOBER		1,897	2,315	1,756		1,789	2,317	10,074
NOVEMBER		1,855	2,279	1,667		1,705	2,167	9,673
DECEMBER		2,013	2,430	1,751		1,652	2,154	10,000
TOTAL	0	22,641	28,658	20,264	0	19,099	25,789	116,451 116,451

OCCUPIED

DAYS	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
2005								
JANUARY		2,230	2,499	1,744		1,682	1,970	10,125
FEBRUARY		1,998	2,290	1,533		1,485	1,797	9,103
MARCH		2,199	2,453	1,727		1,679	1,945	10,003
APRIL		2,085	2,215	1,594		1,566	1,994	9,454
MAY		2,095	2,132	1,655		1,500	2,054	9,436
JUNE		1,942	2,069	1,677		1,402	1,975	9,065
JULY		2,118	2,026	1,781		1,315	1,994	9,234
AUGUST								0
SEPTEMBER								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	0	14,667	15,684	11,711	0	10,629	13,729	66,420 66,420

ALLOCATION PERCENTAGE  
2004

DAYS	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
FEBRUARY	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
MARCH	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
APRIL	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
MAY	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
JUNE	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
JULY	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%
AUGUST	0.00%	18.68%	23.72%	17.45%	17.70%	22.45%	100.00%
SEPTEMBER	0.00%	18.79%	22.76%	17.64%	18.38%	22.43%	100.00%
OCTOBER	0.00%	18.83%	22.98%	17.43%	17.76%	23.00%	100.00%
NOVEMBER	0.00%	19.18%	23.56%	17.23%	17.63%	22.40%	100.00%
DECEMBER	0.00%	20.13%	24.30%	17.51%	16.52%	21.54%	100.00%

ALLOCATION PERCENTAGE  
2005

DAYS	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
FEBRUARY	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
MARCH	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
APRIL	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
MAY	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
JUNE	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%
JULY	0.00%	22.94%	21.94%	19.29%	14.24%	21.59%	100.00%