



Facility Name & ID Number Meadows

# 0021766 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	99	Intermediate/DD	99	36,135	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	33,890	975		34,865	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,890	975		34,865	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.49%

D. How many bed-hold days during this year were paid by the Department? 283 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 08/1975

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 08/1975 NO

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

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

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED   
CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Meadows # 0021766 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	239,524	11,641	4,099	255,264	(9)	255,255	(4,963)	250,292		1
2	Food Purchase		147,550		147,550		147,550		147,550		2
3	Housekeeping	107,947	23,174		131,121		131,121		131,121		3
4	Laundry	128,878	19,429		148,307		148,307		148,307		4
5	Heat and Other Utilities			102,882	102,882		102,882		102,882		5
6	Maintenance	81,273	11,807	47,238	140,318		140,318		140,318		6
7	Other (specify):*										7
8	TOTAL General Services	557,622	213,601	154,219	925,442	(9)	925,433	(4,963)	920,470		8
	B. Health Care and Programs										
9	Medical Director			18,975	18,975	(13,282)	5,693		5,693		9
10	Nursing and Medical Records	964,060	46,783	265,568	1,276,411	(46,349)	1,230,062		1,230,062		10
10a	Therapy	31,809			31,809	13,127	44,936		44,936		10a
11	Activities	61,253	7,821	32	69,106		69,106		69,106		11
12	Social Services	163,321		28,581	191,902	(14,927)	176,975		176,975		12
13	CNA Training					48,149	48,149		48,149		13
14	Program Transportation			29	29		29		29		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,220,443	54,604	313,185	1,588,232	(13,282)	1,574,950		1,574,950		16
	C. General Administration										
17	Administrative	160,168			160,168		160,168	(27,923)	132,245		17
18	Directors Fees										18
19	Professional Services			53,739	53,739	(786)	52,954		52,954		19
20	Dues, Fees, Subscriptions & Promotions			18,741	18,741	1,545	20,286		20,286		20
21	Clerical & General Office Expenses	148,717	15,232	(36,779)	127,170	702	127,872	29,153	157,025		21
22	Employee Benefits & Payroll Taxes			437,691	437,691	786	438,477	(5,839)	432,638		22
23	Inservice Training & Education										23
24	Travel and Seminar			793	793	(245)	548		548		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			36,530	36,530		36,530	21,141	57,671		26
27	Other (specify):*										27
28	TOTAL General Administration	308,885	15,232	510,715	834,832	2,002	836,834	16,532	853,366		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,086,950	283,437	978,119	3,348,506	(11,289)	3,337,217	11,569	3,348,786		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 &amp; ID Number

Meadows

#0021766

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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			9,062	9,062	(1,993)	7,069	58,183	65,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							126,879	126,879			32
33	Real Estate Taxes							211,424	211,424			33
34	Rent-Facility & Grounds			728,800	728,800		728,800	(728,800)				34
35	Rent-Equipment & Vehicles			10,078	10,078		10,078		10,078			35
36	Other (specify):*											36
37	TOTAL Ownership			747,940	747,940	(1,993)	745,947	(332,314)	413,633			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			4,415	4,415	13,282	17,697		17,697			39
40	Barber and Beauty Shops			3,421	3,421		3,421		3,421			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			276,990	276,990		276,990		276,990			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			284,826	284,826	13,282	298,108		298,108			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,086,950	283,437	2,010,885	4,381,272		4,381,272	(320,745)	4,060,527			45

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

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	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals		2.2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	2,614	30.3		9
10 Interest and Other Investment Income	(34,414)	32.3		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				25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	(288,945)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (71,128)		\$	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)	(249,617)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (249,617)		36
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (320,745)		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					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 Physician	x		13,282	9.3	46
47 TOTAL (C): (sum of lines 38-46)			\$ 13,282		47

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Byrn T. Witt	50%	Zachary House	Streamwood			
Barbara S. Witt	50%	Zachary House	Streamwood			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Facility Rent	\$ 728,800	Byrn T. Witt & Barbara S. Witt	100.00%	\$	\$	(728,800)	1
2	V	17 Management Fee		Byrn T. Witt & Barbara S. Witt	100.00%	18,000		18,000	2
3	V	30 Depreciation		Byrn T. Witt & Barbara S. Witt	100.00%	56,634		56,634	3
4	V	32 Interest		Byrn T. Witt & Barbara S. Witt	100.00%	161,293		161,293	4
5	V	17							5
6	V	33 Real Estate Taxes		Byrn T. Witt & Barbara S. Witt	100.00%	211,424		211,424	6
7	V	17 Financial	51,696	Robin Witt		51,696			7
8	V	26 Property Insurance		Byrn T. Witt & Barbara S. Witt	100.00%	31,832		31,832	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 780,496			\$ 530,879	\$ *	(249,617)	14

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

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Byrn T. Witt		Administrator	50%		7.2	60.00%	Salary	\$ 18,000	17.3	1
2	Robin Witt	Chief Financial Office	Administration			24.36	60.90%	Salary	51,696	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 69,696		13

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

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

Facility Name & ID Number Meadows # 0021766 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

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	Reporting Period Interest Expense	
											Name of Lender
<b>A. Directly Facility Related</b>											
<b>Long-Term</b>											
1				-		\$	\$		-	\$	1
2	HUD	X	Debt Refinance / Bldg Construction	Varies	08/31/06	2,700,000	2,695,912	03/31/36	0.0600	161,293	2
3				-					-		3
4				-					Interest Income	(34,414)	4
5				-					-		5
<b>Working Capital</b>											
6				-					-		6
7				-					-		7
8				-					-		8
9	TOTAL Facility Related					\$ 2,700,000	\$ 2,695,912			\$ 126,879	9
<b>B. Non-Facility Related*</b>											
10				-					-		10
11				-					-		11
12				-					-		12
13				-					-		13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$ 2,700,000	\$ 2,695,912			\$ 126,879	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.)





Facility Name & ID Number Meadows

# 0021766 Report Period Beginning:

01/01/2007 Ending: 12/31/2007

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	52,300	Jun-86	\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	3

Facility Name &amp; ID Number Meadows

# 0021766

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98	1986	1975	\$ 1,500,000	\$	30	\$	\$	\$ 1,500,000	4
5		1996	1996	1,478,674		39	37,915	37,915	436,178	5
6	1	1996	1996	15,000		39	385	385	4,317	6
7										7
8										8
Improvement Type**										
9	Remodeling		1976	3,548		10			3,548	9
10			1977	21,344		10			21,344	10
11			1979	169		10			169	11
12			1980	9,111		10			9,111	12
13			1981	3,203		10			3,203	13
14			1983	7,355		10			7,355	14
15			1984	11,356		10			11,356	15
16	Garage		1985	3,165		10			3,165	16
17	Remodeling		1986	2,386		10			2,386	17
18	Water Heater & Fire Alarm System		1987	3,199		15			3,199	18
19	Roof		1988	40,520		20			40,520	19
20	Heat Pump		1988	1,900		15			1,900	20
21	Carpeting		1988	10,119		5			10,119	21
22	Carpeting		1989	4,185		5			4,185	22
23	Roof		1990	3,527		20			3,527	23
24	Kitchen		1990	2,319		10			2,319	24
25	Heater Repairs		1991	840		7			840	25
26	Improvements		1993	737	19	10		(19)	737	26
27	Water Heater		1995	3,000		7			3,000	27
28	Air Conditioners		1995	5,627		5			5,627	28
29	Unit Heaters		1995	737		5			737	29
30	Exterior Doors		1995	628	16	39	16		202	30
31	Garage Door		1996	385		10			385	31
32	Parking Lot Repair		1996	6,655		20	333	333	3,831	32
33	Driveway		1996	22,572		20	1,129	1,129	12,988	33
34	Walk-in Freezer & Cooler		1996	12,333		10			12,333	34
35	Air Conditioning Units		1996	3,554		5			3,554	35
36	Draperies		1997	16,239		39	416	416	4,370	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number Meadows

# 0021766

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	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fencing	1997	\$ 8,090	\$ 207	39	\$ 207	\$	\$ 2,175	37
38	Windows & Doors	1997	2,128		39	55	55	578	38
39	New Building Addition	1998	7,500		39	192	192	1,920	39
40	Time Clock System	1999	8,785		5			8,785	40
41	Air Conditioning Units	1999	7,589		5			7,589	41
42	Time Clock System	2001	1,452		5			1,452	42
43	Telephone Equipment	2001	1,850		5			1,850	43
44	Air Conditioning Units	2001	4,568		39	117	117	767	44
45	Window Screens	2001	1,400		39	36	36	235	45
46	Draperies	2001	4,118		39	106	106	728	46
47	Magnetic Door Holders	2002	1,350		7	193	193	1,119	47
48	6 Air Conditioner Units	2002	4,671		39	120	120	489	48
49	12 Resident Room Closet Doors	2002	2,346		39	60	60	255	49
50	Nurse Call System	2002	38,000		5	7,600	7,600	34,980	50
51	Magnetic Door Holders	2002	3,696		5	151	151	3,696	51
52	Signage	2003	1,698		7	243	243	729	52
53	Flooring	2002	1,731		10	173	173	588	53
54	Draperies	2003	1,052		7	150	150	450	54
55	Windows	2003	710		39	18	18	54	55
56	HVAC Units	2003	3,813		5	763	763	2,289	56
57	Carpeting	2003	10,994		10	1,099	1,099	3,297	57
58	Parking Lot	2004	26,879		15	1,792	1,792	5,376	58
59	HVAC Units	2004	5,825		5	1,165	1,165	3,495	59
60	Signage	2004	318		5	64	64	192	60
61	Security System	2004	18,600	1,272	5	3,720	2,448	11,160	61
62	HVAC Units	2005	484		5	97	97	282	62
63	Nurse call system	2005	6,231		5	1,246	1,246	3,260	63
64	Electrical cabling	2005	1,450		5	290	290	748	64
65	HVAC Units	2005	281		5	56	56	141	65
66	Air conditioning units	2006	1,656	400	7	237	(163)	315	66
67	Security System	2006	3,590	989	7	513	(476)	597	67
68	Draperies	2006	1,610		7	230	230	459	68
69	Toilets	2006	1,295		39	33	33	66	69
70	TOTAL (lines 4 thru 69)		\$ 3,380,147	\$ 2,903		\$ 60,920	\$ 58,017	\$ 2,216,621	70

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward	\$ 3,380,147	\$ 2,903		\$ 60,920	\$ 58,017	\$ 2,216,621	1
2	Interior doors	2006 2,200		39	56	56	103	2
3	Double egress doors	2006 5,908		39	151	151	262	3
4	Bathroom vanities	2006 1,104		39	28	28	45	4
5	Payroll time clock	2006 6,440		7	920	920	1,318	5
6	Telephone system	2006 669		7	96	96	130	6
7	Air conditioning units	2007 555	59	7	39	(20)	39	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)	\$ 3,397,023	\$ 2,962		\$ 62,210	\$ 59,248	\$ 2,218,518	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 52,611	\$ 2,870	\$ 2,870	\$	Various	\$ 49,500	71
72	Current Year Purchases	2,167	172	172		Various	172	72
73	Fully Depreciated Assets	169,151					169,151	73
74								74
75	TOTALS	\$ 223,929	\$ 3,042	\$ 3,042	\$		\$ 218,823	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,645,952	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,004	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,252	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 59,248	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,437,341	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.  YES  NO

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

\*\*

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: \$ 10,078 Description: Copier: \$7,534; Mailing Machine: \$2,544

(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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		12		12
3	Classroom Wages (a)		11,222		11,222
4	Clinical Wages (b)		5,611		5,611
5	In-House Trainer Wages (c)		31,091		31,091
6	Transportation				
7	Contractual Payments		213		213
8	CNA Competency Tests				
9	TOTALS	\$	\$ 48,149	\$	\$ 48,149
10	SUM OF line 9, col. 1 and 2 (e)	\$	48,149		

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	35
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>35</b>

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		180	8,325		180	8,325	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits		133	13,283		133	13,283	5
6	Dental Care	39.3	visits		44	4,415		44	4,415	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			\$	357	26,023	\$	357	\$ 26,023	14

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

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Meadows

# 0021766

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007 (last day of reporting year)

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

	1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 237,092	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,314,651		3
4 Supply Inventory (priced at FIFO)	6,328		4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	(1,163,760)		8
9 Other(specify):			9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 394,311	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cost	9,455		15
16 Equipment, at Historical Cost	269,307		16
17 Accumulated Depreciation (book methods)	(207,699)		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)	\$ 71,063	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 465,374	\$	25

	1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ (21,421)	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable			30
31 Accrued Taxes Payable (excluding real estate taxes)	(1,974)		31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (23,395)	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (23,395)	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ (441,979)	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (465,374)	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 697,351	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(8,597)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 688,754	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	217,219	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	(463,994)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (246,775)	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)	\$ 441,979	24 *

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

Facility Name & ID Number Meadows

# 0021766

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,564,077	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,564,077	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	34,414	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 34,414	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,598,491	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	925,442	31
32	Health Care	1,588,232	32
33	General Administration	834,832	33
<b>B. Capital Expense</b>			
34	Ownership	747,940	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,836	35
36	Provider Participation Fee	276,990	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,381,272	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	217,219	41
42	Income Taxes		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 217,219	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 &amp; ID Number Meadows

# 0021766

Report Period Beginning:

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Ending:

12/31/2007

## 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	906	1,007	\$ 34,658	\$ 34.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,261	2,379	63,953	26.88	3
4	Licensed Practical Nurses	5,577	7,926	152,724	19.27	4
5	CNAs & Orderlies	37,075	39,189	408,379	10.42	5
6	CNA Trainees	1,734	1,734	16,833	9.71	6
7	Licensed Therapist	1,485	1,650	16,261	9.86	7
8	Rehab/Therapy Aides	1,120	1,173	15,548	13.25	8
9	Activity Director	619	649	8,720	13.44	9
10	Activity Assistants	3,647	4,238	52,533	12.40	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,542	1,680	20,048	11.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,244	20,524	214,513	10.45	15
16	Dishwashers					16
17	Maintenance Workers	4,886	5,196	81,273	15.64	17
18	Housekeepers	9,638	10,815	107,947	9.98	18
19	Laundry	11,795	13,298	128,878	9.69	19
20	Administrator	1,788	1,788	62,549	34.98	20
21	Assistant Administrator					21
22	Other Administrative	1,296	1,296	51,696	39.89	22
23	Office Manager					23
24	Clerical	6,825	6,973	131,982	18.93	24
25	Vocational Instruction	2,160	2,160	31,091	14.39	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,031	7,986	123,793	15.50	28
29	Resident Services Coordinator	1,965	2,045	39,528	19.33	29
30	Habilitation Aides (DD Homes)	19,520	21,165	183,333	8.66	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Behavior Dev'l	4,442	4,846	73,090	15.08	33
34	TOTAL (lines 1 - 33)	146,556	159,717	\$ 2,019,329 *	\$ 12.64	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	96	\$ 4,099	1.3	35
36	Medical Director	57	5,693	9.3	36
37	Medical Records Consultant			10.3	37
38	Nurse Consultant	178	8,900	10.3	38
39	Pharmacist Consultant	18	1,800	10.3	39
40	Physical Therapy Consultant	60	3,713	10a.3	40
41	Occupational Therapy Consultant	17	1,089	10a.3	41
42	Respiratory Therapy Consultant			10a.3	42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant			11.3	44
45	Social Service Consultant	6	180	12.3	45
46	Other(specify) Psychologist	24	2,400	12.3	46
47				12.3	47
48	Psychiatrist	52	12,875	12.3	48
49	TOTAL (lines 35 - 48)	508	\$ 40,748		49

## C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	28	\$ 1,430	10.3	50
51	Licensed Practical Nurses	4,429	245,513	10.3	51
52	Certified Nurse Assistants/Aides			10.3	52
53	TOTAL (lines 50 - 52)	4,456	\$ 246,943		53

Facility Name & ID Number Meadows

# 0021766

Report Period Beginning:

01/01/2007

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Georgette Miller	Administrator		75,282	Workers' Compensation Insurance	\$ 58,404	IDPH License Fee	\$ 300	
Robin Witt	CFO		84,886	Unemployment Compensation Insurance	15,403	Advertising: Employee Recruitment	11,027	
				FICA Taxes	153,534	Health Care Worker Background Check	848	
				Employee Health Insurance	203,969	(Indicate # of checks performed <u>53</u> )		
				Employee Meals		Patient Background Checks <u>3</u>	48	
				Illinois Municipal Retirement Fund (IMRF)*		IARF Membership Dues	5,916	
				Staff Appreciation	5,566	Other Dues & Licenses	1,325	
				Employee Life/Disability	814	Sec of State/City of Rolling Meadows	822	
				Employee Physicals	786	Subscriptions		
					8,649			
				Allocation of Benefits	(14,488)	Less: Public Relations Expense	( )	
				Rounding	1	Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 160,168	TOTAL (agree to Schedule V, line 22, col.8)	\$ 432,638	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,286	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Seminar Expense	548
(Attach a copy of any management service agreement)								
C. Professional Services							Entertainment Expense	( )
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Clifton Gunderson	Accounting		7,980	TOTAL		\$	TOTAL	\$ 548
Alpha Communications	Consulting		178					
Robert Rein CPA	Consulting		4,940					
Christenson Computer	Computer		8,011					
Information Control	Consulting		1,569					
Achieve Health	Computer		3,532					
Reclassification			786					
Dac Easy	Consulting		299					
Duane Morris	Legal		26,443					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 53,738					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Meadows

# 0021766

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IARF Membership Dues 5,916
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 6.33
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 10,669 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. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 276,990  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% 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. \$ N/A
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.