



Facility Name & ID Number Meadows

# 0021766 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>99</u>	Intermediate/DD	<u>99</u>	<u>36,135</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>34,838</u>	<u>730</u>		<u>35,568</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,838</u>	<u>730</u>		<u>35,568</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.43%

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

208 (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 08/1975

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

YES  Date 08/1975 NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

## STATE OF ILLINOIS

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Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2005 Ending: 12/31/2005  
 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	201,708	10,322	4,801	216,831		216,831	(4,418)	212,413		1
2	Food Purchase		135,456		135,456		135,456	(722)	134,734		2
3	Housekeeping	96,818	19,851		116,669		116,669		116,669		3
4	Laundry	120,248	24,237		144,485		144,485		144,485		4
5	Heat and Other Utilities			81,167	81,167		81,167		81,167		5
6	Maintenance	76,724	6,782	30,754	114,260		114,260		114,260		6
7	Other (specify):*										7
8	TOTAL General Services	495,498	196,648	116,722	808,868		808,868	(5,140)	803,728		8
	B. Health Care and Programs										
9	Medical Director			28,800	28,800	(20,160)	8,640		8,640		9
10	Nursing and Medical Records	1,020,531	38,868	33,790	1,093,189	(190)	1,092,999		1,092,999		10
10a	Therapy	34,528			34,528	12,884	47,412		47,412		10a
11	Activities	97,260	5,554	296	103,110		103,110		103,110		11
12	Social Services	180,088		23,271	203,359	(14,941)	188,418		188,418		12
13	CNA Training					2,247	2,247		2,247		13
14	Program Transportation			166	166		166		166		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,332,407	44,422	86,323	1,463,152	(20,160)	1,442,992		1,442,992		16
	C. General Administration										
17	Administrative	140,474			140,474		140,474	(25,685)	114,789		17
18	Directors Fees										18
19	Professional Services			30,776	30,776	941	31,717		31,717		19
20	Dues, Fees, Subscriptions & Promotions			10,082	10,082	432	10,514		10,514		20
21	Clerical & General Office Expenses	119,350	10,201	(33,282)	96,269	(1,727)	94,542	29,047	123,589		21
22	Employee Benefits & Payroll Taxes			467,952	467,952	455	468,407	(14,506)	453,901		22
23	Inservice Training & Education										23
24	Travel and Seminar			545	545	(69)	476		476		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			24,718	24,718		24,718	10,904	35,622		26
27	Other (specify):*										27
28	TOTAL General Administration	259,824	10,201	500,791	770,816	32	770,848	(240)	770,608		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,087,729	251,271	703,836	3,042,836	(20,128)	3,022,708	(5,380)	3,017,328		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 Meadows #0021766 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## 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	
30	D. Ownership											
30	Depreciation			4,945	4,945		4,945	121,551	126,496			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							195,527	195,527			32
33	Real Estate Taxes							210,801	210,801			33
34	Rent-Facility & Grounds			729,600	729,600		729,600	(729,600)				34
35	Rent-Equipment & Vehicles			9,538	9,538	(32)	9,506		9,506			35
36	Other (specify):*											36
37	TOTAL Ownership			744,083	744,083	(32)	744,051	(201,721)	542,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			8,357	8,357	20,160	28,517		28,517			39
40	Barber and Beauty Shops			5,222	5,222		5,222		5,222			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			270,039	270,039		270,039		270,039			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			283,618	283,618	20,160	303,778		303,778			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,087,729	251,271	1,731,537	4,070,537		4,070,537	(207,101)	3,863,436			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 Meadows # 0021766 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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		2.2		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	15,612	30.3		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional		20.3		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	(76,712)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (61,100)		\$	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
Amortization of Organization & Pre-Operating Expense				33
34 Adjustments for Related Organization Costs (Schedule VII)	(146,001)			34
35 Other- Attach Schedule				35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (146,001)			36
(sum of SUBTOTALS				
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (207,101)			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		x			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		20,160	9.3	46
47 TOTAL (C): (sum of lines 38-46)			\$ 20,160		47

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
Byrn T. Witt	50%	Zachary House	Streamwood			
Barbara S. Witt	50%	Zachary House	Streamwood			

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	34 Facility Rent	\$ 729,600	Byrn T. Witt & Barbara S. Witt	100.00%	\$ -	\$ (729,600)	1
2	V	17 Management Fee	-	Byrn T. Witt & Barbara S. Witt	100.00%	18,000	18,000	2
3	V	30 Depreciation	-	Byrn T. Witt & Barbara S. Witt	100.00%	107,004	107,004	3
4	V	32 Interest	-	Byrn T. Witt & Barbara S. Witt	100.00%	229,289	229,289	4
5	V	17	-			-		5
6	V	33 Real Estate Taxes	-	Byrn T. Witt & Barbara S. Witt	100.00%	210,801	210,801	6
7	V	17 Financial	49,140	Robin Witt		49,141	1	7
8	V	26 Property Insurance	-	Byrn T. Witt & Barbara S. Witt	100.00%	18,504	18,504	8
9	V		-			-		9
10	V		-			-		10
11	V		-			-		11
12	V		-			-		12
13	V		-			-		13
14	Total		\$ 778,740			\$ 632,739	\$ * (146,001)	14

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

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## 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	Byrn T. Witt		Administrator	50%		7.2	60%	Salary	\$ 18,000	17.3	1
2	Robin Witt	Chief Financial Officer	Administration			24	60%	Salary	49,141	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 67,141		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 Meadows

# 0021766 Report Period Beginning: 01/01/2005

Ending: 12/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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)	Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1							\$	\$			\$	1
2												2
3	HUD		X	Debt Refinance / Bldg Constructio	Varies	Aug-95	2,702,300	2,596,697	Mar-36	0.0880	229,289	3
4										Interest Income	(33,762)	4
5												5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 2,702,300	\$ 2,596,697			\$ 195,527	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,702,300	\$ 2,596,697			\$ 195,527	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

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

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block; color: red; font-weight: bold;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.         </div>			
1. Real Estate Tax accrual used on 2004 report.		\$ 208,477	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.)		\$ 209,639	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,162	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 209,639	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. <span style="color: red;">(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</span>		\$	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. <span style="color: red;">(Attach a copy of the real estate tax appeal board's decision.)</span>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 210,801	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	208,444	8
	2001	197,391	9
	2002	201,231	10
	2003	208,477	11
	2004	209,639	12
<span style="color: blue;">Based on estimate from county treasurer</span>			
			<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:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 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, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Meadows COUNTY Cook  
FACILITY IDPH LICENSE NUMBER 0021766  
CONTACT PERSON REGARDING THIS REPORT Jean Adaskivich  
TELEPHONE (847) 397-0055 FAX #: (847) 397-0477

**A. Summary of Real Estate Tax Cost**

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. <u>02-35-100-016-0000</u>	<u>3250 South Plum Grove Road</u>	\$ <u>209,639.00</u>	\$ <u>209,639.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>209,639.00</u>	\$ <u>209,639.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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 Meadows

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,000 B. General Construction Type: Exterior Brick Frame Concrete Block Number of Stories One

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	Nursing Home	52,300	Jun-86	\$ 25,000	1
2					2
3	TOTALS	52,300		\$ 25,000	3

Facility Name &amp; ID Number Meadows

# 0021766

Report Period Beginning:

01/01/2005

Ending: 12/31/2005

## 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	98		Jun-86	Jun-75	\$ 1,500,000	\$	30	\$ 50,000	\$ 50,000	\$ 1,467,366	4
5			Jun-96	Jun-96	1,478,674		39	37,915	37,915	360,348	5
6	1		Oct-96	Oct-96	15,000		39	385	385	3,547	6
7											7
8											8
	Improvement Type**										
9	Remodeling		Jan-76		3,548		10			3,548	9
10			Jan-77		21,344		10			21,344	10
11			Jan-79		169		10			169	11
12			Jan-80		9,111		10			9,111	12
13			Jan-81		3,203		10			3,203	13
14			Jan-83		7,355		10			7,355	14
15			Jan-84		11,356		10			11,356	15
16	Garage		Jan-85		3,165		10			3,165	16
17	Remodeling		Jan-86		2,386		10			2,386	17
18	Water Heater & Fire Alarm System		Jan-87		3,199		15			3,199	18
19	Roof		Jan-88		40,520		20			40,520	19
20	Heat Pump		Jan-88		1,900		15			1,900	20
21	Carpeting		Jan-88		10,119		5			10,119	21
22	Carpeting		Jan-89		4,185		5			4,185	22
23	Roof		Jan-90		3,527		20	176	176	3,428	23
24	Kitchen		Jan-90		2,319		10			2,319	24
25	Heater Repairs		Jan-91		840		7			840	25
26	Improvements		Jan-93		737	19	10		(19)	737	26
27	Water Heater		Mar-95		3,000		7			3,000	27
28	Air Conditioners		Aug-95		5,627		5			5,627	28
29	Unit Heaters		Dec-95		737		5			737	29
30	Exterior Doors		May-95		628	16	39	16		170	30
31	Garage Door		Jun-96		385		10	39	39	370	31
32	Parking Lot Repair		Jun-96		6,655		20	333	333	3,165	32
33	Driveway		Jun-96		22,572		20	1,129	1,129	10,730	33
34	Walk-in Freezer & Cooler		Jun-96		12,333		10	1,233	1,233	11,719	34
35	Air Conditioning Units		Sep-96		3,554		5			3,554	35
36	Draperies		Jun-97		16,239		39	416		3,538	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Meadows

# 0021766

Report Period Beginning:

01/01/2005

Ending: 12/31/2005

## 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	Fencing	Jun-97	\$ 8,090	\$ 207	39	\$ 207	\$	\$ 1,761	37
38	Windows & Doors	Jun-97	2,128		39	55	55	468	38
39	New Building Addition	Jan-98	7,500		39	192	192	1,536	39
40	Time Clock System	Jun-99	8,785		5			8,785	40
41	Air Conditioning Units	Jun-99	7,589		5			7,589	41
42	Time Clock System	Jul-01	1,452		5	290	290	1,282	42
43	Telephone Equipment	Feb-01	1,850		5	370	370	1,810	43
44	Air Conditioning Units	Jun-01	4,568		39	117	117	533	44
45	Window Screens	Jun-01	1,400		39	36	36	163	45
46	Draperies	Feb-01	4,118		39	106	106	516	46
47	Magnetic Door Holders	Jan-02	1,350		7	193	193	733	47
48	6 Air Conditioner Units	Aug-02	4,671		39	120	120	249	48
49	12 Resident Room Closet Doors	Aug-02	2,346		39	60	60	135	49
50	Nurse Call System	Jun-02	38,000		5	7,600	7,600	19,780	50
51	Magnetic Door Holders	Jan-02	3,696		5	739	739	2,806	51
52	Signage	Dec-03	1,698		7	243	243	243	52
53	Flooring	Nov-02	1,731		10	173	173	242	53
54	Draperies	Apr-03	1,052		7	150	150	150	54
55	Windows	Jun-03	710		39	18	18	18	55
56	HVAC Units	Jun-03	3,813		5	763	763	763	56
57	Carpeting	Dec-03	10,994		10	1,099	1,099	1,099	57
58	Parking Lot	Oct-04	26,879		15	1,792	1,792	1,792	58
59	HVAC Units	Sep-04	5,825		5	1,165	1,165	1,165	59
60	Signage	Sep-04	318		5	64	64	64	60
61	Security System	Dec-04	18,600	3,534	5	3,720	186	3,720	61
62	HVAC Units	Feb-05	484		5	88	88	88	62
63	Nurse call system	May-05	6,231		5	768	768	768	63
64	Electrical cabling	Jun-05	1,450		5	168	168	168	64
65	HVAC Units	Jun-05	281		5	29	29	29	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,371,996	\$ 3,776		\$ 111,967	\$ 107,775	\$ 2,061,210	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	\$ 45,508	\$	\$ 14,425	\$ 14,425	Various	\$ 45,508	71
72	Current Year Purchases	2,084	104	104		Various	104	72
73	Fully Depreciated Assets	169,151					169,151	73
74								74
75	TOTALS	\$ 216,743	\$ 104	\$ 14,529	\$ 14,425		\$ 214,763	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)	\$ 3,613,739	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,880	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 126,496	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 122,616	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,275,973	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: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

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

12.	_____ /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 \_\_\_\_\_.

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: \$ 9,506

Description: Copier: \$6,707; Mailing Machine: \$2,799

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies		24		24
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)		1,423		1,423
6 Transportation				
7 Contractual Payments		800		800
8 CNA Competency Tests				
9 TOTALS	\$	\$ 2,247	\$	\$ 2,247
10 SUM OF line 9, col. 1 and 2 (e)	\$	2,247		

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

- (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	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$		\$		1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		189	9,450		189	9,450	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits		202	20,160		202	20,160	5
6	Dental Care	39.3	visits		84	8,357		84	8,357	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): Medical Supplies	39.2								13
14	TOTAL			\$	475	\$ 37,967	\$	475	\$ 37,967	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.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Meadows

# 0021766

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 648,747	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	670,336		3
4	Supply Inventory (priced at FIFO )	5,978		4
5	Short-Term Investments	672,141		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,562		7
8	Accounts Receivable (owners or related parties)	(758,883)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,243,881	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,455		15
16	Equipment, at Historical Cost	252,818		16
17	Accumulated Depreciation (book methods)	(193,836)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 68,437	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,312,318	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ (182,065)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	(919)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (182,984)	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (182,984)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,129,334)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,312,318)	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,457,142	1
2	Restatements (describe):		2
3	Prior period adjustment	(31,211)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,425,931	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	558,885	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	(855,482)	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)	\$ (296,597)	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)	\$ 1,129,334	24 *

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

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Meadows

# 0021766

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	\$ 4,595,660	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,595,660	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	33,762	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,762	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,629,422	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	808,868	31
32	Health Care	1,463,152	32
33	General Administration	770,816	33
<b>B. Capital Expense</b>			
34	Ownership	744,083	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	13,579	35
36	Provider Participation Fee	270,039	36
<b>D. Other Expenses (specify):</b>			
37			37
38	Gain on Sale of Fixed Assets		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,070,537	40
41	Income before Income Taxes (line 30 minus line 40)**	558,885	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 558,885	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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	1,856	2,109	\$ 58,324	\$ 27.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,814	4,042	91,612	22.67	3
4	Licensed Practical Nurses	5,345	5,696	147,815	25.95	4
5	CNAs & Orderlies	20,323	22,069	268,778	12.18	5
6	CNA Trainees					6
7	Licensed Therapist	1,328	1,388	13,283	9.57	7
8	Rehab/Therapy Aides	1,166	1,295	21,246	16.41	8
9	Activity Director	1,653	1,840	26,747	14.54	9
10	Activity Assistants	4,728	5,229	70,513	13.48	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,360	1,664	17,681	10.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,889	15,126	179,608	11.87	15
16	Dishwashers					16
17	Maintenance Workers	3,745	4,351	76,724	17.63	17
18	Housekeepers	8,282	8,971	96,818	10.79	18
19	Laundry	10,399	11,051	120,248	10.88	19
20	Administrator	1,403	1,588	47,649	30.01	20
21	Assistant Administrator					21
22	Other Administrative	904	1,248	49,140	39.37	22
23	Office Manager					23
24	Clerical	4,767	5,491	102,801	18.72	24
25	Vocational Instruction	1,920	2,155	27,287	12.66	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,186	12,392	180,088	14.53	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	30,863	33,634	367,775	10.93	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Behavior Dev'l	3,740	3,949	58,939	14.93	33
34	TOTAL (lines 1 - 33)	132,671	145,288	\$ 2,023,076 *	\$ 13.92	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	120	\$ 4,793	1.3	35
36	Medical Director	86	8,640	9.3	36
37	Medical Records Consultant			10.3	37
38	Nurse Consultant	201	10,025	10.3	38
39	Pharmacist Consultant	18	1,800	10.3	39
40	Physical Therapy Consultant	56	3,149	10a.3	40
41	Occupational Therapy Consultant	5	285	10a.3	41
42	Respiratory Therapy Consultant			10a.3	42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant			11.3	44
45	Social Service Consultant	6	180	12.3	45
46	Other(specify) Psychologist	17	1,700	12.3	46
47	Behavior Dev'l Consultant			12.3	47
48	Psychiatrist	65	6,450	12.3	48
49	TOTAL (lines 35 - 48)	572	\$ 37,022		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	17	\$ 891	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Certified Nurse Assistants/Aides	611	22,746	10.3	52
53	TOTAL (lines 50 - 52)	627	\$ 23,637		53





Facility Name &amp; ID Number Meadows

# 0021766

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## 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. IARF Membership Dues 4,468
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,004 Line 10.2
- (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. \$ 270,039  
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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? Yes  
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? Yes  
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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.