

Facility Name & ID Number Meadowbrook Manor of LaGrange

0047274 Report Period Beginning: 8/25/05 Ending: 2/28/06

III. STATISTICAL DATA

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

	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	94	Skilled (SNF)	94	17,672	1
2		Skilled Pediatric (SNF/PED)			2
3	109	Intermediate (ICF)	109	20,492	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	38,164	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	3,127	1,953	1,734	6,814	8
9	SNF/PED					9
10	ICF	14,485	2,321	490	17,296	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,612	4,274	2,224	24,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.17%

D. How many bed-hold days during this year were paid by the Department? None (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 Non-allowable costs have been eliminated in Schedule V, Column 7.

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 8/25/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/25/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 94 and days of care provided 1,156

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Short year cost report
Tax Year: 12/31/05 Fiscal Year: 2/28/06

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

Facility Name & ID Number Meadowbrook Manor of LaGrange # 0047274 Report Period Beginning: 8/25/05 Ending: 2/28/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	112,648	13,263	5,702	131,613		131,613		131,613		1
2	Food Purchase		119,405		119,405		119,405	(219)	119,186		2
3	Housekeeping	65,827	16,732		82,559		82,559		82,559		3
4	Laundry	59,284	12,535		71,819		71,819	(3,439)	68,380		4
5	Heat and Other Utilities			146,191	146,191		146,191		146,191		5
6	Maintenance	25,651	36,693	51,156	113,500		113,500	12,336	125,836		6
7	Other (specify):* Emp Ben.-Mgmt Co.							2,870	2,870		7
8	TOTAL General Services	263,410	198,628	203,049	665,087		665,087	11,548	676,635		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,447,123	316,688	11,949	1,775,760		1,775,760	4,515	1,780,275		10
10a	Therapy	105,286	1,224	128,679	235,189		235,189	(37,395)	197,794		10a
11	Activities	46,291	6,991	1,650	54,932		54,932		54,932		11
12	Social Services	40,086		1,391	41,477		41,477	5,613	47,090		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Emp Ben.-Mgmt Co.							7,394	7,394		15
16	TOTAL Health Care and Programs	1,638,786	324,903	152,669	2,116,358		2,116,358	(19,873)	2,096,485		16
	C. General Administration										
17	Administrative	36,923		274,135	311,058		311,058	(250,584)	60,474		17
18	Directors Fees										18
19	Professional Services			217,668	217,668		217,668	(13,930)	203,738		19
20	Dues, Fees, Subscriptions & Promotions			14,469	14,469		14,469	(1,155)	13,314		20
21	Clerical & General Office Expenses	57,421	21,560	30,536	109,517		109,517	67,488	177,005		21
22	Employee Benefits & Payroll Taxes			349,881	349,881		349,881		349,881		22
23	Inservice Training & Education										23
24	Travel and Seminar			697	697		697	599	1,296		24
25	Other Admin. Staff Transportation			131	131		131	986	1,117		25
26	Insurance-Prop.Liab.Malpractice			91,272	91,272		91,272	10,794	102,066		26
27	Other (specify):* Emp Ben.-Mgmt Co.							20,853	20,853		27
28	TOTAL General Administration	94,344	21,560	978,789	1,094,693		1,094,693	(164,949)	929,744		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,996,540	545,091	1,334,507	3,876,138		3,876,138	(173,274)	3,702,864		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 Meadowbrook Manor of LaGrange #0047274 Report Period Beginning: 8/25/05 Ending: 2/28/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,020	11,020		11,020	85,126	96,146			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,900	37,900		37,900	137,076	174,976			32
33	Real Estate Taxes							240,338	240,338			33
34	Rent-Facility & Grounds			681,290	681,290		681,290	(681,290)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			730,210	730,210		730,210	(218,750)	511,460			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,427		93,427		93,427		93,427			39
40	Barber and Beauty Shops			2,608	2,608		2,608		2,608			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,942	56,942		56,942		56,942			42
43	Other (specify):* Nonallow. Costs	-		108,944	108,944		108,944	(108,944)				43
44	TOTAL Special Cost Centers		93,427	168,494	261,921		261,921	(108,944)	152,977			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,996,540	638,518	2,233,211	4,868,269		4,868,269	(500,968)	4,367,301			45

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

**See Schedule of adjustments attached at end of cost report.

Facility Name & ID Number Meadowbrook Manor of LaGrange

0047274

Report Period Beginning:

8/25/05

Ending:

2/28/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(219)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,851)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(338)	43		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	(1,679)	20		17
18	Fines and Penalties	(5,000)	43		18
19	Entertainment	(388)	43		19
20	Contributions	(1,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(16,155)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,200)	43		24
25	Fund Raising, Advertising and Promotional	(27,892)	43		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 See Page 5A	(8,619)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,841)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(345,127)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (345,127)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (500,968)		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						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

Meadowbrook Manor of LaGrange

ID# 0047274

Report Period Beginning: 8/25/05

Ending: 2/28/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Physician Fees	\$ (389)	43	1
2	Laboratory	(1,361)	43	2
3	Laundry Income	(3,439)	4	3
4	Radiology	(3,430)	43	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	(8,619)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meadowbrook Manor of LaGrange

0047274

Report Period Beginning:

8/25/05

Ending:

2/28/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(219)	0	0	0	0	0	0	0	0	0	0	(219)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,439)	0	0	0	0	0	0	0	0	0	0	(3,439)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	12,336	0	0	0	0	0	0	0	12,336	6
7	Other (specify):* Emp Ben.-Mgmt	0	0	0	2,870	0	0	0	0	0	0	0	2,870	7
8	TOTAL General Services	(3,658)	0	0	15,206	0	11,548	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	4,515	0	0	0	0	0	0	0	4,515	10
10a	Therapy	0	0	0	(37,395)	0	0	0	0	0	0	0	(37,395)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	5,613	0	0	0	0	0	0	0	5,613	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):* Emp Ben.-Mgmt	0	0	0	7,394	0	0	0	0	0	0	0	7,394	15
16	TOTAL Health Care and Programs	0	0	0	(19,873)	0	(19,873)	16						
	C. General Administration													
17	Administrative	0	0	0	(250,584)	0	0	0	0	0	0	0	(250,584)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,155)	0	0	2,225	0	0	0	0	0	0	0	(13,930)	19
20	Fees, Subscriptions & Promotions	(1,679)	0	78	446	0	0	0	0	0	0	0	(1,155)	20
21	Clerical & General Office Expenses	0	0	0	67,488	0	0	0	0	0	0	0	67,488	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	599	0	0	0	0	0	0	0	599	24
25	Other Admin. Staff Transportation	0	0	0	986	0	0	0	0	0	0	0	986	25
26	Insurance-Prop.Liab.Malpractice	0	0	10,794	0	0	0	0	0	0	0	0	10,794	26
27	Other (specify):* Emp Ben.-Mgmt	0	0	0	20,853	0	0	0	0	0	0	0	20,853	27
28	TOTAL General Administration	(17,834)	0	10,872	(157,987)	0	(164,949)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,492)	0	10,872	(162,654)	0	(173,274)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meadowbrook Manor of LaGrange

0047274

Report Period Beginning:

8/25/05

Ending:

2/28/06

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	0	0	84,350	776	0	0	0	0	0	0	0	85,126	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,851)	0	140,927	0	0	0	0	0	0	0	0	137,076	32
33	Real Estate Taxes	0	0	240,338	0	0	0	0	0	0	0	0	240,338	33
34	Rent-Facility & Grounds	0	0	(681,290)	0	0	0	0	0	0	0	0	(681,290)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* Mtg. Insurance	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,851)	0	(215,675)	776	0	(218,750)	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):* Nonallowable Cos	(130,498)	0	0	21,554	0	0	0	0	0	0	0	(108,944)	43
44	TOTAL Special Cost Centers	(130,498)	0	0	21,554	0	(108,944)	44						
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(155,841)	0	(204,803)	(140,324)	0	0	0	0	0	0	0	(500,968)	45

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
		Butterfield Health Care II, Inc. d/b/a	Naperville	J&D Partners, L.P.	Bolingbrook	Lessor
		Meadowbrook Manor of Naperville		MMN Partners, L.P.	Naperville	Lessor
		Butterfield Health Care, Inc. d/b/a	Bolingbrook	Butterfield Health		
See Schedule 6C	See Schedule 6C	Meadowbrook Manor		Care Group, Inc.	Bolingbrook	Management Co.
				MML Properties, LLC	LaGrange	Lessor
		Seneca Nursing Home, Inc. d/b/a Lee Manor	Des Plaines	Seneca Building		
				Limited Ptsp.	Des Plaines	Lessor

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V		681,290	MML Properties, LLC (Page 6A)	100.00%	476,487	(204,803)	5
6	V							6
7	V		333,275	Butterfield Health Care Group, Inc. (Page 6B)	100.00%	192,951	(140,324)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,014,565			\$ 669,438	\$ * (345,127)	14

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

VII. RELATED PARTIES (continued)

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)		
15	V	20 Fees & Subscriptions	\$	MML Properties, LLC	100.00%	\$ 78	\$	78	15
16	V	26 Insurance-Prop, Liab, Malpractice		MML Properties, LLC	100.00%	10,794		10,794	16
17	V	30 Depreciation		MML Properties, LLC	100.00%	84,350		84,350	17
18	V	32 Interest Expense		MML Properties, LLC	100.00%	140,927		140,927	18
19	V	33 Real Estate Taxes		MML Properties, LLC	100.00%	240,338		240,338	19
20	V	34 Rent	681,290	MML Properties, LLC	100.00%			(681,290)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 681,290			\$ 476,487	\$ *	(204,803)	39

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

VII. RELATED PARTIES (continued)

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)
15	V	6 Maintenance Salaries	\$	Butterfield Health Care Group, Inc.	100.00%	\$ 12,336	\$ 12,336
16	V	7 Employee Benefits-Gen. Svc		Butterfield Health Care Group, Inc.	100.00%	2,870	2,870
17	V	10 Central Supply Salaries		Butterfield Health Care Group, Inc.	100.00%	4,515	4,515
18	V	10a Therapy Salaries	59,055	Butterfield Health Care Group, Inc.	100.00%	21,660	(37,395)
19	V	12 Social Service Salaries		Butterfield Health Care Group, Inc.	100.00%	5,613	5,613
20	V	15 Employee Benefits-Nursing		Butterfield Health Care Group, Inc.	100.00%	7,394	7,394
21	V	17 Administrative Salaries	274,135	Butterfield Health Care Group, Inc.	100.00%	23,551	(250,584)
22	V	19 Professional Services		Butterfield Health Care Group, Inc.	100.00%	2,225	2,225
23	V	20 Fees & Subscriptions		Butterfield Health Care Group, Inc.	100.00%	446	446
24	V	21 Clerical & General Office Exp.	85	Butterfield Health Care Group, Inc.	100.00%	67,573	67,488
25	V	24 Travel & Seminar		Butterfield Health Care Group, Inc.	100.00%	599	599
26	V	25 Other Admin. Staff Trans.		Butterfield Health Care Group, Inc.	100.00%	986	986
27	V	27 Employee Benefits-Gen Adm		Butterfield Health Care Group, Inc.	100.00%	20,853	20,853
28	V	30 Depreciation		Butterfield Health Care Group, Inc.	100.00%	776	776
29	V	43 Other (Non-Allowable Expenses)		Butterfield Health Care Group, Inc.	100.00%	21,554	21,554
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 333,275			\$ 192,951	\$ * (140,324)

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

Butterfield Health Care VII, LLC
D/B/A Meadowbrook Manor of LaGrange
Provider #0047274
Period 8/25/05 to 2/28/06

Schedule 6C

VII. Section A. - Related Parties - Column 1 (Owners)

<u>Name</u>	<u>Ownership %</u>
RBJ Investments, LP	25.00%
Jafari Family LLC	25.00%
Louis William Dimas Family Limited Partnership	15.00%
Nicholas and Dorothy Vangel	25.00%
Christopher Vangel Descendant's GST Exempt Trust U/A/D 6/21/99	5.00%
Katherine Hocuk Descendant's GST Exempt Trust U/A/D 6/21/99	5.00%
	<u>100.00%</u>

Facility Name & ID Number Meadowbrook Manor of LaGrange # 0047274 Report Period Beginning: 8/25/05 Ending: 2/28/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Robert Jafari	Stockholder	Executive Director	25.00	27,678	2	5.00	Salary	\$ 6,919	L.17, C.7	1	
2	Dorothy Vangel	Stockholder	Executive Director	20.00	21,000	0	0.00	N/A		N/A	2	
3	Christopher Vangel	Operating Spvr	Administrative	5.00	28,881	8	20.00	Salary	7,222	L.17, C.7	3	
4	Kianoosh Jafari	Stockholder	Medical Director	25.00	12,000	16	40.00	N/A		N/A	4	
5	Sean Dimas	Stockholder	Administrative	6.67	21,290	0	0.00	N/A		N/A	5	
6											6	
7	Note 1-	Robert Jafari and Christopher Vangel received compensation from two other nursing home which were										7
8		Butterfield Health Care II, Inc. d/b/a Meadowbrook Manor of Naperville and Butterfield Healthcare Inc. d/b/a Meadowbrook Manor										8
9	Note 2-	Dorothy Vangel received \$21,000 of Directors Fees from Seneca Nursing Home, Inc. d/b/a Lee Manor										9
10	Note 3-	Kianoosh Jafari received \$6,000 of Medical Director Fees from Butterfield Health Care II, Inc. d/b/a Meadowbrook Manor-Naperville										10
11		and \$6,000 of Medical Director Fees from Butterfield Health Care, Inc. d/b/a Meadowbrook Manor										11
12	Note 4-	Sean Dimas received \$21,290 of salaries from Seneca Nursing Home, Inc. d/b/a Lee Manor										12
13								TOTAL	\$ 14,141		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 Meadowbrook Manor of LaGrange

0047274

Report Period Beginning:

8/25/05

Ending: 2/28/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Butterfield Health Care Group, Inc.
 Street Address 18 W 140 Butterfield Road, Suite 1670
 City / State / Zip Code Oak Brook Terrace, IL 60181
 Phone Number (630) 932-3220
 Fax Number (630) 759-4406

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance Salaries	Resident Days	117,157	3	\$ 59,946	\$ 59,946	24,110	\$ 12,336	1
2	7	Employee Benefits-Gen. Svc	Resident Days	117,157	3	13,946	0	24,110	2,870	2
3	10	Central Supply Salaries	Resident Days	117,157	3	21,941	21,941	24,110	4,515	3
4	10a	Therapy Salaries	Gross Charges	1,954,909	3	527,016	527,016	80,368	21,660	4
5	10a	Therapy Agency	Direct Cost	1,890	2	1,890	0	0	0	5
6	12	Social Service Salaries	Resident Days	117,157	3	27,276	27,276	24,110	5,613	6
7	15	Employee Benefits-Nursing	Resident Days	117,157	3	35,929	0	24,110	7,394	7
8	17	Administrative Salaries	Resident Days	117,157	3	114,439	114,439	24,110	23,551	8
9	19	Professional Services	Resident Days	117,157	3	10,813	0	24,110	2,225	9
10	20	Fees & Subscriptions	Resident Days	117,157	3	2,164	0	24,110	446	10
11	21	Clerical & General Office Exp.	Resident Days	117,157	3	328,347	321,130	24,110	67,573	11
12	24	Travel & Seminar	Resident Days	117,157	3	2,910	0	24,110	599	12
13	25	Other Admin. Staff Trans.	Resident Days	117,157	3	4,793	0	24,110	986	13
14	27	Employee Benefits-Gen Adm	Resident Days	117,157	3	101,330	0	24,110	20,853	14
15	30	Depreciation	Resident Days	117,157	3	3,768	0	24,110	775	15
16	43	Other (Non-Allowable Expenses)	Resident Days	117,157	3	104,735	81,505	24,110	21,555	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,361,243	\$ 1,153,253		\$ 192,951	25

Facility Name & ID Number

Meadowbrook Manor of LaGrange

0047274

Report Period Beginning:

8/25/05

Ending:

2/28/06

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										
										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	JP Morgan Chase		X	Mortgage	\$28,559.00	8/25/05	\$ 3,600,000	\$ 3,600,000	8/25/10	Libor+2.5	\$ 133,956	1							
2	JP Morgan Chase		X	Amortization of Loan Costs							6,971	2							
3												3							
4												4							
5												5							
Working Capital																			
6	Shareholder loan	X		Working Capital	N/A	10/31/05	1,357,500	1,357,500	N/A	N/A		6							
7	JP Morgan Chase		X	Working Capital	N/A	8/25/05	1,080,000	1,080,000	8/25/06	Prime-.5	37,900	7							
8												8							
9	TOTAL Facility Related				\$28,559.00		\$ 6,037,500	\$ 6,037,500			\$ 178,827	9							
B. Non-Facility Related*																			
10												10							
11							Offset Interest Income				(3,851)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (3,851)	14							
15	TOTALS (line 9+line14)						\$ 6,037,500	\$ 6,037,500			\$ 174,976	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # 36

* 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.)

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 2004 report. Credit p		\$	374,841 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.)	2004	\$	184,679 2
3. Under or (over) accrual (line 2 minus line 1).		\$	(190,162) 3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	430,500 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.		\$	240,338 7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000		8
	2001		9
	2002		10
	2003		11
	2004	348,925	12
2004 Tax Bill	348,925	369000	Balance at 12/31/05
Estimated Increase	1.06	30750	1/31/06 accrual
Total	369,861	30750	2/28/06 accrual
Use	369000 (\$30,750 per month)	430500	Total accrual at 2/28/06
			FOR OHF USE ONLY
			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:

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.

Facility Name & ID Number Meadowbrook Manor of LaGrange

0047274 Report Period Beginning:

8/25/05 Ending:

2/28/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,985 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 3

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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>178,272</u>	<u>2005</u>	<u>\$ 1,561,408</u>	1
2					2
3	TOTALS			\$ 1,561,408	3

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	203	2005	1911	\$ 2,646,175	\$	40	\$ 44,103	\$ 44,103	\$ 44,103	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Install Compressor		2005	1,750	85	10	85		85	9
10	Elevator Overhaul		2005	4,245	208	10	208		208	10
11	Front Porch Carpeting		2005	2,086	102	10	102		102	11
12	Remodeling 1st floor-tile and paint		2005	26,770	1,308	10	1,308		1,308	12
13	Refurbish boiler		2005	21,650	1,058	10	1,058		1,058	13
14	Furnish and install boiler feed pump		2005	2,750	134	10	134		134	14
15	Furnish and install condensate pump		2005	2,565	125	10	125		125	15
16	Furnish and install extrol & relief valve		2005	1,729	85	10	85		85	16
17	Sign		2006	4,350	217	10	217		217	17
18	Remodeling 1st floor-tile and paint		2006	3,698	185	10	185		185	18
19	Remodeling 1st floor-carpet		2006	6,831	342	10	342		342	19
20	Fire Department standpipe connections		2006	1,443	72	10	72		72	20
21	Furnish and install new heating coil on MUA unit		2006	5,595	280	10	280		280	21
22	Repair MUA unit		2006	3,300	165	10	165		165	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

*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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,734,937	\$ 4,366		\$ 48,469	\$ 44,103	\$ 48,469	70

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

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	674,112	6,654	46,901	40,247	10 Yrs	46,901	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.			776	776	5-10 Yrs		74
75	TOTALS	\$ 674,112	\$ 6,654	\$ 47,677	\$ 41,023		\$ 46,901	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	N/A									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)	\$ 4,970,457	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,020	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,146	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 85,126	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 95,370	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	New building costs	\$ 68,224	92
93			93
94			94
95		\$ 68,224	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 Meadowbrook Manor of LaGrange

0047274

Report Period Beginning: 8/25/05

Ending: 2/28/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning N/A

Ending N/A

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

Fiscal Year Ending Annual Rent

12. /2006 \$

13. /2007 \$

14. /2008 \$

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 .

N/A

N/A

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: N/A

(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			<u>N/A</u>		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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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)	
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	L. 10A, C. 7	215 hrs	\$ 7,676	11	\$ 567		226	\$ 8,243	1
2	Licensed Speech and Language Development Therapist	L. 10A, C. 7	46 hrs	1,649	223	12,497		269	14,146	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 2,3,7	346 hrs	12,335	398	22,269	1,224	744	35,828	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				93,427		93,427	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy	L. 10A, C. 1,3		105,286	816	34,291		816	139,577	13
14	TOTAL			\$ 126,946	1,448	\$ 69,624	\$ 94,651	2,055	\$ 291,221	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 2/28/06 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits	32,059	32,059	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 102,700)	2,354,425	2,354,425	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,588	55,884	6
7	Other Prepaid Expenses	73,266	73,266	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached Schedule 17A	415,657	665,657	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,924,995	\$ 3,181,291	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,561,408	13
14	Buildings, at Historical Cost		2,646,175	14
15	Leasehold Improvements, at Historical Cost	88,762	88,762	15
16	Equipment, at Historical Cost	82,421	674,112	16
17	Accumulated Depreciation (book methods)	(11,020)	(95,370)	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 (spe Loan Costs)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 160,163	\$ 4,875,087	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,085,158	\$ 8,056,378	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 940,387	\$ 959,594	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,913	38,913	28
29	Short-Term Notes Payable	2,437,500	2,437,500	29
30	Accrued Salaries Payable	80,698	80,698	30
31	Accrued Taxes Payable (excluding real estate taxes)	77,348	77,348	31
32	Accrued Real Estate Taxes(Sch.IX-B)		430,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule 17A	796,570	877,370	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,371,416	\$ 4,901,923	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,600,000	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)	\$	\$ 3,600,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,371,416	\$ 8,501,923	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,286,258)	\$ (445,545)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,085,158	\$ 8,056,378	48

*(See instructions.)

Butterfield Health Care VII, LLC
d/b/a Meadowbrook Manor of LaGrange
Provider #0047274
Period 8/25/05 to 2/28/06

Schedule 17A

XV. Balance Sheet

Current Assets

Line 9 - Other Current Assets

	Operating	After Consolidation
Employee Advances	1,176	1,176
Due from Receiver	351,545	351,545
Other Deposits	43,048	43,048
Due from Prior owner	19,888	19,888
Escrow Deposits		250,000
Total Line 9 Other Current Assets	<u>415,657</u>	<u>665,657</u>

XV. Balance Sheet

Current Liabilities

Line 36 - Other Current Liabilities

	Operating	After Consolidation
Due to Related Party	402,000	777,000
Accrued Rent	294,200	
Due to State of Illinois	100,000	100,000
Other Deposits	370	370
Total Line 36 Other Current Liabilities	<u>796,570</u>	<u>877,370</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,286,258)	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)	\$ (1,286,258)	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)	\$ (1,286,258)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

Facility Name & ID Number Meadowbrook Manor of LaGrange

0047274

Report Period Beginning: 8/25/05

Ending:

2/28/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1		2	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,451,716	1
2	Discounts and Allowances for all Levels	(443,642)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,008,074	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	253,105	6
7	Oxygen	82,396	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 335,501	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	2,733	13
14	Non-Patient Meals	219	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,683	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,076	19
20	Radiology and X-Ray	5,530	20
21	Other Medical Services	136,994	21
22	Laundry	3,439	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 233,674	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,851	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,851	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Wheelchair Rental Revenue</u>	911	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 911	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,582,011	30

1		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	665,087	31
32	Health Care	2,116,358	32
33	General Administration	1,094,693	33
B. Capital Expense			
34	Ownership	730,210	34
C. Ancillary Expense			
35	Special Cost Centers	204,979	35
36	Provider Participation Fee	56,942	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,868,269	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,286,258)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,286,258)	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.
This is a short year cost report

*** 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 Meadowbrook Manor of LaGrange

0047274

Report Period Beginning:

8/25/05

Ending:

2/28/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	967	1,031	\$ 55,347	\$ 53.68	1
2	Assistant Director of Nursing	975	1,031	38,419	37.26	2
3	Registered Nurses	4,705	4,845	132,533	27.35	3
4	Licensed Practical Nurses	18,642	19,233	511,567	26.60	4
5	CNAs & Orderlies	43,551	43,551	548,912	12.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	870	2,205	28,666	13.00	8
9	Activity Director					9
10	Activity Assistants	4,096	4,331	46,291	10.69	10
11	Social Service Workers	1,928	2,045	40,086	19.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,483	10,901	112,648	10.33	15
16	Dishwashers					16
17	Maintenance Workers	1,030	1,094	25,651	23.45	17
18	Housekeepers	7,940	8,265	65,827	7.96	18
19	Laundry	5,671	5,786	59,284	10.25	19
20	Administrator	840	864	36,923	42.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,028	4,156	57,421	13.82	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	992	1,024	12,829	12.53	31
32	Other Health Care(specify)					32
33	Other(specify) See Att Sch 20A	9,181	9,693	224,136	23.12	33
34	TOTAL (lines 1 - 33)	115,899	120,055	\$ 1,996,540 *	\$ 16.63	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	143	\$ 5,702	L. 1, C. 3	35
36	Medical Director	Monthly	9,000	L. 9, C. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	9,478	L. 10, C. 3	38
39	Pharmacist Consultant	Monthly	2,471	L. 10, C. 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	33	1,650	L. 11, C. 3	44
45	Social Service Consultant	26	1,391	L. 12, C. 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	202	\$ 29,692		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Butterfield Health Care VII, LLC
D/B/A Meadowbrook Manor of LaGrange
Provider #0047274
Period 8/25/05 to 2/28/06

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Respiratory Therapy	3,890	4,027	105,286	26.15
Nursing Administration	3,428	3,603	91,598	25.42
Central Supply	856	1,024	14,655	14.31
Ward Clerks	1,007	1,039	12,597	12.12
Total Line 32-Other	9,181	9,693	224,136	23.12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
James Boyle	Administrator	0	\$ 19,385	Workers' Compensation Insurance	\$ 58,092	IDPH License Fee	\$	
Jon Platakis	Administrator	0	17,538	Unemployment Compensation Insurance	68,184	Advertising: Employee Recruitment	5,373	
				FICA Taxes	145,917	Health Care Worker Background Check		
				Employee Health Insurance	56,522	(Indicate # of checks performed 100)	1,000	
				Employee Meals		Illinois Council on Long Term Care	5,954	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Fees & Permits	278	
						Inspections	130	
						Misc. Dues & Subscriptions	133	
TOTAL (agree to Schedule V, line 17, col. 1)				401k Contribution	10,162	Allocation from Management Co.	446	
(List each licensed administrator separately.)			\$ 36,923	Training and Education	3,646	Less: Public Relations Expense	()	
B. Administrative - Other				Other Employee Benefits	7,358	Non-allowable advertising	(0)	
Description			Amount			Yellow page advertising	(0)	
Management Fees (Eliminated in Column 7)			\$ 274,135					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 274,135	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)					\$ 349,881		\$ 13,314	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
See Schedule 21A			217,668	N/A				
							Seminar Expense	697
							Allocation from Management Co.	599
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 217,668				TOTAL	\$ 1,296

* Attach copy of IMRF notifications

**See instructions.

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Seyfarth Shaw	Legal	55,646
Foley & Lardner	Legal	48,537
Wildmann Harrold Allen Dixon	Legal	160
Gould & Ratner	Legal	69,000
American Express Tax & Business Services	Accountants	880
Popowcer Katten	Accountants	6,000
Rehab Management Systems	Billing Consultant	16,346
Paychex	Payroll Service	759
TALX	Unemployment Consultant	212
New England Financial	Employee Benefit Plan Administrator	1,642
Health Data Systems , Inc	Computer Services	12,039
MDI Technologies	Computer Services	4,158
Ivans	Computer Services	113
Titan Electronics	Computer Services	516
Wescom Solutions	Computer Services	1,660
Total (agree to Schedule V, line 19, column 3)		217,668
Non-allowable legal expense		(16,155)
MML Properties		
American Express Tax & Business Serv	Accountants	
Altschuler, Melvoin & Glasser LLP	Accountants	
Non-allowable Legal	Legal	
Allocation from Management Company:		
Hamilton, Thies, Lorch and Bagnell	Legal	153
Jack Murphy	Computer Services	1,686
Paychex	Payroll Processing	386
Non-allowable Legal		
Total (agree to Schedule V, line 19, column 8)		203,738

Facility Name & ID Number Meadowbrook Manor of LaGrange

0047274

Report Period Beginning: 8/25/05

Ending: 2/28/06

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? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$5,954
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,490 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? N/A 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. N/A
- (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. \$ 56,942
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? No 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. \$ 219
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.