

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License 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 05/01/06 to 04/30/07 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: 05/01/06 Ending: 04/30/07

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		59	4,521	4,580	8
9	SNF/PED					9
10	ICF	13,674	7,624		21,298	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,674	7,683	4,521	25,878	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.85%

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 4,521

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 4/30/07 Fiscal Year: 4/30/07

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

Facility Name & ID Number **MEADOW MANOR** # **0011528** Report Period Beginning: **05/01/06** Ending: **04/30/07**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	117,195	19,671	8,253	145,119		145,119	(13,544)	131,575		1
2	Food Purchase		160,133		160,133		160,133	(30,927)	129,206		2
3	Housekeeping	43,704	14,240		57,944		57,944		57,944		3
4	Laundry	21,986	8,606		30,592		30,592		30,592		4
5	Heat and Other Utilities			72,286	72,286		72,286	(400)	71,886		5
6	Maintenance	44,316	32,323	34,225	110,864	2,191	113,055	2,018	115,073		6
7	Other (specify):* Utility Workers	14,064			14,064		14,064		14,064		7
8	TOTAL General Services	241,265	234,973	114,764	591,002	2,191	593,193	(42,853)	550,340		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	2,396	14,396		9
10	Nursing and Medical Records	1,117,016	266,873	43,787	1,427,676	(188,888)	1,238,788	6,043	1,244,831		10
10a	Therapy	45,771	3,819	368,350	417,940	(368,350)	49,590		49,590		10a
11	Activities	52,151	2,863		55,014		55,014		55,014		11
12	Social Services	31,718		5,753	37,471		37,471		37,471		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,246,656	273,555	429,890	1,950,101	(557,238)	1,392,863	8,439	1,401,302		16
	C. General Administration										
17	Administrative	63,152		10,610	73,762	2,460	76,222	40,364	116,586		17
18	Directors Fees										18
19	Professional Services			152,507	152,507		152,507	(141,810)	10,697		19
20	Dues, Fees, Subscriptions & Promotions			52,658	52,658		52,658	(45,299)	7,359		20
21	Clerical & General Office Expenses	47,142	15,860	6,696	69,698		69,698	32,548	102,246		21
22	Employee Benefits & Payroll Taxes			337,225	337,225		337,225	20,967	358,192		22
23	Inservice Training & Education			4,763	4,763		4,763	2,293	7,056		23
24	Travel and Seminar			7,677	7,677	(5,992)	1,685	642	2,327		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			73,159	73,159		73,159	279	73,438		26
27	Other (specify):*			62,987	62,987		62,987	(62,987)			27
28	TOTAL General Administration	110,294	15,860	708,282	834,436	(3,532)	830,904	(153,003)	677,901		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,598,215	524,388	1,252,936	3,375,539	(558,579)	2,816,960	(187,417)	2,629,543		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:

05/01/06

Ending:

04/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			25,513	25,513		25,513	7,160	32,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			869	869		869	(869)				32
33	Real Estate Taxes			24,393	24,393		24,393		24,393			33
34	Rent-Facility & Grounds							5,209	5,209			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			50,775	50,775		50,775	11,500	62,275			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					558,579	558,579		558,579			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	558,579	611,139		611,139			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,598,215	524,388	1,356,271	3,478,874		3,478,874	(175,917)	3,302,957			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: 05/01/06

Ending: 04/30/07

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	BHF USE ONLY	
1	Day Care	\$ (40)	21	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(455)	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	5,105	30		9
10	Interest and Other Investment Income	(869)	32		10
11	Discounts, Allowances, Rebates & Refunds	(873)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,900)	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	(972)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,861)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,115)	27		24
25	Fund Raising, Advertising and Promotional	(44,840)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(352)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(44,016)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (151,895)		\$	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)	(24,022)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (24,022)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (175,917)		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		368,350	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		17,538	10	42
43	Prescription Drugs	X		143,888	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Supplies,O2	X		25,974	10	45
46	Other-Attach Schedule OtherAncilla	X		2,829	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 558,579		47

BHF USE ONLY						
48		49		50		52

MEADOW MANOR

ID# 0011528

Report Period Beginning: 05/01/06

Ending: 04/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MEALS ON WHEELS - EXP. REIMB - FOOD	\$ (28,882)	2	1
2	MEALS ON WHEELS - EXP. REIMB - SALARY	(13,544)	1	2
3	VENDING	(1,590)	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	(44,016)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/06

Ending:

04/30/07

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	(13,544)	0	0	0	0	0	0	0	0	0	0	(13,544)	1
2	Food Purchase	(30,927)	0	0	0	0	0	0	0	0	0	0	(30,927)	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	(44,871)	0	0	0	0	0	0	0	0	0	0	(44,871)	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	289	0	0	0	0	0	0	0	0	0	289	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,861)	(140,685)	0	0	0	0	0	0	0	0	0	(142,546)	19
20	Fees, Subscriptions & Promotions	(45,499)	0	0	0	0	0	0	0	0	0	0	(45,499)	20
21	Clerical & General Office Expenses	(913)	0	0	0	0	0	0	0	0	0	0	(913)	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	(289)	0	0	0	0	0	0	0	0	0	(289)	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):*	(62,987)	0	0	0	0	0	0	0	0	0	0	(62,987)	27
28	TOTAL General Administration	(111,260)	(140,685)	0	(251,945)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(156,131)	(140,685)	0	(296,816)	29								

STATE OF ILLINOIS

Facility Name & ID Number MEADOW MANOR

0011528 Report Period Beginning:

05/01/06 Ending:

Summary B

04/30/07

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	5,105	0	0	0	0	0	0	0	0	0	0	5,105	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	4,236	0	0	0	0	0	0	0	0	0	0	4,236	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)	(151,895)	(140,685)	0	(292,580)	45								

Facility Name & ID Number MEADOW MANOR

0011528

Report Period Beginning:

05/01/06

Ending:

04/30/07

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	0	HILLTOP NURSING HOME, INC	CHARLESTON	Nrsg Home Managers	SPRINGFIELD	MANAGEMENT
SAM KLEIN	95%	JACKSONVILLE CONV. CENTER, INC.	JACKSONVILLE	Meadow Manor West	TAYLORVILLE	RENTAL
IGNACIO DELVALLE	5%	MENARD CONVALESCENT CENTER, INC.	PETERSBURG			
		SUNRISE MANOR OF VIRDEN, INC.	VIRDEN			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 MANGEMENT FEE	\$ 148,727	NURSING HOME MANAGERS, INC.	95.00%	\$	\$ (148,727)	1
2	V	VAR SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	95.00%	116,663	116,663	2
3	V	19 ACCOUNTING		NURSING HOME MANAGERS - DIRECT ALLOCATION	95.00%	8,042	8,042	3
4	V	24 TRAVEL	289	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(289)	4
5	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW		289	289	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		\$ 149,016			\$ 124,994	\$ * (24,022)	14

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

Facility Name & ID Number

MEADOW MANOR

#

0011528

Report Period Beginning:

05/01/06

Ending:

04/30/07

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		MANAGEMENT						\$ 986	17 - 7	1
2											2
3			H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC.,								3
4			A RELATED ORGANIZATION. TOTAL COMPENSATION OF \$4,400								4
5			WAS ALLOCATED AMONG THE FIVE RELATED NURSING HOMES								5
6			BASED UPON 10 HOURS PER WEEK FOR H. RAYMOND KLEIN.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 986		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: 05/01/06

Ending: 04/30/07

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	859,486	DEMAND	6.0000	869	6									
7											7									
8											8									
9	TOTAL Facility Related					\$ 289,726	\$ 859,486			\$ 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	\$ 859,486			\$ 869	15									

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

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

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

Facility Name & ID Number **MEADOW MANOR**

0011528 Report Period Beginning: **05/01/06**

Ending: **04/30/07**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 30,725	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 23,044	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (7,681)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 32,074	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 24,393	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<u>29,786</u>	<u>8</u>
	2003	<u>30,883</u>	<u>9</u>
	2004	<u>32,509</u>	<u>10</u>
	2005	<u>33,888</u>	<u>11</u>
	2006	<u>35,376</u>	<u>12</u>
SEE PAGE 10A LONG TERM CARE REAL ESTATE TAX STATEMENT FOR TAX APPLICABLE TO NURSING HOME			
LINE 4: 16/12 OF \$24,055 = \$32,074			

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>17-13-23-402-002-00</u>	<u>MEADOW MANOR</u>	\$ <u>35,375.56</u>	\$ <u>24,055.38</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>35,375.56</u>	\$ <u>24,055.38</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

05/01/06 Ending:

04/30/07

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:

05/01/06

Ending:

04/30/07

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	1958	\$ 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		15			13,401	14
15	AIR CONDITIONER		1987		3,749	55	15		(55)	3,749	15
16	IMPROVEMENT		1987		6,721	213	15		(213)	6,721	16
17	IMPROVEMENT		1987		2,539	81	15	2	(79)	2,539	17
18	SPRINKLER		1989		890	28	15	3	(25)	890	18
19	IMPROVEMENT		1989		16,132	512	15		(512)	16,132	19
20	IMPROVEMENT		1990		4,004	127	15		(127)	4,004	20
21	IMPROVEMENT		1990		22,907	727	VARIOUS	810	83	15,615	21
22	IMPROVEMENT		1993		2,576	82	VARIOUS	171	89	2,493	22
23	IMPROVEMENT		1994		1,475	47	15	99	52	1,324	23
24	IMPROVEMENT		1995		42,600	1,092	20	2,130	1,038	26,625	24
25	AIR CONDITIONER		1996		6,844	175	15	457	282	5,245	25
26	SMOKE DETECTORS		1996		981	25	15	66	41	752	26
27	SINKS & FAUCETS		1996		2,698	69	15	180	111	2,070	27
28	WINDOWS		1996		3,859	99	15	257	158	2,956	28
29	FIRE DOORS		1996		784	20	15	52	32	598	29
30	NEW DOOR FRAMES		1997		10,035	257	15	669	412	6,355	30
31	SPRINKLER REPAIRS		1997		1,127	29	15	75	46	713	31
32	FIRE DOORS		1998		808	21	15	54	33	459	32
33	AIR CONDITIONER		1998		1,820	47	15	121	74	1,029	33
34	FIRE ALARM SYSTEM		1999		8,250	212	20	412	200	3,509	34
35	WATER HEATER		2000		3,813	98	15	254	156	1,863	35
36	BACKFLOW VALVE		2000		3,998	103	15	266	163	1,890	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:

05/01/06

Ending:

04/30/07

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR CONDITIONER	1999	\$ 2,985	\$ 77	15	\$ 199	\$ 122	\$ 1,575	37
38	DOORS	2001	4,450	114	15	297	183	1,807	38
39	5 TON AIR CONDITIONER	2001	1,613	41	10	162	121	940	39
40	ROOFTOP A/C & HEAT	2001	3,165	81	15	211	130	1,178	40
41	2 ROOMS & BATHROOMS RENOVATED FOR MEDICARE	2002	56,051	1,437	20	2,802	1,365	12,379	41
42	ROOFTOP A/C & HEAT	2002	3,396	87	10	339	252	1,529	42
43	AIR CONDITIONER	2003	1,985	51	10	199	148	761	43
44	SMOKE DETECTORS & EXHAUST SYSTEM	2004	4,838	124	15	323	199	1,034	44
45	ROOF	2004	162,600	4,169	20	8,130	3,961	19,648	45
46	FIRE SUPPRESSION SYSTEM & ELECTRICAL WIRING	2005	6,420	165	20	321	156	607	46
47	HEAT EXCHANGER	2005	1,181	30	15	79	49	112	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	\$ 10,495		\$ 19,140	\$ 8,645	\$ 771,160	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: 05/01/06 Ending: 04/30/07

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	\$ 121,350	\$ 11,959	\$ 10,231	\$ (1,728)	Various	\$ 64,670	71
72	Current Year Purchases	17,009	3,059	1,247	(1,812)	Various	1,247	72
73	Fully Depreciated Assets	367,429				Various	367,429	73
74	Assets No Longer in Service (Includes MM West)	(160,147)					(160,147)	74
75	TOTALS	\$ 345,641	\$ 15,018	\$ 11,478	\$ (3,540)		\$ 273,199	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)	\$ 1,367,994	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,513	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,618	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,105	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,044,359	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: 05/01/06

Ending: 04/30/07

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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number MEADOW MANOR# 0011528

Report Period Beginning:

05/01/06

Ending:

04/30/07

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	\$	2,488	\$ 157,159	\$	2,488	\$ 157,159	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		308	19,814		308	19,814	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		3,639	191,377		3,639	191,377	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 prescrpts				143,888		143,888	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab,Xray,O2,Sup,Othe	39 - 8					46,341		46,341	13
14	TOTAL			\$	6,435	\$ 368,350	\$ 190,229	6,435	\$ 558,579	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: 05/01/06

Ending:

04/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 04/30/07

(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	\$ 58,566	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,096,236		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,501		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)	\$ 1,169,303	\$	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	409,924		16
17	Accumulated Depreciation (book methods)	(1,079,818)		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)	\$ 352,459	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,521,762	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 375,303	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,623		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,441		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,074		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)	\$ 500,441	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	859,486		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)	\$ 859,486	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,359,927	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 161,835	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,521,762	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,406,088)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,406,088)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	92,683	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) CONTRIBUTED CAPITAL	1,475,240	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,567,923	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)	\$ 161,835	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MEADOW MANOR# 0011528Report Period Beginning: 05/01/06Ending: 04/30/07**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	\$ 3,459,689	1
2	Discounts and Allowances for all Levels	(65,909)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,393,780	3
B. Ancillary Revenue			
4	Day Care	40	4
5	Other Care for Outpatients		5
6	Therapy	121,068	6
7	Oxygen	7,722	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 128,830	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	42,881	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	946	21
22	Laundry	1,125	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 45,352	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,132	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,132	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING \$1,590 ADMIT FEE \$825	2,415	28
28a	W/A \$48	48	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,463	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,571,557	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	591,002	31
32	Health Care	1,950,101	32
33	General Administration	834,436	33
B. Capital Expense			
34	Ownership	50,775	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)*	\$ 3,478,874	40
41	Income before Income Taxes (line 30 minus line 40)**	92,683	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 92,683	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:

05/01/06

Ending:

04/30/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 58,741	\$ 28.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,965	4,088	95,540	23.37	3
4	Licensed Practical Nurses	23,068	24,176	396,084	16.38	4
5	CNAs & Orderlies	52,215	54,105	566,651	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,965	4,151	45,771	11.03	8
9	Activity Director	1,832	1,965	17,176	8.74	9
10	Activity Assistants	4,386	4,698	34,975	7.44	10
11	Social Service Workers	1,777	2,139	31,718	14.83	11
12	Dietician					12
13	Food Service Supervisor	2,096	2,224	23,399	10.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,379	10,646	80,252	7.54	15
16	Dishwashers					16
17	Maintenance Workers	4,129	4,240	44,316	10.45	17
18	Housekeepers	5,490	5,835	43,704	7.49	18
19	Laundry	2,864	2,936	21,986	7.49	19
20	Administrator	2,000	2,080	63,152	30.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,034	4,520	47,142	10.43	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 Utility Workers	1,286	1,286	14,064	10.94	32
33	Other(specify) M-O-W Coordinat	1,500	1,540	13,544	8.79	33
34	TOTAL (lines 1 - 33)	126,986	132,709	\$ 1,598,215 *	\$ 12.04	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	287	\$ 8,253	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	16	500	10 - 3	37
38	Nurse Consultant	477	23,517	10 - 3	38
39	Pharmacist Consultant	96	2,850	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	94	5,753	12 - 3	45
46	Other(specify) Medicare Consultant	67	11,920	10 - 3	46
47	Psychiatric Consultant	20	5,000	10 - 3	47
48	Administrative Consultant	368	10,610	17 - 3	48
49	TOTAL (lines 35 - 48)	1,545	\$ 80,403		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number MEADOW MANOR

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 9 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,304 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. \$ 455
- (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 \$5,000, 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

LINE 27 - OTHER GENERAL ADMINISTRATION		
BAD DEBTS	\$ 57,115	
SALES TAX	4,900	
PENALTY	972	
SCHEDULE V - LINE 27 - COLUMN 3	<u>\$ 62,987</u>	

COLUMN 5 - DETAIL OF RECLASSIFICATIONS

FROM:	AMOUNT	LINE #
MEDICARE X-RAYS	\$ (4,236)	10
MEDICARE IV	(12,236)	10
MEDICARE DRUGS	(131,652)	10
MEDICARE LABS	(13,302)	10
MEDICARE SUPPLIES	(6,062)	10
MEDICARE OTHER ANCILLARY	(2,829)	10
OXYGEN	(19,912)	10
PHYSICAL THERAPY	(191,377)	10A
OCCUPATIONAL THERAPY	(157,159)	10A
SPEECH THERAPY	(19,814)	10A
TO: ANCILLARY SERVICES	<u>\$ 558,579</u>	39
TO: ADMINISTRATIVE CONS. MILEAGE	\$ 2,460	17
NURSE CONSULTANT MILEAGE	1,341	10
MAINTENANCE MILEAGE	2,191	6
FROM: TRAVEL	<u>\$ (5,992)</u>	24

PAGE 3 - SCHEDULE V - LINE 23

DETAIL - INSERVICE TRAINING & EDUCATION	
EMPLOYEE TRAINING - ONLINE	\$ 2,448
ACTIVITY COURSE & LODGING	772
MDI TRAINING & LODGING	175
MEDICAID CONSOLIDATED BILLING SEMINAR	100
MANAGEMENT SEMINAR	283
DIETARY MANAGEMENT COURSE	562
HOME OFFICE INSERVICES	423
NURSING HOME MANAGERS ALLOCATION	2,293
SCHEDULE V - LINE 23 - COLUMN 8	<u>\$ 7,056</u>

PAGE 10A - SECTION A - 2006 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	\$ 24,055.38
68% OF THE \$35,375.56 TAX BILL	
MEADOW MANOR WEST PORTION: NON-ALLOWABLE	
32% OF THE \$35,375.56 TAX BILL	11,320.18
TOTAL 2006 REAL ESTATE TAX BILL	<u>\$ 35,375.56</u>

PAGE 13 - SCHEDULE XI - SECTION E
RECONCILIATION OF DEPRECIATION

SCHEDULE XI - SECTION E - LINE 83	\$ 30,618
NURSING HOME MANAGERS ALLOCATION	<u>2,055</u>
SCHEDULE V - LINE 30 - COLUMN 8	\$ <u>32,673</u>

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

YELLOW PAGES	\$ 352
INHAA DUES	100
PUBLIC RELATIONS	44,840
FRANCHISE FEES	291
CHAMBER OF COMMERCE	307
BOILER LICENSE	<u>140</u>
SCHEDULE XIX - SECTION F	\$ <u>46,030</u>

PAGE 19 - SCHEDULE XVII
RECONCILIATION OF INCOME

LINE 43 - NET INCOME	\$ 92,683
* MANAGEMENT FEE 4/06	(10,386)
* MANAGEMENT FEE 4/07	20,356
INTEREST INCOME	(1,132)
RENTAL INCOME	<u>(400)</u>
TAXABLE INCOME	\$ <u>101,121</u>

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

ADMINISTRATOR MILEAGE	\$ 319
PATIENT SCREENING MILEAGE	366
MISCELLANEOUS MILEAGE	737
SEMINARS & WORKSHOP MILEAGE	<u>263</u>
SCHEDULE XIX - SECTION G	\$ <u>1,685</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.

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

#

0011528

PAGE 26

05/01/06

TO

04/30/07

CENTRAL OFFICE COST ALLOCATION
 MEADOW MANOR
 2006

	MAY 06	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN 07	FEB	MARCH	APRIL	2006 TOTAL	LINE #
SALARIES-ADMIN	\$2,796	2,810	2,875	3,303	3,344	3,403	3,329	3,261	\$1,995	\$1,936	\$2,003	\$2,088	\$33,145	17
SALARIES-CLERIC	2,206	2,217	2,268	2,682	2,716	2,764	2,704	2,648	2,671	2,592	2,682	2,795	30,945	21
SALARIES-CONTR	0	0	0	0	0	0	0	0	1,478	1,435	1,484	1,547	5,944	17
SALARIES-NURSE	412	414	423	435	440	448	438	429	647	628	650	678	6,043	10
ACCOUNTING	10	10	10	53	53	54	53	52	110	106	110	115	736	19
WORK COMP INS	20	20	21	45	45	46	45	44	68	66	68	71	558	22
SUPPLIES	94	94	97	64	65	66	64	63	86	84	87	91	954	21
TELEPHONE	134	135	138	123	124	127	124	121	133	129	134	140	1,562	21
EMPL BENEFITS	1,072	1,077	1,102	1,353	1,370	1,394	1,364	1,336	1,240	1,204	1,245	1,298	15,054	22
PAYROLL TAXES	430	432	443	431	436	444	434	425	467	453	469	489	5,355	22
TRAVEL	65	66	67	96	97	99	97	95	62	60	62	65	931	24
IN SERVICE	177	178	182	274	278	283	277	271	93	90	93	97	2,293	23
MEDICAL CONSULT	98	98	101	223	226	230	225	220	243	235	243	254	2,396	9
MACHINE RENTAL	20	20	21	25	26	26	25	25	21	21	21	22	273	6
OWNERS COMP	179	180	185	88	89	90	88	87	0	0	0	0	986	17
INS-PROP,LIAB,WC	29	29	30	111	113	115	112	110	(92)	(89)	(92)	(96)	279	26
DEPRECIATION	163	163	167	170	172	175	171	168	175	170	176	184	2,055	30
RENT	414	416	426	433	439	447	437	428	440	427	442	460	5,209	34
MAINTENANCE	93	94	96	188	190	193	189	185	129	125	129	135	1,745	6
FEES & PUBLICAT	12	12	12	22	22	23	22	22	13	13	13	14	200	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	8,425	8,467	8,663	10,119	10,245	10,426	10,199	9,990	\$9,981	\$9,685	\$10,020	\$10,446	116,663	
FIXED ASSETS	0	0	0	0	0	0	0	0					116,663	
EQUIP - PRIOR	14,019	14,089	14,416	14,672	14,855	15,117	14,789	14,486	14,581	14,149	14,639	15,260	14,590	
EQUIP - CURR	131	220	225	229	232	236	231	519	0	0	251	261	211	
EQUIP - FULLY DEP	4,153	4,173	4,270	4,346	4,400	4,478	4,381	4,291	5,247	5,092	5,268	5,492	4,633	
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	1,463	1,470	1,504	1,531	1,550	1,577	1,543	1,512	1,553	1,507	1,559	1,626	1,533	

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2006

ALLOC PERCENT	D'ADR 0.00%	HLTP 22.87%	JVILLE 22.22%	MEAD M 22.37%	MENARD 14.03%	SUNRISE 18.51%	TOTAL 100.00%
SALARIES-ADMIN	\$0	\$2,940	\$2,857	\$2,875	\$1,804	\$2,379	\$12,855
SALARIES-CLERIC	0	2,319	2,254	2,268	1,423	1,877	10,141
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	433	421	423	266	350	1,893
ACCOUNTING	0	11	10	10	6	9	46
WORK COMP INS	0	21	21	21	13	17	93
SUPPLIES	0	99	96	97	61	80	432
TELEPHONE	0	141	137	138	86	114	616
EMPL BENEFITS	0	1,127	1,095	1,102	691	912	4,927
PAYROLL TAXES	0	452	440	443	278	366	1,978
TRAVEL	0	69	67	67	42	56	300
IN SERVICE	0	186	181	182	114	151	814
MEDICAL CONSULT	0	103	100	101	63	83	450
MACHINE RENTAL	0	21	21	21	13	17	93
OWNERS COMP	0	189	183	185	116	153	825
INS-PROP,LIAB,WC	0	31	30	30	19	25	134
DEPRECIATION	0	171	166	167	105	138	748
RENT	0	436	423	426	267	352	1,904
MAINTENANCE	0	98	95	96	60	79	429
FEES & PUBLIC	0	12	12	12	8	10	54
ADVERTISING	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0
TOTAL	\$0	\$8,858	\$8,606	\$8,663	\$5,434	\$7,169	\$38,731

FIXED ASSETS							
EQUIP - PRIOR	0	14,741	14,321	14,416	9,043	11,929	64,450
EQUIP - CURR	0	230	224	225	141	186	1,006
EQUIP - FULLY DEP	0	4,366	4,242	4,270	2,679	3,534	19,091
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,538	1,494	1,504	944	1,245	6,725

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2006

ALLOC PERCENT	D'ADR 0.00%	HLTP 23.23%	JVILLE 21.96%	MEAD M 22.77%	MENARD 13.68%	SUNRISE 18.37%	TOTAL 100.00%
SALARIES-ADMIN	\$0	\$3,370	\$3,186	\$3,303	\$1,985	\$2,665	\$14,509
SALARIES-CLERIC	0	2,737	2,587	2,682	1,612	2,164	11,782
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	444	419	435	261	351	1,910
ACCOUNTING	0	54	51	53	32	42	231
WORK COMP INS	0	46	43	45	27	36	196
SUPPLIES	0	65	62	64	38	52	281
TELEPHONE	0	125	119	123	74	99	540
EMPL BENEFITS	0	1,381	1,305	1,353	813	1,091	5,943
PAYROLL TAXES	0	440	415	431	259	348	1,892
TRAVEL	0	98	93	96	58	77	422
IN SERVICE	0	280	265	274	165	221	1,205
MEDICAL CONSULT	0	228	215	223	134	180	980
MACHINE RENTAL	0	26	24	25	15	20	111
OWNERS COMP	0	89	85	88	53	71	385
INS-PROP,LIAB,WC	0	114	107	111	67	90	489
DEPRECIATION	0	174	164	170	102	137	747
RENT	0	442	418	433	261	350	1,904
MAINTENANCE	0	191	181	188	113	151	824
FEES & PUBLIC	0	22	21	22	13	18	96
ADVERTISING	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0
TOTAL	\$0	\$10,325	\$9,759	\$10,119	\$6,083	\$8,163	\$44,448

FIXED ASSETS							
EQUIP - PRIOR	0	14,971	14,151	14,672	8,820	11,836	64,450
EQUIP - CURR	0	234	221	229	138	185	1,006
EQUIP - FULLY DEP	0	4,435	4,192	4,346	2,613	3,506	19,091
BLDG - PRIOR	0	0	0	0	0	0	0
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	1,562	1,477	1,531	920	1,235	6,725

ALLOCATION PERCENTAGES USED ON PAGE 27

MEADOW MANOR

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OCCUPIED DAYS 2006	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,331	2,170	2,010		1,459	1,952	9,922
FEBRUARY	2,071	1,914	1,868		1,302	1,756	8,911
MARCH	2,411	2,193	2,142		1,383	1,917	10,046
APRIL	2,269	2,014	2,034		1,346	1,718	9,381
MAY	2,177	1,972	2,041		1,447	1,746	9,383
JUNE	2,081	1,987	2,014		1,386	1,745	9,213
JULY	2,181	2,119	2,133		1,338	1,765	9,536
AUGUST	2,154	2,036	2,111		1,269	1,703	9,273
SEPTEMBER	2,072	1,880	2,074		1,249	1,723	8,998
OCTOBER	1,974	2,055	2,267		1,418	1,951	9,665
NOVEMBER	1,830	1,947	2,126		1,414	1,948	9,265
DECEMBER	2,029	2,088	2,182		1,441	1,968	9,708
TOTAL	25,580	24,375	25,002	0	16,452	21,892	113,301 113,301

ALLOCATION PERCENTAGE 2006	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	23.49%	21.87%	20.26%	14.70%	19.67%	100.00%
FEBRUARY	23.24%	21.48%	20.96%	14.61%	19.71%	100.00%
MARCH	24.00%	21.83%	21.32%	13.77%	19.08%	100.00%
APRIL	24.19%	21.47%	21.68%	14.35%	18.31%	100.00%
MAY	23.20%	21.02%	21.75%	15.42%	18.61%	100.00%
JUNE	22.59%	21.57%	21.86%	15.04%	18.94%	100.00%
JULY	22.87%	22.22%	22.37%	14.03%	18.51%	100.00%
AUGUST	23.23%	21.96%	22.77%	13.68%	18.37%	100.00%
SEPTEMBER	23.03%	20.89%	23.05%	13.88%	19.15%	100.00%
OCTOBER	20.42%	21.26%	23.46%	14.67%	20.19%	100.00%
NOVEMBER	19.75%	21.01%	22.95%	15.26%	21.03%	100.00%
DECEMBER	20.90%	21.51%	22.48%	14.84%	20.27%	100.00%

OCCUPIED DAYS 2007	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,105	2,057	2,233		1,442	1,831	9,668
FEBRUARY	1,883	1,964	1,995		1,398	1,661	8,901
MARCH	2,115	2,213	2,327		1,564	1,816	10,035
APRIL	2,110	2,059	2,367		1,470	1,786	9,792
MAY	2,143	2,106	2,417		1,514	1,774	9,954
JUNE	2,064	2,099	2,224		1,533	1,698	9,618
JULY	2,163	2,215	2,305		1,590	1,731	10,004
AUGUST	2,265	2,186	2,329		1,594	1,714	10,088
SEPTEMBER							0
OCTOBER							0
NOVEMBER							0
DECEMBER							0
TOTAL	16,848	16,899	18,197	0	12,105	14,011	78,060 78,060

ALLOCATION PERCENTAGE 2007	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	21.77%	21.28%	23.10%	14.92%	18.94%	100.00%
FEBRUARY	21.15%	22.06%	22.41%	15.71%	18.66%	100.00%
MARCH	21.08%	22.05%	23.19%	15.59%	18.10%	100.00%
APRIL	21.55%	21.03%	24.17%	15.01%	18.24%	100.00%
MAY	21.53%	21.16%	24.28%	15.21%	17.82%	100.00%
JUNE	21.46%	21.82%	23.12%	15.94%	17.65%	100.00%
JULY	21.62%	22.14%	23.04%	15.89%	17.30%	100.00%
AUGUST	22.45%	21.67%	23.09%	15.80%	16.99%	100.00%