

Facility Name & ID Number Meadows Sheltered Care, Inc.# 0021766 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>99</u>	Intermediate/DD	<u>99</u>	<u>36,234</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.					
	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>33,825</u>	<u>730</u>		<u>34,555</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>33,825</u>	<u>730</u>		<u>34,555</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.37%

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

275 (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)

NoneF. 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

ACCURAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

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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	224,466	16,846	4,750	246,062		246,062	(6,032)	240,030		1
2	Food Purchase		158,428		158,428		158,428		158,428		2
3	Housekeeping	108,470	29,242		137,712		137,712		137,712		3
4	Laundry	143,320	16,660		159,980		159,980		159,980		4
5	Heat and Other Utilities			121,571	121,571		121,571		121,571		5
6	Maintenance	83,003	13,163	44,977	141,143		141,143		141,143		6
7	Other (specify):*										7
8	TOTAL General Services	559,259	234,339	171,298	964,896		964,896	(6,032)	958,864		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400	(10,080)	4,320		4,320		9
10	Nursing and Medical Records	1,187,309	47,697	213,335	1,448,341	(14,483)	1,433,858		1,433,858		10
10a	Therapy	13,123		9,135	22,258	5,728	27,986		27,986		10a
11	Activities	66,831	7,385		74,216	487	74,703		74,703		11
12	Social Services	134,850		12,608	147,458	(6,215)	141,243		141,243		12
13	CNA Training					10,771	10,771		10,771		13
14	Program Transportation			11	11		11		11		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,402,113	55,082	249,489	1,706,684	(13,792)	1,692,892		1,692,892		16
	C. General Administration										
17	Administrative	159,753			159,753		159,753	(29,753)	130,000		17
18	Directors Fees										18
19	Professional Services			69,308	69,308	(2,514)	66,794		66,794		19
20	Dues, Fees, Subscriptions & Promotions			16,023	16,023	973	16,996		16,996		20
21	Clerical & General Office Expenses	163,703	12,967	(16,115)	160,555	(507)	160,048	23,761	183,809		21
22	Employee Benefits & Payroll Taxes			418,539	418,539	2,037	420,576	(13,298)	407,278		22
23	Inservice Training & Education					3,712	3,712		3,712		23
24	Travel and Seminar			414	414	11	425		425		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,815	30,815		30,815	20,585	51,400		26
27	Other (specify):*										27
28	TOTAL General Administration	323,456	12,967	518,984	855,407	3,712	859,119	1,295	860,414		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,284,828	302,388	939,771	3,526,987	(10,080)	3,516,907	(4,737)	3,512,170		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.

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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			8,021	8,021		8,021	53,003	61,024			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							153,891	153,891			32
33	Real Estate Taxes							232,866	232,866			33
34	Rent-Facility & Grounds			730,400	730,400		730,400	(730,400)				34
35	Rent-Equipment & Vehicles			10,751	10,751		10,751		10,751			35
36	Other (specify):*											36
37	TOTAL Ownership			749,172	749,172		749,172	(290,640)	458,532			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			6,585	6,585	10,080	16,665		16,665			39
40	Barber and Beauty Shops			2,066	2,066		2,066		2,066			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			256,456	256,456		256,456		256,456			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			265,107	265,107	10,080	275,187		275,187			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,284,828	302,388	1,954,050	4,541,266		4,541,266	(295,377)	4,245,889			45

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

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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	1,881	30.3		9
10 Interest and Other Investment Income	(6,355)	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		20.3		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(55,147)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,621)		\$	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)	(235,756)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (235,756)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (295,377)		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 Medical Supplies		x			39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Physician	x		10,080	9.3	44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$ 10,080		47

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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	50.00%	Zachary House	Streamwood			
Barbara S. Witt	50.00%	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		\$			\$	\$	1
2	V	34 Facility Rent	730,400	Byrn T. Witt & Barbara S. Witt	100.00%	-	(730,400)	2
3	V	17 Management Fee		Byrn T. Witt & Barbara S. Witt	100.00%	18,000	18,000	3
4	V	30 Depreciation		Byrn T. Witt & Barbara S. Witt	100.00%	52,187	52,187	4
5	V	32 Interest		Byrn T. Witt & Barbara S. Witt	100.00%	160,246	160,246	5
6	V	17				-		6
7	V	33 Real Estate Taxes		Byrn T. Witt & Barbara S. Witt	100.00%	232,866	232,866	7
8	V	17 Financial	50,744	Robin Witt		50,743	(1)	8
9	V	26 Property Insurance		Byrn T. Witt & Barbara S. Witt	100.00%	31,346	31,346	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 781,144			\$ 545,388	\$ * (235,756)	14

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

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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	60%	Salary	\$ 18,000	17.3	1
2	Robin Witt	Chief Financial Officer	Administration			23	58%	Salary	50,743	17.3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 68,743		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.

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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											
										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	HUD	X	Debt Refinance / Bldg Construction	Varies	8/31/06	2,700,000	2,660,913	3/31/36	0.0600	160,246	2									
3				-							3									
4				-					Interest Income Adjustment	(6,355)	4									
5				-							5									
Working Capital																				
6				-							6									
7				-							7									
8				-							8									
9	TOTAL Facility Related					\$ 2,700,000	\$ 2,660,913			\$ 153,891	9									
B. Non-Facility Related*																				
10				-							10									
11				-							11									
12				-							12									
13				-							13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 2,700,000	\$ 2,660,913			\$ 153,891	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.)

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2007 report.	\$	214,214	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.)	\$	223,540	2	
3.	Under or (over) accrual (line 2 minus line 1).	\$	9,326	3	
4.	Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	223,540	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.	\$	232,866	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2003	208,477		8	
	2004	209,639		9	
	2005	217,004		10	
	2006	214,214		11	
	2007	223,540		12	
<u>Based on estimate from county treasurer</u>					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to the Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meadows Sheltered Care, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0021766

CONTACT PERSON REGARDING THIS REPORT Robin Witt

TELEPHONE (847) 397-0055 FAX #: (847) 397-0477

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. <u>02-35-100-016-0000</u>	<u>3250 South Plum Grove Road</u>	<u>\$ 223,540.00</u>	<u>\$ 223,540.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 223,540.00</u>	<u>\$ 223,540.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

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01/01/2008

Ending:

12/31/2008

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).

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	<u>Nursing Home</u>	<u>52,300</u>	<u>June-86</u>	<u>\$ 25,000</u>	1
2					2
3	TOTALS	<u>52,300</u>		<u>\$ 25,000</u>	3

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	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	474,093	5
6	1	1996	1996	15,000		39	385	385	4,702	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		218	30
31	Garage Door		1996	385		10			385	31
32	Parking Lot Repair		1996	6,655		20	333	333	4,164	32
33	Driveway		1996	22,572		20	1,129	1,129	14,117	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		4,786	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 & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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	\$	\$ 2,382	37
38	Windows & Doors	1997	2,128		39	55	55	633	38
39	New Building Addition	1998	7,500		39	192	192	2,112	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	884	44
45	Window Screens	2001	1,400		39	36	36	271	45
46	Draperies	2001	4,118		39	106	106	834	46
47	Magnetic Door Holders	2002	1,350		7	193	193	1,312	47
48	6 Air Conditioner Units	2002	4,671		39	120	120	609	48
49	12 Resident Room Closet Doors	2002	2,346		39	60	60	315	49
50	Nurse Call System	2002	38,000		5	3,020	3,020	38,000	50
51	Magnetic Door Holders	2002	3,696		5			3,696	51
52	Signage	2003	1,698		7	243	243	972	52
53	Flooring	2002	1,731		10	173	173	761	53
54	Draperies	2003	1,052		7	150	150	600	54
55	Windows	2003	710		39	18	18	72	55
56	HVAC Units	2003	3,813		5	763	763	3,052	56
57	Carpeting	2003	10,994		10	1,099	1,099	4,396	57
58	Parking Lot	2004	26,879		15	1,792	1,792	7,168	58
59	HVAC Units	2004	5,825		5	1,165	1,165	4,660	59
60	Signage	2004	318		5	64	64	256	60
61	Security System	2004	18,600	1,018	5	3,720	2,702	14,880	61
62	HVAC Units	2005	484		5	97	97	379	62
63	Nurse call system	2005	6,231		5	1,246	1,246	4,506	63
64	Electrical cabling	2005	1,450		5	290	290	1,038	64
65	HVAC Units	2005	281		5	56	56	197	65
66	Air conditioning units	2006	1,656	286	7	237	(49)	552	66
67	Security System	2006	3,590	706	7	513	(193)	1,110	67
68	Draperies	2006	1,610		7	230	230	689	68
69	Toilets	2006	1,295		39	33	33	99	69
70	TOTAL (lines 4 thru 69)		\$ 3,380,147	\$ 2,252		\$ 56,189	\$ 53,521	\$ 2,272,810	70

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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	\$ 2,252		\$ 56,189	\$ 53,937	\$ 2,272,810	1
2	Interior doors	2006	2,200		39	56	159	2
3	Double egress doors	2006	5,908		39	151	413	3
4	Bathroom vanities	2006	1,104		39	28	73	4
5	Payroll time clock	2006	6,440		7	920	2,238	5
6	Telephone system	2006	669		7	96	226	6
7	Air conditioning units	2007	555	142	7	79	118	7
8	Generator & electrical panel	2008	2,500	1,429	7	90	90	8
9	Handrails	2008	1,864	34	39	32	32	9
10	HVAC Units	2008	1,096		7	145	145	10
11	Replacement Doors	2008	2,859		39	55	55	11
12	Fire Alarm System	2008	17,084		39	79	79	12
13	HVAC Units	2008	791		7	5	5	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)	\$ 3,423,217	\$ 3,857		\$ 57,925	\$ 54,068	\$ 2,276,443	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	\$ 54,778	\$ 2,266	\$ 2,266		Various	\$ 48,739	71
72	Current Year Purchases	1,457	833	833		Various	833	72
73	Fully Depreciated Assets	127,143					127,143	73
74								74
75	TOTALS	\$ 183,378	\$ 3,099	\$ 3,099			\$ 176,715	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	2	
	Reference	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)	\$ 3,631,595	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,956	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,024	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 54,068	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,453,158	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.

Facility Name & ID Number

Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2008

12/31/2008

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: \$ 10,751

Description: Copier: \$8,207; 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. 2009 \$ _____

13. 2010 \$ _____

14. 2011 \$ _____

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>40</u>
		HOURS PER CNA <u>80</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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)	3,494	3,687		7,181
4	Clinical Wages (b)	1,747	1,843		3,590
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments			596	596
8	CNA Competency Tests				
9	TOTALS	\$ 5,241	\$ 5,530	\$ 596	\$ 11,367
10	SUM OF line 9, col. 1 and 2 (e)	\$ 10,771			

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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	32
2. From other facilities (f)	
TOTAL TRAINED	37

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc.# 0021766 Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$		\$				1
2	Licensed Speech and Language Development Therapist	10a.3	hrs				203	9,135		203	9,135	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs									4
5	Physician Care	39.3	visits				101	10,080		101	10,080	5
6	Dental Care	39.3	visits				66	6,585		66	6,585	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	Other (specify): <u>Exceptional Care</u>	39.2										12
13	Other (specify): <u>Medical Supplies</u>	39.2										13
14	TOTAL			\$			370	\$ 25,800	\$	370	\$ 25,800	14

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008 (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	\$ 1,518,243	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	350,554		3
4	Supply Inventory (priced at FIFO)	6,161		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,811,758)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 63,200	\$	10
	B. Long-Term Assets			
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	11,319		15
16	Equipment, at Historical Cost	273,264		16
17	Accumulated Depreciation (book methods)	(215,719)		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 (spc			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 68,864	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 132,064	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,748	\$	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)	(84)		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)	\$ 9,664	\$	38
	D. Long-Term Liabilities			
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)	\$ 9,664	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 122,400	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 132,064	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 441,979	1
2	Restatements (describe):		2
3	Prior period adjustment	160	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 442,139	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	232,757	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	(552,495)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (319,739)	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)	\$ 122,400	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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	\$ 4,767,668	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,767,668	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,355	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,355	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,774,023	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	964,896	31
32	Health Care	1,706,684	32
33	General Administration	855,407	33
B. Capital Expense			
34	Ownership	749,172	34
C. Ancillary Expense			
35	Special Cost Centers	8,651	35
36	Provider Participation Fee	256,456	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,541,266	40
41	Income before Income Taxes (line 30 minus line 40)**	232,757	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 232,757	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,272	1,296	\$ 45,091	\$ 34.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,680	2,680	79,677	29.73	3
4	Licensed Practical Nurses	13,823	14,249	278,947	19.58	4
5	CNAs & Orderlies	5,355	5,785	80,991	14.00	5
6	CNA Trainees	1,150	1,150	10,771	9.37	6
7	Licensed Therapist	844	844	9,076	10.75	7
8	Rehab/Therapy Aides	350	350	4,047	11.56	8
9	Activity Director	120	120	1,888	15.73	9
10	Activity Assistants	4,261	4,680	64,943	13.88	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,476	1,664	24,135	14.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,864	17,185	194,299	11.31	15
16	Dishwashers					16
17	Maintenance Workers	4,044	4,428	83,003	18.75	17
18	Housekeepers	11,190	11,519	108,470	9.42	18
19	Laundry	12,798	13,533	143,320	10.59	19
20	Administrator	1,533	1,921	61,257	31.89	20
21	Assistant Administrator					21
22	Other Administrative	1,002	1,168	50,744	43.45	22
23	Office Manager					23
24	Clerical	6,274	6,957	145,244	20.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,357	6,544	103,104	15.76	28
29	Resident Services Coordinator	1,551	1,714	31,746	18.52	29
30	Habilitation Aides (DD Homes)	59,911	63,193	675,094	10.68	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Behavior Dev'l	1,048	1,202	16,738	13.93	33
34	TOTAL (lines 1 - 33)	152,903	162,182	\$ 2,212,585 *	\$ 13.64	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	117	\$ 4,690	1.3	35
36	Medical Director	43	4,320	9.3	36
37	Medical Records Consultant			10.3	37
38	Nurse Consultant	336	16,788	10.3	38
39	Pharmacist Consultant	18	1,800	10.3	39
40	Physical Therapy Consultant	71	4,686	10a.3	40
41	Occupational Therapy Consultant	16	1,042	10a.3	41
42	Respiratory Therapy Consultant			10a.3	42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	11	487	11.3	44
45	Social Service Consultant	7	210	12.3	45
46	Other(specify) Psychologist	31	3,100	12.3	46
47				12.3	47
48	Psychiatrist	12	3,083	12.3	48
49	TOTAL (lines 35 - 48)	662	\$ 40,206		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,238	\$ 122,386	10.3	50
51	Licensed Practical Nurses	111	4,957	10.3	51
52	Certified Nurse Assistants/Aides	1,165	30,283	10.3	52
53	TOTAL (lines 50 - 52)	3,514	\$ 157,626		53

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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 5,259
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ 10,552 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 256,456
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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.