

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0011528

Facility Name: MEADOW MANOR

Address: 800 MCADAM DRIVE TAYLORVILLE 62568
 Number City Zip Code

County: CHRISTIAN

Telephone Number: (217) 824-2277 **Fax #** (217) 287-7763

HFS ID Number: 370840530001

Date of Initial License for Current Owners: 1963

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/05 to 04/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JERRY W. JENNINGS</u>	
	(Title) <u>CONTROLLER</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number MEADOW MANOR

0011528 Report Period Beginning: 05/01/05 Ending: 04/30/06

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,388	3,388	8
9	SNF/PED					9
10	ICF	13,333	5,866		19,199	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,333	5,866	3,388	22,587	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.46%

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

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

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

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

MEALS ON WHEELS

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

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

YES NO

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

YES NO

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

Date started 1963

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 22 and days of care provided 3,388

Medicare Intermediary ADMINASTAR FEDERAL OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 4/30/06 Fiscal Year: 4/30/06

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

Facility Name & ID Number **MEADOW MANOR** # **0011528** Report Period Beginning: **05/01/05** Ending: **04/30/06**

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	97,973	13,477	6,814	118,264		118,264	(3,177)	115,087		1
2	Food Purchase		101,902		101,902		101,902	(9,772)	92,130		2
3	Housekeeping	35,297	11,280		46,577		46,577		46,577		3
4	Laundry	21,445	9,536		30,981		30,981		30,981		4
5	Heat and Other Utilities			60,618	60,618		60,618	(400)	60,218		5
6	Maintenance	45,051	25,678	32,410	103,139	2,550	105,689	1,422	107,111		6
7	Other (specify):*										7
8	TOTAL General Services	199,766	161,873	99,842	461,481	2,550	464,031	(11,927)	452,104		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	379	12,379		9
10	Nursing and Medical Records	949,598	201,059	76,878	1,227,535	(147,963)	1,079,572	6,677	1,086,249		10
10a	Therapy	39,782	3,724	240,369	283,875	(240,369)	43,506		43,506		10a
11	Activities	47,760	2,414		50,174		50,174		50,174		11
12	Social Services	33,978		4,612	38,590		38,590		38,590		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,071,118	207,197	333,859	1,612,174	(388,332)	1,223,842	7,056	1,230,898		16
	C. General Administration										
17	Administrative	53,385		15,166	68,551	3,260	71,811	34,343	106,154		17
18	Directors Fees										18
19	Professional Services			105,613	105,613		105,613	(96,401)	9,212		19
20	Dues, Fees, Subscriptions & Promotions			24,745	24,745		24,745	(16,044)	8,701		20
21	Clerical & General Office Expenses	42,605	14,261	6,455	63,321		63,321	26,298	89,619		21
22	Employee Benefits & Payroll Taxes			286,617	286,617		286,617	17,147	303,764		22
23	Inservice Training & Education			4,928	4,928		4,928	1,994	6,922		23
24	Travel and Seminar			9,800	9,800	(7,976)	1,824	670	2,494		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			80,779	80,779		80,779	38	80,817		26
27	Other (specify):*			12,130	12,130		12,130	(12,130)			27
28	TOTAL General Administration	95,990	14,261	546,233	656,484	(4,716)	651,768	(44,085)	607,683		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,366,874	383,331	979,934	2,730,139	(390,498)	2,339,641	(48,956)	2,290,685		29

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

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

Facility Name & ID Number MEADOW MANOR #0011528 Report Period Beginning: 05/01/05 Ending: 04/30/06

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			25,853	25,853		25,853	7,369	33,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			869	869		869	(869)				32
33	Real Estate Taxes			23,356	23,356		23,356		23,356			33
34	Rent-Facility & Grounds							4,531	4,531			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			50,078	50,078		50,078	11,031	61,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					390,498	390,498		390,498			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			52,560	52,560	390,498	443,058		443,058			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,366,874	383,331	1,082,572	2,832,777		2,832,777	(37,925)	2,794,852			45

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

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/05

Ending:

04/30/06

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	(195)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(400)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,587	30		9
10	Interest and Other Investment Income	(869)	32		10
11	Discounts, Allowances, Rebates & Refunds	(750)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,421)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(307)	20		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	(1,146)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,709)	27		24
25	Fund Raising, Advertising and Promotional	(15,951)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(12,754)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,915)		\$	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)	990	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 990		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (37,925)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39	Therapy	X		240,369	10a	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		12,560	10	42
43	Prescription Drugs	X		118,110	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Sup & Oxy	X		17,893	10	45
46	Other-Attach Schedule OtherAncill	X		1,566	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 390,498		47

BHF USE ONLY						
48		49		50		52

MEADOW MANOR

ID# 0011528

Report Period Beginning: 05/01/05

Ending: 04/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MEALS ON WHEELS - EXP. REIMB - FOOD	\$ (8,203)	2	1
2	MEALS ON WHEELS - EXP. REIMB - SALARY	(3,177)	1	2
3	VENDING	(1,374)	2	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(12,754)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/05

Ending:

04/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(3,177)	0	0	0	0	0	0	0	0	0	0	(3,177)	1
2	Food Purchase	(9,772)	0	0	0	0	0	0	0	0	0	0	(9,772)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(400)	0	0	0	0	0	0	0	0	0	0	(400)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(13,349)	0	0	0	0	0	0	0	0	0	0	(13,349)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	301	0	0	0	0	0	0	0	0	0	301	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,146)	(95,393)	0	0	0	0	0	0	0	0	0	(96,539)	19
20	Fees, Subscriptions & Promotions	(16,258)	0	0	0	0	0	0	0	0	0	0	(16,258)	20
21	Clerical & General Office Expenses	(750)	0	0	0	0	0	0	0	0	0	0	(750)	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	(301)	0	0	0	0	0	0	0	0	0	(301)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(12,130)	0	0	0	0	0	0	0	0	0	0	(12,130)	27
28	TOTAL General Administration	(30,284)	(95,393)	0	(125,677)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,633)	(95,393)	0	(139,026)	29								

STATE OF ILLINOIS

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/05 Ending:

Summary B

04/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,587	0	0	0	0	0	0	0	0	0	0	5,587	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(869)	0	0	0	0	0	0	0	0	0	0	(869)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,718	0	0	0	0	0	0	0	0	0	0	4,718	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(38,915)	(95,393)	0	(134,308)	45								

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/05

Ending:

04/30/06

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	47.50	HILLTOP NURSING HOME, INC.	CHARLESTON	Nrsg Home Managers	SPRINGFIELD	MANAGEMENT
SAM KLEIN	47.50	JACKSONVILLE CONV. CENTER, INC.	JACKSONVILLE	Meadow Manor West	TAYLORVILLE	
IGNACIO DELVALLE	5.00	MENARD CONVALESCENT CENTER, INC.	PETERSBURG			
		SUNRISE MANOR OF VIRDEN, INC.	VIRDEN			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 MANAGEMENT FEE	\$ 104,158	NURSING HOME MANAGERS, INC.	95.00%	\$	\$ (104,158)	1
2	V	VAR SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	95.00%	96,383	96,383	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS - DIRECT ALLOCATION	95.00%	8,765	8,765	3
4	V	24 TRAVEL	301	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(301)	4
5	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW		301	301	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 104,459			\$ 105,449	\$ * 990	14

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

Facility Name & ID Number MEADOW MANOR # 0011528 Report Period Beginning: 05/01/05 Ending: 04/30/06

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	H. RAYMOND KLEIN	OWNER	MANAGEMENT	47.50					\$ 2,018	17 - 7	1	
2											2	
3											3	
4			H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC.,									4
5			A RELATED ORGANIZATION. TOTAL COMPENSATION OF \$10,010									5
6			WAS ALLOCATED AMONG THE FIVE RELATED NURSING HOMES									6
7			BASED UPON 10 HOURS PER WEEK FOR H. RAYMOND KLEIN.									7
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 2,018		13	

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

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

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning: 05/01/05

Ending: 04/30/06

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	STOCKHOLDERS	X		WORKING CAPITAL		06/26/00	289,726	2,299,726	DEMAND	6.0000	869	6								
7											7									
8											8									
9	TOTAL Facility Related						\$ 289,726	\$ 2,299,726			\$ 869	9								
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 289,726	\$ 2,299,726			\$ 869	15								

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MEADOW MANOR COUNTY CHRISTIAN

FACILITY IDPH LICENSE NUMBER 0011528

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-13-23-402-002</u>	<u>MEADOW MANOR</u>	\$ <u>33,888.00</u>	\$ <u>23,043.84</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>33,888.00</u>	\$ <u>23,043.84</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number MEADOW MANOR

0011528 Report Period Beginning:

05/01/05 Ending:

04/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,061 B. General Construction Type: Exterior MASONRY Frame STEEL & WOOD Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>25,061</u>	<u>1963</u>	<u>\$ 3,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	25,061		\$ 3,000	3

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/05

Ending:

04/30/06

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	48		1963	1658	\$ 226,688	\$	25	\$	\$	\$ 226,688	4
5	48			1967	289,148		30			289,148	5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENT		1979		5,775		15			5,775	9
10	IMPROVEMENT		1980		5,207		VARIOUS			5,207	10
11	IMPROVEMENT		1981		635		10			635	11
12	IMPROVEMENT		1982		36,795		15			36,795	12
13	IMPROVEMENT		1984		44,410		15			44,410	13
14	IMPROVEMENT		1986		13,401	198	15		(198)	13,401	14
15	AIR CONDITIONER		1987		3,749	89	15		(89)	3,749	15
16	IMPROVEMENT		1987		6,721	213	15		(213)	6,721	16
17	IMPROVEMENT		1987		2,539	81	15	169	88	2,537	17
18	SPRINKLER		1989		890	28	15	59	31	887	18
19	IMPROVEMENT		1989		16,132	512	15		(512)	16,132	19
20	IMPROVEMENT		1990		4,004	127	15	266	139	4,004	20
21	IMPROVEMENT		1990		22,907	727	VARIOUS	811	84	14,805	21
22	IMPROVEMENT		1993		2,576	82	VARIOUS	172	90	2,322	22
23	IMPROVEMENT		1994		1,475	47	15	98	51	1,225	23
24	IMPROVEMENT		1995		42,600	1,092	20	2,130	1,038	24,495	24
25	AIR CONDITIONER		1996		6,844	175	15	456	281	4,788	25
26	SMOKE DETECTORS		1996		981	25	15	65	40	686	26
27	SINKS & FAUCETS		1996		2,698	69	15	180	111	1,890	27
28	WINDOWS		1996		3,859	99	15	257	158	2,699	28
29	FIRE DOORS		1996		784	20	15	52	32	546	29
30	NEW DOOR FRAMES		1997		10,035	257	15	669	412	5,686	30
31	SPRINKLER REPAIRS		1997		1,127	29	15	75	46	638	31
32	FIRE DOORS		1998		808	21	15	54	33	405	32
33	AIR CONDITIONER		1998		1,820	47	15	121	74	908	33
34	FIRE ALARM SYSTEM		1999		8,250	212	20	413	201	3,097	34
35	WATER HEATER		2000		3,813	98	15	254	156	1,609	35
36	BACKFLOW VALVE		2000		3,998	103	15	267	164	1,624	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/05

Ending:

04/30/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	AIR CONDITIONER	1999	\$ 2,985	\$ 77	15	\$ 199	\$ 122	\$ 1,376	37
38	DOORS	2001	4,450	114	15	297	183	1,510	38
39	5 TON AIR CONDITIONER	2001	1,613	41	10	161	120	778	39
40	ROOFTOP A/C & HEAT	2001	3,165	81	15	211	130	967	40
41	2 ROOMS & BATHROOMS RENOVATED FOR MEDICARE	2002	56,051	1,437	20	2,803	1,366	9,577	41
42	ROOFTOP A/C & HEAT	2002	3,396	87	10	340	253	1,190	42
43	AIR CONDITIONER	2003	1,985	51	10	199	148	562	43
44	SMOKE DETECTORS & EXHAUST SYSTEM	2004	4,838	124	15	323	199	711	44
45	ROOF	2004	162,600	4,169	20	8,130	3,961	11,518	45
46	FIRE SUPPRESSION SYSTEM & ELECTRICAL WIRING	2005	6,420	140	20	286	146	286	46
47	HEAT EXCHANGER	2005	1,181	11	15	33	22	33	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)		\$ 1,019,353	\$ 10,683		\$ 19,550	\$ 8,867	\$ 752,020	70

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

Facility Name & ID Number MEADOW MANOR # 0011528 Report Period Beginning: 05/01/05 Ending: 04/30/06

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	\$ 128,180	\$ 13,598	\$ 11,233	\$ (2,365)	Various	\$ 70,952	71
72	Current Year Purchases	10,340	1,572	657	(915)	Various	657	72
73	Fully Depreciated Assets	350,259				Various	350,259	73
74	Assets No Longer in Service (Includes MM West)	(160,147)					(160,147)	74
75	TOTALS	\$ 328,632	\$ 15,170	\$ 11,890	\$ (3,280)		\$ 261,721	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,350,985	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,853	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,440	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,587	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,013,741	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	MM WEST CLOSED 9/6/01	\$ 310,256	\$	\$	86
87	PER 4/30/04 - DESK REVIEW				87
88					88
89					89
90					90
91	TOTALS	\$ 310,256	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning: 05/01/05

Ending: 04/30/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2007 \$ _____

13. _____/2008 \$ _____

14. _____/2009 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number MEADOW MANOR# 0011528

Report Period Beginning:

05/01/05

Ending:

04/30/06

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 8	hrs	\$	1,613	\$ 100,895	\$	1,613	\$ 100,895	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		127	9,103		127	9,103	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		2,163	130,371		2,163	130,371	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 8	# of prescripts				118,110		118,110	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab,Xray,O2,Supp,Oth	39 - 8					32,019		32,019	13
14	TOTAL			\$	3,903	\$ 240,369	\$ 150,129	3,903	\$ 390,498	14

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

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

Ending:

04/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 04/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,193	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	796,383		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,584		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 833,160	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,000		13
14	Buildings, at Historical Cost	1,019,353		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	392,915		16
17	Accumulated Depreciation (book methods)	(1,054,304)		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)	\$ 360,964	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,194,124	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 191,177	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,579		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,005		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,725		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)	\$ 300,486	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,299,726		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)	\$ 2,299,726	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,600,212	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,406,088)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,194,124	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,265,779)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,265,779)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(140,309)	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)	\$ (140,309)	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)	\$ (1,406,088)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning: 05/01/05

Ending: 04/30/06

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,704,312	1
2	Discounts and Allowances for all Levels	(100,362)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,603,950	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	59,616	6
7	Oxygen	11,641	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 71,257	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,575	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	400	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	663	21
22	Laundry	890	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,528	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,609	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,609	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	1,374	28
28a	ADMIT FEE	750	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,124	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,692,468	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	461,481	31
32	Health Care	1,612,174	32
33	General Administration	656,484	33
B. Capital Expense			
34	Ownership	50,078	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	52,560	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,832,777	40
41	Income before Income Taxes (line 30 minus line 40)**	(140,309)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (140,309)	43

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

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

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

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

Facility Name & ID Number **MEADOW MANOR**

0011528

Report Period Beginning:

05/01/05

Ending:

04/30/06

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	1,720	1,800	\$ 44,499	\$ 24.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,413	4,781	103,278	21.60	3
4	Licensed Practical Nurses	17,831	18,513	287,637	15.54	4
5	CNAs & Orderlies	47,388	48,756	514,184	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,533	3,663	39,782	10.86	8
9	Activity Director	1,962	2,077	19,986	9.62	9
10	Activity Assistants	3,867	3,898	27,774	7.13	10
11	Social Service Workers	2,231	2,429	33,978	13.99	11
12	Dietician					12
13	Food Service Supervisor	1,823	2,002	21,789	10.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,800	9,923	73,007	7.36	15
16	Dishwashers					16
17	Maintenance Workers	4,470	4,620	45,051	9.75	17
18	Housekeepers	4,884	5,035	35,297	7.01	18
19	Laundry	3,027	3,073	21,445	6.98	19
20	Administrator	2,000	2,080	53,385	25.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,992	4,265	42,605	9.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>M-O-W Coordinat</u>	405	405	3,177	7.84	33
34	TOTAL (lines 1 - 33)	113,346	117,320	\$ 1,366,874 *	\$ 11.65	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	241	\$ 6,814	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	18	555	10 - 3	37
38	Nurse Consultant	818	37,981	10 - 3	38
39	Pharmacist Consultant	96	2,800	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	77	4,612	12 - 3	45
46	Other(specify)				46
47	<u>SEE ATTACHED SCHEDULE</u>	582	43,100	VARIOUS	47
48					48
49	TOTAL (lines 35 - 48)	1,952	\$ 107,862		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	242	7,458	10 - 3	51
52	Certified Nurse Assistants/Aides	8	150	10 - 3	52
53	TOTAL (lines 50 - 52)	250	\$ 7,608		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,251 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 52,560
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 195
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

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

PAGE 3 & 4 - SCHEDULE V

PAGE 3 - SCHEDULE V - LINE 23

LINE 27 - OTHER GENERAL ADMINISTRATION	
BAD DEBTS	8,709
SALES TAX	3,421
SCHEDULE V - LINE 27 - COLUMN 3	<u>\$ 12,130</u>

DETAIL - INSERVICE TRAINING & EDUCATION	
IHCA TRAINING	\$ 475
ACTIVITY COURSE & LODGING	1,664
LIFE SAFETY COURSE	175
PRESSURE ULCERS & INCONTINENCE SEMINAR	350
QUALITY HEALTH FORUM	230
MDI TRAINING & LODGING	519
CPR CLASS	220
MEDICAID REIMBURSEMENT SEMINAR	490
MEDICARE SEMINAR	50
FOOD SANITATION COURSE	109
HOME OFFICE INSERVICES	646
NURSING HOME MANAGERS ALLOCATION	1,994
SCHEDULE V - LINE 23 - COLUMN 8	<u>\$ 6,922</u>

COLUMN 5 - DETAIL OF RECLASSIFICATIONS

FROM:	AMOUNT	LINE #
MEDICARE X-RAYS	\$ (2,300)	10
MEDICARE IV	(7,184)	10
MEDICARE DRUGS	(110,926)	10
MEDICARE LABS	(10,260)	10
MEDICARE SUPPLIES	(219)	10
MEDICARE OTHER ANCILLARY	(1,566)	10
OXYGEN	(17,674)	10
PHYSICAL THERAPY	(130,371)	10A
OCCUPATIONAL THERAPY	(100,895)	10A
SPEECH THERAPY	(9,103)	10A
TO: ANCILLARY SERVICES	<u>\$ 390,498</u>	39
TO: ADMINISTRATIVE CONS. MILEAGE	\$ 3,260	17
NURSE CONSULTANT MILEAGE	2,166	10
MAINTENANCE MILEAGE	2,550	6
FROM: TRAVEL	<u>\$ (7,976)</u>	24

PAGE 10A - SECTION A - 2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

MEADOW MANOR PORTION: ALLOWABLE	\$ 23,043.84
68% OF THE \$33,888.00 TAX BILL	
MEADOW MANOR WEST PORTION: NON-ALLOWABLE	
32% OF THE \$33,888.00 TAX BILL	10,844.16
TOTAL 2005 REAL ESTATE TAX BILL	<u>\$ 33,888.00</u>

PAGE 13 - SCHEDULE XI - SECTION E
RECONCILIATION OF DEPRECIATION

SCHEDULE XI - SECTION E - LINE 83	\$ 31,440
NURSING HOME MANAGERS ALLOCATION	<u>1,782</u>
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 33,222</u>

PAGE 19 - SCHEDULE XVII
RECONCILIATION OF INCOME

LINE 43 - NET INCOME	\$ (140,309)
* MANAGEMENT FEE 4/05	(8,687)
* MANAGEMENT FEE 4/06	10,386
INTEREST INCOME	(1,609)
RENTAL INCOME	<u>(400)</u>
TAXABLE INCOME	<u>\$ (140,619)</u>

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

PAGE 23 - SCHEDULE XX - QUESTION 12

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

PAGE 20 - SCHEDULE XVIII - SECTION B
CONSULTANT SERVICES

	# HOURS	COST	LINE & COL
UTILIZATION REVIEW	28	\$ 2,775	10 - 3
PSYCHIATRIC CONSULTANT	6	1,500	10 - 3
MEDICARE CONSULTANT	96	23,659	10 - 3
ADMINISTRATIVE CONSULTANT	<u>452</u>	<u>15,166</u>	17 - 3
SCHEDULE XVIII - LINE 47	<u>582</u>	<u>\$ 43,100</u>	

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

INHAA DUES	\$ 200
LTCNA DUES	105
ADMINISTRATOR LICENSE	100
PUBLIC RELATIONS	15,951
FRANCHISE FEES	266
CHAMBER OF COMMERCE	307
CLIA LAB WAIVER	<u>150</u>
SCHEDULE XIX - SECTION F	<u>\$ 17,079</u>

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

ADMINISTRATOR MILEAGE	\$ 235
PATIENT SCREENING MILEAGE	474
ACTIVITY MILEAGE	215
MISCELLANEOUS MILEAGE	672
SEMINARS & WORKSHOP MILEAGE	<u>228</u>
SCHEDULE XIX - SECTION G	<u>\$ 1,824</u>

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

0011528 PAGE 26 05/01/05 TO 04/30/06

CENTRAL OFFICE COST ALLOCATION
MEADOW MANOR
2005

	MAY 05	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN 06	FEB	MARCH	APRIL	2005 TOTAL	LINE #
SALARIES-ADMIN	\$2,379	\$2,509	\$2,616	\$2,662	\$2,716	\$2,714	\$2,831	\$2,768	\$2,604	\$2,695	\$2,741	\$2,787	\$32,024	17
SALARIES-CLERIC	1,708	1,802	1,878	2,090	2,132	2,130	2,222	2,173	2,054	2,126	2,162	2,199	24,677	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	426	449	468	727	742	742	773	756	383	397	404	410	6,677	10
ACCOUNTING	7	8	8	15	15	15	16	15	9	10	10	10	138	19
WORK COMP INS	15	16	17	49	50	50	52	51	19	19	20	20	380	22
SUPPLIES	81	85	89	58	59	59	61	60	87	90	92	94	914	21
TELEPHONE	105	111	116	118	120	120	125	123	125	129	131	133	1,457	21
EMPL BENEFITS	823	868	905	1,050	1,071	1,070	1,116	1,092	998	1,033	1,050	1,068	12,146	22
PAYROLL TAXES	340	359	374	366	373	373	389	380	401	415	422	429	4,621	22
TRAVEL	62	65	68	102	104	104	108	106	61	63	64	65	971	24
IN SERVICE	264	278	290	93	94	94	98	96	165	171	174	177	1,994	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	91	94	96	98	379	9
MACHINE RENTAL	17	18	19	32	33	33	34	34	19	19	20	20	300	6
OWNERS COMP	145	153	159	169	172	172	179	175	167	173	176	179	2,018	17
INS-PROP,LIAB,WC	27	28	29	(31)	(31)	(31)	(33)	(32)	27	28	28	29	38	26
DEPRECIATION	122	129	134	149	152	152	159	155	151	157	159	162	1,782	30
RENT	326	343	358	370	377	377	393	384	386	399	406	413	4,531	34
MAINTENANCE	67	71	74	107	109	109	113	111	87	90	91	93	1,122	6
FEES & PUBLICAT	7	7	7	28	29	29	30	30	11	11	12	12	214	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	\$6,921	7,300	\$7,611	\$8,153	\$8,317	\$8,312	\$8,669	\$8,478	\$7,846	\$8,119	\$8,258	\$8,398	96,383	
FIXED ASSETS		0											96,383	
EQUIP - PRIOR	10,392	10,961	11,427	8,255	8,421	8,416	8,777	8,583	13,056	13,511	13,742	13,974	10,793	
EQUIP - CURR	81	324	338	4,571	4,663	4,660	4,861	4,753	0	0	128	130	2,042	
EQUIP - FULLY DEP	3,348	3,532	3,682	3,799	3,876	3,873	4,040	3,950	3,867	4,002	4,071	4,139	3,848	
BLDG - PRIOR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	1,180	1,244	1,297	1,338	1,365	1,364	1,423	1,392	1,362	1,410	1,434	1,458	1,356	

MONTAGGIONE											
MONTAGGIONE - 1						MONTAGGIONE - 2					
DATA	ORA	INTELL.	INTELL.	INTELL.	INTELL.	DATA	ORA	INTELL.	INTELL.	INTELL.	INTELL.
1998	10	10	10	10	10	1998	10	10	10	10	10
1998	11	11	11	11	11	1998	11	11	11	11	11
1998	12	12	12	12	12	1998	12	12	12	12	12
1998	13	13	13	13	13	1998	13	13	13	13	13
1998	14	14	14	14	14	1998	14	14	14	14	14
1998	15	15	15	15	15	1998	15	15	15	15	15
1998	16	16	16	16	16	1998	16	16	16	16	16
1998	17	17	17	17	17	1998	17	17	17	17	17
1998	18	18	18	18	18	1998	18	18	18	18	18
1998	19	19	19	19	19	1998	19	19	19	19	19
1998	20	20	20	20	20	1998	20	20	20	20	20
1998	21	21	21	21	21	1998	21	21	21	21	21
1998	22	22	22	22	22	1998	22	22	22	22	22
1998	23	23	23	23	23	1998	23	23	23	23	23
1998	24	24	24	24	24	1998	24	24	24	24	24
1998	25	25	25	25	25	1998	25	25	25	25	25
1998	26	26	26	26	26	1998	26	26	26	26	26
1998	27	27	27	27	27	1998	27	27	27	27	27
1998	28	28	28	28	28	1998	28	28	28	28	28
1998	29	29	29	29	29	1998	29	29	29	29	29
1998	30	30	30	30	30	1998	30	30	30	30	30
1998	31	31	31	31	31	1998	31	31	31	31	31

