

		FOR BHF USE					

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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.

<p>I. IDPH Facility ID Number: <u>0011544</u></p> <p>Facility Name: <u>Meadows Mennonite Home</u></p> <p>Address: <u>24588 Church Street</u> <u>Chenoa</u> <u>61726</u> <small>Number City Zip Code</small></p> <p>County: <u>McLean</u></p> <p>Telephone Number: <u>(309) 747-2702</u> Fax # <u>(309) 747-2944</u></p> <p>HFS ID Number: <u>37-0791831001</u></p> <p>Date of Initial License for Current Owners: <u>1958</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501 (c) 3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Roger W. Hasler</u> Telephone Number: <u>(309) 747-2702</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2006</u> to <u>12/31/2006</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Roger W. Hasler</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Chief Financial Officer</u></td> </tr> </table> <table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>()</u></td> <td style="border: none;">Fax # ()</td> </tr> </table> <p align="center"> 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 </p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Roger W. Hasler</u>			(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) <u>()</u>	Fax # ()
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Facility Name & ID Number Meadows Mennonite Home

0011544 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	22	Skilled (SNF)	22	8,030	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,420	3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,035	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	2,059	5,343		7,402	8
9	SNF/PED					9
10	ICF	14,413	14,800		29,213	10
11	ICF/DD					11
12	SC		847		847	12
13	DD 16 OR LESS					13
14	TOTALS	16,472	20,990		37,462	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.55%

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

_____ (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 1958

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

YES Date 1958 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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	260,915	16,038	7,688	284,641	-	284,641	-	284,641		1
2	Food Purchase		268,038		268,038	-	268,038	(4,328)	263,710		2
3	Housekeeping	184,823	25,068	-	209,891	-	209,891	-	209,891		3
4	Laundry	60,370	13,855	-	74,225	-	74,225	-	74,225		4
5	Heat and Other Utilities			253,331	253,331	-	253,331	(43,235)	210,096		5
6	Maintenance	136,392	15,716	107,815	259,923	-	259,923	(75,472)	184,451		6
7	Other (specify):*				-		-		-		7
8	TOTAL General Services	642,500	338,715	368,834	1,350,049	-	1,350,049	(123,035)	1,227,014		8
	B. Health Care and Programs										
9	Medical Director	-	-	5,400	5,400	-	5,400	-	5,400		9
10	Nursing and Medical Records	2,059,519	76,560	19,011	2,155,090	(652)	2,154,438	-	2,154,438		10
10a	Therapy	15,930	334	2,517	18,781	-	18,781	-	18,781		10a
11	Activities	81,549	2,261	777	84,587	-	84,587	(392)	84,195		11
12	Social Services	66,154	-	1,110	67,264	-	67,264	-	67,264		12
13	CNA Training	-	-	-	-	652	652	-	652		13
14	Program Transportation	-	-	-	-	-	-	-	-		14
15	Other (specify):*				-		-		-		15
16	TOTAL Health Care and Programs	2,223,152	79,155	28,815	2,331,122	-	2,331,122	(392)	2,330,730		16
	C. General Administration										
17	Administrative	125,271	-	-	125,271	-	125,271	-	125,271		17
18	Directors Fees				-	-	-	-	-		18
19	Professional Services			38,877	38,877	-	38,877	-	38,877		19
20	Dues, Fees, Subscriptions & Promotions			22,715	22,715	-	22,715	(12,027)	10,688		20
21	Clerical & General Office Expenses	171,348	12,282	158,653	342,283	(21,686)	320,597	(30,123)	290,474		21
22	Employee Benefits & Payroll Taxes			567,705	567,705	-	567,705	(17,973)	549,732		22
23	Inservice Training & Education			-	-	-	-	-	-		23
24	Travel and Seminar			-	-	5,097	5,097	(282)	4,815		24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-		25
26	Insurance-Prop.Liab.Malpractice			93,643	93,643	-	93,643	(11,724)	81,919		26
27	Other (specify):*				-		-		-		27
28	TOTAL General Administration	296,619	12,282	881,593	1,190,494	(16,589)	1,173,905	(72,129)	1,101,776		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,162,271	430,152	1,279,242	4,871,665	(16,589)	4,855,076	(195,556)	4,659,520		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 Mennonite Home #0011544 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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			503,265	503,265		503,265	(25,039)	478,226		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			264,444	264,444		264,444	(44,554)	219,890		32
33	Real Estate Taxes			40,793	40,793		40,793	(40,793)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles					4,110	4,110		4,110		35
36	Other (specify):*										36
37	TOTAL Ownership			808,502	808,502	4,110	812,612	(110,386)	702,226		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			71,175	71,175		71,175		71,175		42
43	Other (specify):*	61,232	1,199	4,680	67,111	12,479	79,590	(79,590)			43
44	TOTAL Special Cost Centers	61,232	1,199	75,855	138,286	12,479	150,765	(79,590)	71,175		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,223,503	431,351	2,163,599	5,818,453		5,818,453	(385,532)	5,432,921		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 Mennonite Home

0011544

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	(1,832)	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	7,445	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	(9,288)	20.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,739)	20.3		28
29	Other-Attach Schedule	(379,118)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (385,532)		\$	30

BHF USE ONLY					
48		49		50	
				51	
				52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (385,532)		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.

		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			46
47	TOTAL (C): (sum of lines 38-46)			\$		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
				Meadows Mennonite Retirement Home	Chenoa	Independent Living Housing

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							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		\$			\$	\$ *	14

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

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 Mennonite Home

0011544 Report Period Beginning: 01/01/2006

Ending: 2/31/200 12/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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 Mennonite Home

0011544

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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
						Amount of Note	Reporting Period Interest Expense				
Name of Lender	Related**	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
	YES	NO									
A. Directly Facility Related											
Long-Term											
1	GMAC	X	Mortgage	\$8,319.00	6/1976	\$ 1,620,000	\$ 523,031	6/2016	0.0500	\$ 28,267	1
2	FmHA #2	X	Mortgage	\$9,876.00	2/1996	1,782,500	1,459,749	3/2028	0.0500	73,909	2
3	FmHA #3	X	Mortgage	\$13,475.00	2/4/02	2,500,000	2,368,589	12/14/2034	0.0475	113,192	3
4	Heartland Bk & Trust	X	Mortgage	\$4,575.00	2/4/02	1,000,000	738,932	2/4/2033	0.0575	43,475	4
5											5
Working Capital											
6	Heartland Bk & Trust	X	Working Capital		Jun-06	300,000		Jun-07	0.0850	5,391	6
7	Loyalty Loans	X	Mortgage - renew annually		Various	13,500	3,605	Various	0.0700	210	7
8	Residential to Health Center	X	Working Capital		Various		364,621	Various			8
9	TOTAL Facility Related			\$36,245.00		\$ 7,216,000	\$ 5,458,527			\$ 264,444	9
B. Non-Facility Related*											
10	Other Long-Term Facility Related										10
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$ 7,216,000	\$ 5,458,527			\$ 264,444	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 the 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 Meadows Mennonite Home COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0011544

CONTACT PERSON REGARDING THIS REPORT Roger W. Hasler

TELEPHONE (309) 747-2702 FAX #: (309) 747-2944

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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 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 Meadows Mennonite Home

0011544 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 76,955 B. General Construction Type: Exterior Masonry Frame Brick, Steel, Wood Number of Stories Two

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	683,400	1920	\$ 15,065	1
2	Facility		1950	27,033	2
3	TOTALS	683,400		\$ 42,098	3

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			Jan-23	Jan-23	\$ 74,144	\$	50	\$	\$	\$ 74,144	4
5	23		Jan-52	Jan-52	86,314		50			86,314	5
6	25		Jan-66	Jan-66	225,617	3,884	50	4,512	628	184,987	6
7	94		Jan-78	Jan-78	2,348,846	58,921	40	58,721	(200)	1,702,711	7
8	17		Nov-97	Nov-97	3,898,885	97,472	40	97,472		893,271	8
		Improvement Type**									
9		Various Building Improvements		Jul-79	78,921		20			78,921	9
10		Various Building Improvements		Jan-80	3,362	66	20		(66)	3,362	10
11		Various Building Improvements		Jul-81	3,427		20			3,427	11
12		Various Building Improvements		Jun-83	186,656		20			186,656	12
13		Various Building Improvements		Jul-84	1,298		20			1,298	13
14		Various Building Improvements		Oct-85	31,287		10			31,287	14
15		Various Building Improvements		Jul-86	35,542		10			35,542	15
16		Various Building Improvements		Jul-87	3,888	150	30	130	(20)	2,532	16
17		Various Building Improvements		Jul-88	182,020	8,263	20	9,101	838	168,365	17
18		Various Building Improvements		Jul-89	107,129	3,940	20	5,356	1,416	93,735	18
19		Various Building Improvements		Jul-90	36,676	2,720	10		(2,720)	36,676	19
20		Various Building Improvements		Jul-91	12,480	542	10		(542)	12,480	20
21		Various Building Improvements		Jul-92	36,879	1,400	10		(1,400)	36,879	21
22		Various Building Improvements		Jul-93	3,505	501	10		(501)	3,505	22
23		Various Building Improvements		Jul-94	93,480	2,486	15	6,232	3,746	77,906	23
24		Various Building Improvements		Oct-95	45,902	2,442	20	2,295	(147)	25,629	24
25		Various Building Improvements		Jul-96	244,463	7,482	20	12,223	4,741	128,358	25
26		Engineering cad & survey		Aug-96	675	45	15	45		466	26
27		Excavating		Sep-96	2,000	133	15	133		1,365	27
28		Boiler Repair - Cleveland		Mar-96	503		3			503	28
29		Roof A/C Repair		Nov-96	718		7			718	29
30		Window Coverings		May-96	1,039		7			1,039	30
31		Sewage Pump Repairs		Nov-96	1,685		7			1,685	31
32		Siding		Nov-97	22		7			22	32
33		Siding		Nov-97	245		7			245	33
34		Alzheimer Unit		Nov-97	144,484	3,612	40	3,612		33,102	34
35		Insulated Glass Rm 42		Sep-97	677	68	10	68		631	35
36		Service-Intercom System Repairs		Mar-97	871		7			871	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 Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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	Fiber Optics - Computer Wiring	Jun-97	\$ 2,887	\$	5	\$	\$	\$ 2,887	37
38	Liquid Storage Cabinet Tank	Jun-97	572		5			572	38
39	Paging System - Bennett	Jun-97	2,288		7			2,288	39
40	Install Heating Cooling	Jun-97	15,161	1,011	15	1,011		9,609	40
41	Compressors (5)	Jul-97	1,653		7			1,653	41
42	Window blinds	Aug-97	1,539		7			1,539	42
43	Motor a/C Motor & Starter for 2 Ton Unit	Aug-97	715		5			715	43
44	Repair Cool	Sep-97	749		5			749	44
45	2 Roof top Units	Oct-97	1,295		7			1,295	45
46	A/C Part Repairs	Oct-97	733		5			733	46
47	Power Server -Timeclock	Nov-97	150	10	15	10		91	47
48	2 Carrier Heating & Cooling	Dec-97	19,250	1,283	15	1,283		11,649	48
49	Intercom Wiring Repairs	Nov-97	696		3			696	49
50	Carousel Tub	Nov-97	12,423	828	15	828		7,588	50
51	Landscaping	Nov-97	30,518	2,035	15	2,035		18,649	51
52	Curtains, Valances	Nov-97	10,077	672	15	672		6,158	52
53	Patio Garden Landscaping	Nov-97	12,842	856	15	856		7,845	53
54	Fence & Gate	Nov-97	10,162	254	40	254		2,328	54
55	Telephone Wiring	Nov-97	1,462	97	15	97		889	55
56	Draperies - Clark	Nov-97	869	58	15	58		532	56
57	ASI Sign System	Nov-97	2,547	170	15	170		1,558	57
58	Rocks for 2 Courtyards	Sep-98	2,070	138	15	138		1,140	58
59	Asphalt Maintenance	Sep-98	5,500	550	15	367	(183)	3,058	59
60	Window Room # 51	Sep-98	444	44	10	44		366	60
61	Magnetic Gate Contact	May-98	228		7			228	61
62	Carpet Res. Room	Sep-98	330		5			330	62
63	Carpet 3 Rooms	Dec-98	793		5			793	63
64	Maintenance Shop	Dec-98	909	45	20	45		362	64
65	2 A/C Compressors	Jun-98	1,006		7			1,006	65
66	Heat & Air Thermostat	Mar-98	1,410		7			1,410	66
67	Natural Gas Steamer	Oct-98	7,495		7			7,495	67
68	Heat Duct Repair	Jan-98	761		7			761	68
69	Repair Engine & Generator	Nov-98	1,322		5			1,322	69
70	TOTAL (lines 4 thru 69)		\$ 8,044,496	\$ 202,178		\$ 207,768	\$ 5,590	\$ 4,006,926	70

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

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2006 Ending:

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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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,044,496	\$ 202,178		\$ 207,768	\$ 5,590	\$ 4,006,926	1
2	Alarm system Phase 1	Dec-98	44,529	2,226	20	2,226		17,967	2
3	Sewage Pump Rehab	Feb-98	7,208		7			7,208	3
4	Water Tower Rehab	May-98	63,699	3,185	20	3,185		27,487	4
5	OSHA Upgrades	Oct-98	111		5			111	5
6	Required OSHA Items	Sep-98	458		5			458	6
7	Eye Wash Station	Sep-98	585		5			585	7
8	1 CS Spill Kits	Dec-98	122		5			122	8
9	Repair Roadway	Apr-99	3,500	233	15	233		1,804	9
10	Landscaping Improvements	Jun-99	2,259	151	15	151		1,133	10
11	Station 1 Door Keypads	May-99	1,442	144	10	144		1,093	11
12	Station 1 Code Alert System	May-99	15,298	1,530	10	1,530		11,607	12
13	Station 1 Nurse Call System	Jun-99	11,924	1,192	10	1,192		8,945	13
14	Ceiling Installation	Sep-99	1,945	130	15	130		943	14
15	Improvements to Brown Shed	Nov-99	1,288	129	10	129		914	15
16	Safety Bars in Alzheimer's Unit	Feb-99	2,350	157	15	157		1,230	16
17	Bronze Door & Closer	Mar-99	1,806	120	15	120		931	17
18	Hardware for Exisisting Doors in Alzheimer's Unit	Mar-99	5,536	369	15	369		2,861	18
19	Sensor Base for Alarm	Jan-99	231		7	3	3	231	19
20	Repair Boiler Station 4	Mar-99	1,140		5			1,140	20
21	Repair Generator	Nov-99	3,067		5			3,067	21
22	Water Heater for Kitchen	Nov-99	878		15	59	59	418	22
23	Panic Devices on Doors in alzheimer Unit	Nov-99	688	82	7	92	10	688	23
24	Alarm System	Apr-99	7,562	378	20	378		2,900	24
25	Storage Cabinets & Installation	Apr-99	5,242	187	7	245	58	5,242	25
26	Elevator Eye	Apr-99	1,978	132	15	132		1,013	26
27	Fire Alarm System Materials & Labor	May-99	27,650	1,383	20	1,383		10,492	27
28	Compressor for Freezer	Jun-99	1,809		7	131	131	1,809	28
29	Sewer Improvements (Check Valves)	Sep-99	1,312		20	66	66	479	29
30	New Pipes in Well	Nov-99	921		20	46	46	326	30
31	New Alzheimer Unit Sign	Mar-99	1,144	76	15	76		593	31
32	Station 4 Door Seal Parts & Labor	Nov-99	1,163	78	15	78		553	32
33	Carpet - Station 5	Feb-00	1,126		5			1,126	33
34	TOTAL (lines 1 thru 33)		\$ 8,264,467	\$ 214,060		\$ 220,023	\$ 5,963	\$ 4,122,402	34

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

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

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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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,264,467	\$ 214,060		\$ 220,023	\$ 5,963	\$ 4,122,402	1
2	Station 5 Remodel	Feb-00	320		10	32	32	219	2
3	Station 5 Tile	Jun-00	530		5			530	3
4	Bathroom Fixtures - Station 5	Jun-00	1,675	167	10	168	1	1,092	4
5	Garage Door Enlargement	Nov-00	1,276	128	10	128		782	5
6	Elevator Cylinder	Feb-00	16,746	1,116	15	1,116		7,632	6
7	Fire Alarm System	Feb-00	18,000	1,200	15	1,200		8,206	7
8	Mastercare hydrobath	Mar-00	9,490	1,356	7	1,356		9,157	8
9	Door Locks on Soiled Linen Closet	Mar-00	568	81	7	81		547	9
10	Air Conditioner Motor	Jul-00	657	94	7	94		603	10
11	Air Conditioner Compressor	Aug-00	1,732	247	7	247		1,565	11
12	Alarm System	Jul-00	35,000	3,500	10	3,500		22,467	12
13	Alarm System	Oct-00	18,060	1,806	10	1,806		11,138	13
14	Alarm System Sensor	Dec-00	864	123	7	123		746	14
15	Premium Lawn	Apr-00	755	50	15	50		334	15
16	Parking Lot Addition	May-00	7,355	490	15	490		3,256	16
17	New Controller for Sewer	Jan-00	1,573		7	225	225	1,556	17
18	Sewer Improvements (Check Valves)	May-00	752		7	107	107	705	18
19	Water main Work	Jun-00	2,203	110	20	110		716	19
20	Water Main Extension	Jun-00	8,465	423	20	423		2,751	20
21	Chlorinator	Jul-00	1,389	198	7	198		1,271	21
22	Generator Repair	Feb-01	506		7	72	72	422	22
23	Generator Repair/Trans.	Mar-01	1,434	171	7	205	34	1,189	23
24	Boiler Repair	Mar-01	1,044	62	7	149	87	861	24
25	Air Conditioner Compressor	Jun-01	700	100	7	100		555	25
26	Air Conditioner Compressor	Jul-01	1,200	172	7	171	(1)	933	26
27	Storm Windows	Aug-01	2,071	207	10	207		1,104	27
28	Simplex Fire Alarm	Oct-01	763	127	5	122	(5)	763	28
29	Phase II Bldg Renov	Mar-02	950,000	31,667	30	31,667		150,526	29
30	Phase II Bldg Renov -K	Apr-02	1,187,500	39,583	30	39,583		186,311	30
31	Renovation 2002	Nov-02	80,684	2,689	30	2,689		11,095	31
32	Renovation 2002	Dec-02	182,708	6,090	30	6,090		24,627	32
33	Pairie Control- 4FCU flow problem	Nov-02	6,694	446	15	446		1,834	33
34	TOTAL (lines 1 thru 33)		\$ 10,807,181	\$ 306,463		\$ 312,978	\$ 6,515	\$ 4,577,895	34

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

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,807,181	\$ 306,463		\$ 312,978	\$ 6,515	\$ 4,577,895	1
2	Phase II Renovation	Oct-02	456,101	15,203	30	15,203		63,353	2
3	Garage Doors	Nov-02	1,166	117	10	117		478	3
4	Roof	Oct-02	125,025	4,168	30	4,168		17,551	4
5	Stained Glass -Chapel	Apr-02	1,063	152	7	152		722	5
6	Water Heater	Jun-02	4,599	657	7	657		3,008	6
7	Generator	Jun-02	1,565	224	7	224		1,015	7
8	Air Conditioner	Jun-02	5,150	736	7	736		3,315	8
9	Air Conditioner	Jun-02	1,495	214	7	214		964	9
10	Heating UN/Steam	Jan-02	1,424	203	7	203		998	10
11	Air Hood	Apr-02	4,970	710	7	710		3,342	11
12	Fire Protection System	Apr-02	2,572	367	7	367		1,728	12
13	Nation Custom Vent Ducts	Apr-02	830	119	7	119		560	13
14	New Road	Nov-02	3,911	261	15	261		1,074	14
15	Sub Pump	Apr-02	2,448		7	350	350	1,647	15
16	Sewage Pump Station	Aug-02	1,906		20	95	95	415	16
17	Lift Station Eng	Sep-02	1,860	93	20	93		398	17
18	Lift Station Eng	Oct-02	1,674	84	20	84		353	18
19	Pump Station Eng	Nov-02	1,169	58	20	58		239	19
20	Lift Station Eng Review	Dec-02	720	36	20	36		145	20
21	Lift Station Eng	Jul-02	950	48	20	48		212	21
22	Pump Station Eng	Aug-02	1,603	80	20	80		349	22
23	Chiller Compressor Replacement	Oct-02	2,418	345	7	345		1,438	23
24	Medline-Borders & Shades/ Dining Rm	Feb-03	3,195	456	7	456		1,778	24
25	Phase II Renov Project	Apr-03	244,941	8,165	30	8,165		30,624	25
26	Tile Specialists-Adm Bld Entry	Jul-03	1,455	182	8	182		634	26
27	Tile Specialists-Adm Bldg Hallway	Apr-03	9,350	1,169	8	1,169		4,336	27
28	Tile Specialists - Lounge Carpet	Apr-03	2,950	369	8	369		1,369	28
29	Code Alert-Security System	Oct-03	69,151	6,915	10	6,915		22,204	29
30	Jay's Plumbing - Hot Water Heater mixing valve	Dec-03	2,980	298	10	298		915	30
31	New Lift Station	Apr-03	97,919	4,896	20	4,896		17,974	31
32	Roof Repairs	Apr-04	1,270	127	10	127		349	32
33	Electrical	Dec-04	2,900	414	7	414		831	33
34	TOTAL (lines 1 thru 33)		\$ 11,867,911	\$ 353,329		\$ 360,289	\$ 6,960	\$ 4,762,213	34

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

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

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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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,867,911	\$ 353,329		\$ 360,289	\$ 6,960	\$ 4,762,213	1
2	Water Heaters	Apr-04	12,523	1,252	10	1,252		3,420	2
3	Water Softner	Oct-04	7,398	740	10	740		1,604	3
4	Asphalt Sealcoat	Sep-04	22,833	7,611	3	7,611		17,745	4
5	Sidewalk	Jul-05	2,450	123	20	123		180	5
6	Shingles	Oct-05	21,650	1,083	20	1,083		1,302	6
7	Flooring/Carpet	Jul-05	9,999	1,250	8	1,250		1,777	7
8	Brick Repairs	Oct-05	2,230	223	10	223		271	8
9	Wall covering and modification	Apr-05	28,744	4,020	7	4,106	86	7,189	9
10	Fire system and sprinkler	Jul-05	6,238	624	10	624		889	10
11	A/C, Duct Htrs	Jul-05	16,952	1,280	10	1,695	415	2,475	11
12	Generator	Jan-05	1,191	79	15	79		154	12
13	Cooling tower refurbishment	Apr-06	6,142	658	7	627	(31)	627	13
14	Air separator & fan coil units	Jan-06	16,162	1,503	10	1,479	(24)	1,479	14
15	Window treatments	Feb-06	3,385	403	7	415	12	415	15
16	Iron filters	Apr-06	2,467	185	10	179	(6)	179	16
17	Chiller compressor	Sep-06	9,294	232	10	265	33	265	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	TOTAL (lines 1 thru 33)		\$ 12,037,569	\$ 374,595		\$ 382,040	\$ 7,445	\$ 4,802,184	34

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

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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	
1	Totals from Page 12E, Carried Forward		\$ 12,037,569	\$ 374,595		\$ 382,040	\$ 7,445	\$ 4,802,184	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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	TOTAL (lines 1 thru 33)		\$ 12,037,569	\$ 374,595		\$ 382,040	\$ 7,445	\$ 4,802,184	34

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

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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		
1	Totals from Page 12F, Carried Forward	\$ 12,037,569	\$ 374,595		\$ 382,040	\$ 7,445	\$ 4,802,184		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 12,037,569	\$ 374,595		\$ 382,040	\$ 7,445	\$ 4,802,184		34

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

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 471,006	\$ 79,312	\$ 79,312	\$	various	\$ 464,233	71
72	Current Year Purchases	77,302	10,683	10,683		various	10,683	72
73	Fully Depreciated Assets	331,487				various	331,487	73
74								74
75	TOTALS	\$ 879,795	\$ 89,995	\$ 89,995	\$		\$ 806,403	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	Grounds Maintenance	1999 Dodge D350	Feb-99	\$ 29,024	\$	\$	\$	5	\$ 29,024	76
77	Patient Transport	2004 Pontiac Montana	Oct-04	10,609	2,122	2,122		5	4,692	77
78	Grounds Maintenance	2004 JD 1420 Mower	Nov-04	7,608	1,522	1,522		5	3,198	78
79	Grounds Maintenance	Other	Various	11,775	2,733	2,733		5	11,775	79
80	TOTALS			\$ 59,016	\$ 6,377	\$ 6,377	\$		\$ 48,689	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)	\$ 13,018,478	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 470,967	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 478,412	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,445	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,657,276	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	Residential Housing Units	\$ 1,235,200	\$ 28,155	\$ 802,094	86
87	Residential Vehicles	49,027	1,500	48,902	87
88	CEO House Remodeling	71,092	2,643	34,112	88
89	Land	158,040			89
90					90
91	TOTALS	\$ 1,513,359	\$ 32,298	\$ 885,108	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$	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

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: \$ 4,110 Description: Copier

(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 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		22		22
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		630		630
8	CNA Competency Tests				
9	TOTALS	\$	\$ 652	\$	\$ 652
10	SUM OF line 9, col. 1 and 2 (e)	\$ 652			

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

- (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 Meadows Mennonite Home

0011544 Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	10a.3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescripts							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			\$		\$	\$		\$	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 Meadows Mennonite Home

0011544

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 142,609	\$	1
2	Cash-Patient Deposits	13,271		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (6,000))	434,153		3
4	Supply Inventory (priced at FIFO)			4
5	Short-Term Investments	8,496		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	28,015		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 626,544	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,595,966		12
13	Land	200,138		13
14	Buildings, at Historical Cost	8,044,753		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,984,039		16
17	Accumulated Depreciation (book methods)	(5,920,425)		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): Construction in Process			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,904,471	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,531,015	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (80,902)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(13,271)		28
29	Short-Term Notes Payable	(31,356)		29
30	Accrued Salaries Payable	(104,033)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(41,970)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Expenses	(255,219)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (526,751)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(565,135)		39
40	Mortgage Payable	(5,059,051)		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)	\$ (5,624,186)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (6,150,937)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,380,078)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (10,531,015)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,523,584	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,523,584	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(143,504)	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) Rounding	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (143,506)	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)	\$ 4,380,078	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

1		2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,006,560	1
2	Discounts and Allowances for all Levels	(1,117,192)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,889,368	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	17,976	6
7	Oxygen	6,786	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 24,762	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,516	13
14	Non-Patient Meals	4,327	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	392	18
19	Laboratory	15,315	19
20	Radiology and X-Ray		20
21	Other Medical Services	66,665	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 89,215	23
	D. Non-Operating Revenue		
24	Contributions	375,836	24
25	Interest and Other Investment Income***	44,554	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 420,390	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential Revenue	249,683	28
28a	Other Income	1,531	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 251,214	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,674,949	30

1		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,350,049	31
32	Health Care	2,331,122	32
33	General Administration	1,190,494	33
	B. Capital Expense		
34	Ownership	808,502	34
	C. Ancillary Expense		
35	Special Cost Centers	67,111	35
36	Provider Participation Fee	71,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,818,453	40
41	Income before Income Taxes (line 30 minus line 40)**	(143,504)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (143,504)	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.

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	1,803	2,072	\$ 69,382	\$ 33.49	1
2	Assistant Director of Nursing	1,944	2,147	51,304	23.90	2
3	Registered Nurses	10,425	11,398	307,725	27.00	3
4	Licensed Practical Nurses	16,250	17,876	379,037	21.20	4
5	CNAs & Orderlies	97,932	105,764	1,228,504	11.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,233	1,318	15,930	12.09	8
9	Activity Director	1,704	1,932	23,250	12.03	9
10	Activity Assistants	6,915	7,582	58,299	7.69	10
11	Social Service Workers	3,446	3,751	66,154	17.64	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,112	32,687	15.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,350	29,120	228,228	7.84	15
16	Dishwashers					16
17	Maintenance Workers	3,775	4,421	60,920	13.78	17
18	Housekeepers	17,798	19,631	184,823	9.41	18
19	Laundry	5,791	6,306	60,370	9.57	19
20	Administrator	1,853	2,120	125,271	59.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,160	2,459	78,576	31.95	23
24	Clerical	8,110	8,688	85,291	9.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	1,539	1,771	23,567	13.31	33
34	TOTAL (lines 1 - 33)	211,988	230,468	\$ 3,079,318 *	\$ 13.36	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	205	\$ 7,688	1.3	35
36	Medical Director	76	5,400	9.3	36
37	Medical Records Consultant	48	1,755	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	8	600	10.3	39
40	Physical Therapy Consultant	29	1,629	10a.3	40
41	Occupational Therapy Consultant	14	770	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	118	10a.3	43
44	Activity Consultant	10	477	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	392	\$ 18,437		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10.3	50
51	Licensed Practical Nurses	17	594	10.3	51
52	Certified Nurse Assistants/Aides	728	15,366	10.3	52
53	TOTAL (lines 50 - 52)	744	\$ 15,960		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? Yes
If YES, give association name and amount. Life Services Network of IL 6,266
- (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? 6.1
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,420 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. \$ 71,175
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.
Hskpng & Laundry split on time spent.
- (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? Yes Indicate the amount. \$ 1,832
- (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? 100% of Program
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? 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? Yes
Firm Name: Heinold-Banwart, Ltd The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes 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.