

		FOR BHF USE				

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IMPORTANT NOTICE

2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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

<p>I. IDPH License ID Number: <u>0042275</u></p> <p>Facility Name: <u>Zachary House</u></p> <p>Address: <u>1102 East Avenue</u> <u>Streamwood</u> <u>60107</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(630) 483-0537</u> Fax # <u>(630) 483-0537</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/16/96</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY NON-PROFIT Charitable Corp.</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Robin Witt</u> Telephone Number: <u>(630) 483-0537</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY NON-PROFIT Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Trust	<input type="checkbox"/> Individual	<input type="checkbox"/> State	IRS Exemption Code _____	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I, <u>Robin Witt</u>, certify that the contents of this report are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>I intend to represent or falsify information.</p> <p>(Signed) _____ (Date) _____</p> <p>Officer or Administrator of Provider (Type or Print Name) <u>Robin Witt</u></p> <p>(Title) <u>Chief Financial Officer</u></p> <p>(Signed) _____ (Date) _____</p> <p>Paid Preparer (Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) <u>()</u> Fax # <u>()</u></p> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Phone # (217) 782-1630 Springfield, IL 62763-0001</p>
<input type="checkbox"/> VOLUNTARY NON-PROFIT Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																							
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	<input type="checkbox"/> Limited Liability Co.																								
	<input type="checkbox"/> Trust																								
	<input type="checkbox"/> Other _____																								

Facility Name & ID Number Zachary House

0042275 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		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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 Total
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,707			5,707
14	TOTALS	5,707			5,707

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.46%

D. How many bed-hold days during this year were paid by the Department? 45 (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 12/16/96

J. Was the facility purchased or leased after January 1, 1978? YES Date 12/16/96 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.

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

					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
Operating Expenses										
1 Dietary	26,457	867	1,920	29,244	(2,235)	27,009	6,032	33,041		1
2 Food Purchase		22,949		22,949		22,949		22,949		2
3 Housekeeping	127	4,262		4,389		4,389		4,389		3
4 Laundry		3,041		3,041		3,041		3,041		4
5 Heat and Other Utilities			16,716	16,716		16,716		16,716		5
6 Maintenance	4,273	6,756	13,665	24,694		24,694		24,694		6
7 Other (specify):*										7
8 TOTAL General Services	30,857	37,875	32,301	101,033	(2,235)	98,798	6,032	104,830		8
B. Health Care and Programs										
9 Medical Director										9
10 Nursing and Medical Records	160,661	214	4,221	165,096	(250)	164,846		164,846		10
10a Therapy										10a
11 Activities		406		406		406		406		11
12 Social Services			1,140	1,140	(600)	540		540		12
13 CNA Training										13
14 Program Transportation										14
15 Other (specify):*										15
16 TOTAL Health Care and Programs	160,661	620	5,361	166,642	(850)	165,792		165,792		16
C. General Administration										
17 Administrative	38,976			38,976		38,976	59,752	98,728		17
18 Directors Fees										18
19 Professional Services			2,000	2,000	(16)	1,984		1,984		19
20 Dues, Fees, Subscriptions & Promotions			228	228	16	244		244		20
21 Clerical & General Office Expenses		2,783	55,362	58,145		58,145	(23,760)	34,385		21
22 Employee Benefits & Payroll Taxes			59,760	59,760	2,235	61,995	13,298	75,293		22
23 Inservice Training & Education										23
24 Travel and Seminar			81	81		81		81		24
25 Other Admin. Staff Transportation										25
26 Insurance-Prop.Liab.Malpractice							10,761	10,761		26
27 Other (specify):*										27
28 TOTAL General Administration	38,976	2,783	117,431	159,190	2,235	161,425	60,051	221,476		28
29 TOTAL Operating Expense (sum of lines 8, 16 & 28)	230,494	41,278	155,093	426,865	(850)	426,015	66,083	492,098		29

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

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

Facility Name & ID Number Zachary House #0042275 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense D. Ownership	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
30	Depreciation			6,892	6,892	6,892	13,511	20,403			30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			44,571	44,571	44,571	1,128	45,699			33
34	Rent-Facility & Grounds			156,000	156,000	156,000	(156,000)				34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			207,463	207,463	207,463	(141,361)	66,102			37
	Ancillary Expense E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		2,027		2,027	850	2,877	2,877			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			44,450	44,450	44,450		44,450			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		2,027	44,450	46,477	850	47,327	47,327			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	230,494	43,305	407,006	680,805		680,805	(75,278)	605,527		45

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

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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 Amount	Refer- ence	3 BHF USE	
1	NON-ALLOWABLE EXPENSES Day Care	\$		ONLY	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	13,511	30.3		9
10	Interest and Other Investment Income		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		(660)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 12,851		\$	30

BHF USE ONLY							
48		49		50		51	
							52

(See instructions.)

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

	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)	(88,129)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (88,129)	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))		\$ (75,278) 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.)	Yes	No	Amount	Reference
38		x	\$	38
39		x		39
40		x		40
41		x		41
42		x		42
43		x		43
44	x		850	10.3 44
45		x		45
46		x		46
47	TOTAL (C): (sum of lines 38-46)		\$ 850	47

Facility Name & ID Number Zachary House# 0042275

01/01/2008 Ending: 12/31/2008

Report Period Beginning:

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.

OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Byrn T. Witt	50%	Meadows	Rolling Meadows			
Barbara S. Witt	50%	Meadows	Rolling Meadows			

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
1	V	17	Administrative	\$ -	Meadows		\$ 12,000	\$ 12,000	1
2	V	17	Administrator	-	Meadows		11,608	11,608	2
3	V	17	Chief Financial Officer	-	Meadows		36,144	36,144	3
4	V	1	Dietary Manager	-	Meadows		6,032	6,032	4
5	V	21	Personnel, Accounting, Etc.	-	Meadows		18,459	18,459	5
6	V	21	General Office Supplies	-	Meadows		2,245	2,245	6
7	V	21	General Office Other	-	Meadows		5,936	5,936	7
8	V	22	Employee Benefits	-	Meadows		13,298	13,298	8
9	V	21	Administrative Overhead	49,740	Meadows			(49,740)	9
10	V	34	Facility Rent	156,000	Byrn T. Witt & Barbara S. Witt	100%		(156,000)	10
11	V	32	Interest	-	Byrn T. Witt & Barbara S. Witt	100%			11
12	V	26	Insurance	-	Meadows		10,761	10,761	12
13	V	33	Real Estate Tax	44,571	Byrn T. Witt & Barbara S. Witt	100%	45,699	1,128	13
14	Total			\$ 250,311			\$ 162,182	\$ * (88,129)	14

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

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

	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		8 Schedule V. Line & Column Reference	
						Hours	Percent	in Compensation for this Reporting Period**	Amount		
1	Byrn T. Witt		Administrator	50%		5	40%	Salary	12,000	17.3	1
2	Robin Witt	Chief Financial Officer	Administration	-0- %		17	42%	Salary	36,144	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	\$ 48,144		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 Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office YES NO

Street Address Meadows Sheltered Care, Inc.
3250 South Plum Grove Road
 Name of Related Organization Rolling Meadows, IL 60008
(847) 397-0055
 City / State / Zip Code (847) 397-0477
 Phone Number

or parent organization costs? (See instructions) If necessary, please attach worksheets. YES NO

B. Show the allocation of costs below.

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	17.1	Administrator	Direct Cost	2,285	2	72,865	72,865	364	11,608	2
3	21.1	Office	Direct Cost	7,841	2	163,703	163,703	884	18,459	3
4	17.1	CFO	Direct Cost	2,000	2	86,887	86,887	832	36,144	4
5	1.1	Dietary	Direct Cost	2,080	2	30,167	30,167	416	6,032	5
6	21.2	Office Supplies	Expenses	2,596,534	2	12,967		449,511	2,245	6
7	21.3	Office Other	Expenses	2,596,534	2	34,287		449,511	5,936	7
8	22.3	Employee Benefits	Salary	2,284,828	2	420,576		72,243	13,298	8
9	26.3	Insurance	Expenses	2,596,534	2	62,161		449,511	10,761	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					\$ 883,614	\$ 353,623		\$ 104,483	25

STATE OF ILLINOIS

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.) 5

	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1					\$ -		\$	\$			\$	1
2					-							2
3					-							3
4					-							4
5					-							5
	Working Capital											
6					-							6
7					-							7
8					-							8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10					-							10
11					-							11
12					-							12
13					-							13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Zachary House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042275

CONTACT PERSON REGARDING THIS REPORT Robin Witt

TELEPHONE (630) 483-0537 FAX #: (630) 483-0537

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. 06-25-301-043-0000	1100 East Avenue	\$ 44,571.00	\$ 44,571.00
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 44,571.00	\$ 44,571.00

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.

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,680 B. General Construction Type: Exterior Brick & Siding Frame Wood 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:

A. Land.

		² Square Feet	³ Year Acquired	⁴ Cost	
1	<u>ICF/DD 16</u> <u>Use</u>	<u>52,695</u>	<u>May-95</u>	<u>\$ 145,000</u>	1
2					2
3	TOTALS	<u>52,695</u>		<u>\$ 145,000</u>	3

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	B. 1		2	3	4	5	6	7	8	9	
	Beds*		Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
			Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	16	FOR BHF USE ONLY	1996	1996	\$ 509,864	\$	39	\$ 13,073	\$ 13,073	\$ 156,876	4
5											5
6											6
7											7
8											8
9		Landscaping		1997	16,650		39	427	427	4,961	9
10		Improvement Type** Time Clock System		1999	1,057		5			1,057	10
11		Floor Covering		2002	2,985	182	7	426	244	1,914	11
12		Wall Covering		2002	672	41	7	96	55	432	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38	Improvement Type**								38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	70

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

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	1
2	Improvement Type**								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	34

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

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	1
2	Improvement Type**								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	34

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

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	1
2	Improvement Type**								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	34

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

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	1
2	Improvement Type**								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	34

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

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3	4	5	6	7	8	9	
		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	1
2	Improvement Type**								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	34

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

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3	4	5	6	7	8	9	
		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	1
2	Improvement Type**								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	34

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

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3	4	5	6	7	8	9	
		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	1
2	Improvement Type**								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	34

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

Facility Name & ID Number Zachary House

0042275

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

B.	1	3	4	5	6	7	8	9	
		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	1
2	Improvement Type**								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,228	\$ 223		\$ 14,022	\$ 13,799	\$ 165,240	34

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

Facility Name & ID Number Zachary House

0042275

01/01/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	Category of	1 Cost	Report Period Beginning			Component Life 5	Accumulated Depreciation 6	
			Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments			
71	Equipment	\$ 27,708	\$ 82	\$ 82		\$ 27,437	71	
72	Purchased in Prior Years	803	449	161	(288)	161	72	
73	Current Year Purchases	2,541				2,541	73	
74	Fully Depreciated Assets						74	
75	TOTALS	\$ 31,052	\$ 531	\$ 243	\$ (288)	\$ 30,139	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	Patient Transport	2006 Ford Van	2006	31,971	6,138	6,138		5	22,763	78
79										79
80	TOTALS			\$ 31,971	\$ 6,138	\$ 6,138	\$		\$ 22,763	80

E. Summary of Care-Related Assets

	1 Reference	Amount	
81	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 739,251	81
82	Total Historical Cost (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,892	82
83	Current Book Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,403	83 **
84	Straight Line Depreciation (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,511	84
85	Adjustments (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 218,142	85
	Accumulated Depreciation		

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 Zachary House

0042275

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? YES NO

If NO, see instructions.

		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

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.	<u> </u> /2009	\$ _____
13.	<u> </u> /2010	\$ _____
14.	<u> </u> /2011	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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)	
			Staff Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$		\$				1
2	Licensed Speech and Language	10a.3	hrs									2
3	Licensed Occupational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs									4
5	Physician Care	39.3	visits									5
6	Dental Care	39.3	visits			9	850		9	850		6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39.2	# of prescrpts					2,027			2,027	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			\$		9	\$ 850	\$ 2,027	9	\$ 2,877		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 Zachary House# 0042275Report Period Beginning: 01/01/2008Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008 (last day of reporting year)

	1	2	After Consolidation*	
	Operating			
A. Current Assets				
<i>This report must be completed even if financial statements are attached.</i>				
1 Cash on Hand and in Banks	\$ 378,677	\$		1
2 Cash-Patient Deposits				2
3 Accounts & Short-Term Notes Receivable- Patients (less allowance)	35,176			3
4 Supply Inventory (priced at FIFO)	258			4
5 Short-Term Investments				5
6 Prepaid Insurance				6
7 Other Prepaid Expenses				7
8 Accounts Receivable (owners or related parties)	1,404,358			8
9 Other(specify):				9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,818,469	\$		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				15
16 Equipment, at Historical Cost	42,213			16
17 Accumulated Depreciation (book methods)	(32,382)			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)	\$ 9,831	\$		24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,828,300	\$		25

	1	2	After Consolidation*	
	Operating			
C. Current Liabilities				
26 Accounts Payable	\$ 1,655	\$		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)	204			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
36 Other Current Liabilities(specify):				36
37				37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,859	\$		38
D. Long-Term Liabilities				
39 Long-Term Notes Payable				39
40 Mortgage Payable				40
41 Bonds Payable				41
42 Deferred Compensation				42
43 Other Long-Term Liabilities(specify):				43
44				44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$		45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,859	\$		46
47 TOTAL EQUITY(page 18, line 24)	\$ 1,826,441	\$		47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,828,300	\$		48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,681,736	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,681,735	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	144,706	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 144,706	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,826,441	24 *

* This must agree with page 17, line 47.

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

Do not net revenue against expense.
 classifications of revenue and expense must be provided on this form, even if financial statements are attached.

2

Note: This schedule should show gross revenue and expenses.			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 820,396	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 820,396	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	800	24
25	Interest and Other Investment Income***	4,315	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,115	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)	\$ 825,511	30

Expenses			
		Amount	
A. Operating Expenses			
31	General Services	101,033	31
32	Health Care	166,642	32
33	General Administration	159,190	33
B. Capital Expense			
34	Ownership	207,463	34
C. Ancillary Expense			
35	Special Cost Centers	2,027	35
36	Provider Participation Fee	44,450	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 680,805	40
41	Income before Income Taxes (line 30 minus line 40)**	144,706	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 144,706	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 Zachary House# 0042275

01/01/2008

Ending:

12/31/2008

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

	1	2**	3	4	
(This schedule must cover the entire reporting period.)	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	429	8,028	18.71	4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician	416	6,032	14.50	12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	2,026	26,457	12.05	15
16	Dishwashers				16
17	Maintenance Workers	230	4,273	18.58	17
18	Housekeepers	12	128	10.69	18
19	Laundry				19
20	Administrator	2,089	50,584	22.15	20
21	Assistant Administrator				21
22	Other Administrative	832	36,144	43.44	22
23	Office Manager				23
24	Clerical	884	18,458	20.88	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	9,763	152,633	14.51	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	16,681	\$ 302,737 *	\$ 17.01	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	48	\$ 1,920	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	135	3,371	10.3	38
39	Pharmacist Consultant	12	600	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant				44
45	Social Service Consultant			12.3	45
46	Other(specify)			12.3	46
47					47
48				12.3	48
49	TOTAL (lines 35 - 48)	195	\$ 5,891		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Zachary House

0042275

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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? 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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \$ - 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. \$ 44,450
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. \$ 2,235 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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.