

		FOR BHF USE				

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**2011**  
 STATE OF ILLINOIS  
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
 FOR LONG-TERM CARE FACILITIES  
 (FISCAL YEAR 2011)

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

<p>I. IDPH License ID Number: <u>0011544</u></p> <p>Facility Name: <u>Meadows Mennonite Retirement Community Association, Inc.</u></p> <p>Address: <u>24588 Church Street</u> <u>Chenoa</u> <u>61726</u>  <small>Number City Zip Code</small></p> <p>County: <u>McLean</u></p> <p>Telephone Number: <u>(309) 747-2702</u> Fax # <u>(309) 747-2944</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1958</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code <u>501 (c) 3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other         </td> </tr> </table> <p>In the event there are further questions about this report, please contact:        Name: <u>Roger W. Hasler</u> Telephone Number: <u>(309) 747-2702</u>        Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Roger W. Hasler</u>            (Title) <u>Chief Financial Officer</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # <u>( )</u> </td> </tr> </table> <p align="right">       MAIL TO: BUREAU OF HEALTH FINANCE        ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Roger W. Hasler</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Roger W. Hasler</u> (Title) <u>Chief Financial Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>							

Facility Name & ID Number Meadows Mennonite Retirement Community Association, Inc.

# 0011544 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	116	Skilled (SNF)	116	42,340	1
2		Skilled Pediatric (SNF/PED)			2
3	14	Intermediate (ICF)	14	5,110	3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,035	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	Private Pay	4 Other	5 Total	
8	SNF	796	5,017	2,389	8,202	8
9	SNF/PED					9
10	ICF	13,851	15,405		29,256	10
11	ICF/DD	-	-			11
12	SC	-	-			12
13	DD 16 OR LESS	-	-			13
14	TOTALS	14,647	20,422	2,389	37,458	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.645438098

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 1958

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

YES  Date 1958 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 116 and days of care provided 2,389

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Meadows Mennonite Retirement Community As # 0011544 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	312,923	22,225	7,200	342,348	-	342,348	-	342,348		1
2	Food Purchase		328,124		328,124	-	328,124	(2,376)	325,748		2
3	Housekeeping	239,525	28,913	4	268,442	-	268,442	-	268,442		3
4	Laundry	62,169	17,294	-	79,463	-	79,463	-	79,463		4
5	Heat and Other Utilities			237,695	237,695	-	237,695	(62,270)	175,425		5
6	Maintenance	215,832	17,957	187,677	421,466	-	421,466	(126,885)	294,581		6
7	Other (specify):*	-	-	-	-	-	-	-	-		7
8	<b>TOTAL General Services</b>	830,449	414,513	432,576	1,677,538	-	1,677,538	(191,531)	1,486,007		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,400	5,400	-	5,400		5,400		9
10	Nursing and Medical Records	2,568,297	106,018	7,331	2,681,646	(600)	2,681,046		2,681,046		10
10a	Therapy	24,785	103	745,440	770,328	-	770,328		770,328		10a
11	Activities	89,460	3,520	354	93,334	-	93,334	(415)	92,919		11
12	Social Services	99,783			99,783	-	99,783		99,783		12
13	CNA Training				-	600	600		600		13
14	Program Transportation				-	-	-		-		14
15	Other (specify):*				-	-	-		-		15
16	<b>TOTAL Health Care and Programs</b>	2,782,325	109,641	758,525	3,650,491	-	3,650,491	(415)	3,650,076		16
	<b>C. General Administration</b>										
17	Administrative	136,535	-	-	136,535	-	136,535	-	136,535		17
18	Directors Fees			-	-	-	-	-	-		18
19	Professional Services			32,195	32,195	-	32,195	(2,000)	30,195		19
20	Dues, Fees, Subscriptions & Promotions			22,579	22,579	(681)	21,898	(13,579)	8,319		20
21	Clerical & General Office Expenses	236,280	12,314	164,963	413,557	(44,394)	369,163	(27,430)	341,733		21
22	Employee Benefits & Payroll Taxes			789,884	789,884	-	789,884	(37,271)	752,613		22
23	Inservice Training & Education			-	-	-	-	-	-		23
24	Travel and Seminar			16,196	16,196	-	16,196	(2,141)	14,055		24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-		25
26	Insurance-Prop.Liab.Malpractice			93,348	93,348	-	93,348	(19,612)	73,736		26
27	Other (specify):*		-	-	-	-	-	-	-		27
28	<b>TOTAL General Administration</b>	372,815	12,314	1,119,165	1,504,294	(45,075)	1,459,219	(102,033)	1,357,186		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,985,589	536,468	2,310,266	6,832,323	(45,075)	6,787,248	(293,979)	6,493,269		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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			508,068	508,068	-	508,068	(65,318)	442,750			30
31	Amortization of Pre-Op. & Org.			-	-	-	-	-	-			31
32	Interest			189,474	189,474	-	189,474	(14,053)	175,421			32
33	Real Estate Taxes			44,302	44,302	-	44,302	(44,302)	-			33
34	Rent-Facility & Grounds			-	-	-	-	-	-			34
35	Rent-Equipment & Vehicles			41	41	6,406	6,447	-	6,447			35
36	Other (specify):*			-	-	-	-	-	-			36
37	TOTAL Ownership			741,885	741,885	6,406	748,291	(123,673)	624,618			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-	-	-	-	-			38
39	Ancillary Service Centers	-	57,177	6,252	63,429	-	63,429	-	63,429			39
40	Barber and Beauty Shops	-	-	-	-	-	-	-	-			40
41	Coffee and Gift Shops	-	-	-	-	-	-	-	-			41
42	Provider Participation Fee	-	-	233,062	233,062	-	233,062	-	233,062			42
43	Other (specify):*	106,024	-	-	106,024	38,669	144,693	(144,693)	-			43
44	TOTAL Special Cost Centers	106,024	57,177	239,314	402,515	38,669	441,184	(144,693)	296,491			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,091,613	593,645	3,291,465	7,976,723	-	7,976,723	(562,345)	7,414,378			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,724)	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	(12,516)	30.3		9
10	Interest and Other Investment Income	(14,053)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,059)	20.3		28
29	Other-Attach Schedule	(520,993)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (562,345)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (562,345)		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			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			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Facility Name & ID Number

Meadows Mennonite Retirement Community Association, Inc.

# 0011544

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Meadows Mennonite Retirement Community Association, Inc # 0011544 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Meadows Mennonite Retirement Community As # 0011544 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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										
										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	GMAC		X	Mortgage	8,319	6/1976	\$ 1,620,000	\$	6/2016	0.0500	\$ 1,843	1							
2	FmHA #2		X	Mortgage	9,876	2/1996	1,782,500	1,197,126	Feb-26	0.0500	61,270	2							
3	FmHA #3		X	Mortgage	13,475	2/4/02	2,500,000	2,081,044	Feb-32	0.0475	100,218	3							
4	Heartland Bk & Trust		X	Mortgage	4,575	2/4/02	1,000,000	555,389	Feb-32	0.0375	26,073	4							
5					-							5							
Working Capital																			
6					-							6							
7	Loyalty Loans		X	Mortgage - renew annually	-	Various	13,500	500	Various	.0300 - .0600	70	7							
8	Residential to Health Center	X		Working Capital	-	10/11/07	160,000	315,454	Various			8							
9	TOTAL Facility Related				\$36,245.00		\$ 7,076,000	\$ 4,149,513			\$ 189,474	9							
B. Non-Facility Related*																			
10					-							10							
11					-							11							
12					-							12							
13					-							13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 7,076,000	\$ 4,149,513			\$ 189,474	15							

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

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

(See instructions.)

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

(See instructions.)



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates  
 RE: 2010 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 2010 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2010.

Please complete the Real Estate Tax Statement below and include it in the 2011 cost report along with a copy of your 2010 real estate tax bill.

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.

**2010 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Meadows Mennonite Retirement Community Association, Inc. COUNTY McLean  
 FACILITY IDPH LICENSE NUMBER 0011544  
 CONTACT PERSON REGARDING THIS REPORT Roger W. Hasler  
 TELEPHONE (309) 747-2702 FAX #: (309) 747-2944

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation*. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Meadows Mennonite Retirement Community Association, Inc.

# 0011544

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			1923	1923	\$ 74,144	\$	50	\$	\$	\$ 74,144	4
5	23		1952	1952	86,314		50			86,314	5
6	25		1966	1966	225,617	3,850	50	4,512	662	207,547	6
7	94		1978	1978	2,348,846	58,722	40	58,721	(1)	1,996,316	7
8	17		1997	1997	3,898,885	97,472	40	97,472		1,380,631	8
	Improvement Type**										
9		Various Building Improvements		1979	78,921		20			78,921	9
10		Various Building Improvements		1980	3,362	66	20		(66)	3,362	10
11		Various Building Improvements		1981	3,427		20			3,427	11
12		Various Building Improvements		1983	186,656		20			186,656	12
13		Various Building Improvements		1984	1,298		20			1,298	13
14		Various Building Improvements		1985	31,287		10			31,287	14
15		Various Building Improvements		1986	35,542		10			35,542	15
16		Various Building Improvements		1987	3,888	150	30	130	(20)	3,182	16
17		Various Building Improvements		1988	182,020	7,952	20		(7,952)	182,020	17
18		Various Building Improvements		1989	107,129	3,656	20		(3,656)	107,129	18
19		Various Building Improvements		1990	36,676		10			36,676	19
20		Various Building Improvements		1991	12,480	30	10		(30)	12,480	20
21		Various Building Improvements		1992	36,879	251	10		(251)	36,879	21
22		Various Building Improvements		1993	3,505	103	10		(103)	3,505	22
23		Various Building Improvements		1994	93,480	1,280	15		(1,280)	93,480	23
24		Various Building Improvements		1995	45,902	3,219	20	2,295	(924)	37,104	24
25		Various Building Improvements		1996	244,463	7,184	20	12,223	5,039	189,473	25
26		Engineering cad & survey		1996	675	26	15	29	3	675	26
27		Excavating		1996	2,000	89	15	103	14	2,000	27
28		Boiler Repair - Cleveland		1996	503		3			503	28
29		Roof A/C Repair		1996	718		7			718	29
30		Window Coverings		1996	1,039		7			1,039	30
31		Sewage Pump Repairs		1996	1,685		7			1,685	31
32		Siding		1997	22		7			22	32
33		Siding		1997	245		7			245	33
34		Alzheimer Unit		1997	144,484	3,612	40	3,612		51,162	34
35		Insulated Glass Rm 42		1997	677		10			677	35
36		Service-Intercom System Repairs		1997	871		7			871	36

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

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

See Page 12A, Line 70 for total

## XL OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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	Fiber Optics - Computer Wiring	1997	\$ 2,887	\$	5	\$	\$	2,887	37
38	Liquid Storage Cabinet Tank	1997	572		5			572	38
39	Paging System - Bennett	1997	2,288		7			2,288	39
40	Install Heating Cooling	1997	15,161	1,011	15	1,011		14,664	40
41	Compressors (5)	1997	1,653		7			1,653	41
42	Window blinds	1997	1,539		7			1,539	42
43	Motor a/C Motor & Starter for 2 Ton Unit	1997	715		5			715	43
44	Repair Cool	1997	749		5			749	44
45	2 Roof top Units	1997	1,295		7			1,295	45
46	A/C Part Repairs	1997	733		5			733	46
47	Power Server -Timeclock	1997	150	10	15	10		141	47
48	2 Carrier Heating & Cooling	1997	19,250	1,283	15	1,283		18,064	48
49	Intercom Wiring Repairs	1997	696		3			696	49
50	Carousel Tub	1997	12,423	828	15	828		11,728	50
51	Landscaping	1997	30,518	2,035	15	2,035		28,824	51
52	Curtains, Valances	1997	10,077	672	15	672		9,518	52
53	Patio Garden Landscaping	1997	12,842	856	15	856		12,125	53
54	Fence & Gate	1997	10,162	508	40	254	(254)	3,598	54
55	Telephone Wiring	1997	1,462	97	15	97		1,374	55
56	Draperies - Clark	1997	869	58	15	58		822	56
57	ASI Sign System	1997	2,547	170	15	170		2,408	57
58	Rocks for 2 Courtyards	1998	2,070	138	15	138		1,830	58
59	Asphalt Maintenance	1998	5,500	61	15	367	306	4,893	59
60	Window Room # 51	1998	444		10			444	60
61	Magnetic Gate Contact	1998	228		7			228	61
62	Carpet Res. Room	1998	330		5			330	62
63	Carpet 3 Rooms	1998	793		5			793	63
64	Maintenance Shop	1998	909	45	20	45		587	64
65	2 A/C Compressors	1998	1,006		7			1,006	65
66	Heat & Air Thermostat	1998	1,410		7			1,410	66
67	Natural Gas Steamer	1998	7,495		7			7,495	67
68	Heat Duct Repair	1998	761		7			761	68
69	Repair Engine & Generator	1998	1,322		5			1,322	69
70	TOTAL (lines 4 thru 69)		\$ 8,044,496	\$ 195,434		\$ 186,921	\$ (8,513)	\$ 4,984,462	70

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

## XL. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,044,496	\$ 195,434		\$ 186,921	\$ (8,513)	\$ 4,984,462	1
2	Alarm system Phase 1	1998	44,529	2,226	20	2,226		29,097	2
3	Sewage Pump Rehab	1998	7,208		7			7,208	3
4	Water Tower Rehab	1998	63,699	3,185	20	3,185		43,412	4
5	OSHA Upgrades	1998	111		5			111	5
6	Required OSHA Items	1998	458		5			458	6
7	Eye Wash Station	1998	585		5			585	7
8	1 CS Spill Kits	1998	122		5			122	8
9	Repair Roadway	1999	3,500	233	15	233		2,969	9
10	Landscaping Improvements	1999	2,259	151	15	151		1,888	10
11	Station 1 Door Keypads	1999	1,442		10			1,442	11
12	Station 1 Code Alert System	1999	15,298		10			15,298	12
13	Station 1 Nurse Call System	1999	11,924		10			11,924	13
14	Ceiling Installation	1999	1,945	130	15	130		1,593	14
15	Improvements to Brown Shed	1999	1,288		10			1,288	15
16	Safety Bars in Alzheimer's Unit	1999	2,350	157	15	157		2,015	16
17	Bronze Door & Closer	1999	1,806	120	15	120		1,531	17
18	Hardware for Exisisting Doors in Alzheimer's Unit	1999	5,536	369	15	369		4,706	18
19	Sensor Base for Alarm	1999	231		7			231	19
20	Repair Boiler Station 4	1999	1,140		5			1,140	20
21	Repair Generator	1999	3,067		5			3,067	21
22	Water Heater for Kitchen	1999	878		15	59	59	713	22
23	Panic Devices on Doors in alzheimer Unit	1999	688		7			688	23
24	Alarm System	1999	7,562	504	20	378	(126)	4,790	24
25	Storage Cabinets & Installation	1999	5,242		7			5,242	25
26	Elevator Eye	1999	1,978	132	15	132		1,673	26
27	Fire Alarm System Materials & Labor	1999	27,650	1,383	20	1,383		17,407	27
28	Compressor for Freezer	1999	1,809		7			1,809	28
29	Sewer Improvements (Check Valves)	1999	1,312		20	66	66	809	29
30	New Pipes in Well	1999	921		20	46	46	556	30
31	New Alzheimer Unit Sign	1999	1,144	76	15	76		973	31
32	Station 4 Door Seal Parts & Labor	1999	1,163	78	15	78		943	32
33	Carpet - Station 5	2000	1,126		5			1,126	33
34	TOTAL (lines 1 thru 33)		\$ 8,264,467	\$ 204,178		\$ 195,710	\$ (8,468)	\$ 5,151,276	34

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

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,264,467	\$ 204,178		\$ 195,710	\$ (8,468)	\$ 5,151,276	1
2	Station 5 Remodel	2000	320		10			320	2
3	Station 5 Tile	2000	530		5			530	3
4	Bathroom Fixtures - Station 5	2000	1,675		10			1,675	4
5	Garage Door Enlargement	2000	1,276		10			1,276	5
6	Elevator Cylinder	2000	16,746	1,116	15	1,116		13,212	6
7	Fire Alarm System	2000	18,000	1,200	15	1,200		14,206	7
8	Mastercare hydrobath	2000	9,490		7			9,490	8
9	Door Locks on Soiled Linen Closet	2000	568		7			568	9
10	Air Conditioner Motor	2000	657		7			657	10
11	Air Conditioner Compressor	2000	1,732		7			1,732	11
12	Alarm System	2000	35,000		10			35,000	12
13	Alarm System	2000	18,060		10			18,060	13
14	Alarm System Sensor	2000	864		7			864	14
15	Premium Lawn	2000	755	50	15	50		584	15
16	Parking Lot Addition	2000	7,355	490	15	490		5,706	16
17	New Controller for Sewer	2000	1,573		7			1,573	17
18	Sewer Improvements (Check Valves)	2000	752		7			752	18
19	Water main Work	2000	2,203	110	20	110		1,266	19
20	Water Main Extension	2000	8,465	423	20	423		4,866	20
21	Chlorinator	2000	1,389		7			1,389	21
22	Generator Repair	2001	506		7			506	22
23	Generator Repair/Trans.	2001	1,434		7			1,434	23
24	Boiler Repair	2001	1,044		7			1,044	24
25	Air Conditioner Compressor	2001	700		7			700	25
26	Air Conditioner Compressor	2001	1,200		7			1,200	26
27	Storm Windows	2001	2,071	138	10	139	1	2,071	27
28	Simplex Fire Alarm	2001	763		5			763	28
29	Phase II Bldg Renov	2002	950,000	31,667	30	31,667		308,861	29
30	Phase II Bldg Renov -K	2002	1,187,500	39,583	30	39,583		384,226	30
31	Renovation 2002	2002	80,684	2,689	30	2,689		24,540	31
32	Renovation 2002	2002	182,708	6,090	30	6,090		55,077	32
33	Pairie Control- 4FCU flow problem	2002	6,694	446	15	446		4,064	33
34	TOTAL (lines 1 thru 33)		\$ 10,807,181	\$ 288,180		\$ 279,713	\$ (8,467)	\$ 6,049,488	34

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

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,807,181	\$ 288,180		\$ 279,713	\$ (8,467)	\$ 6,049,488	1
2	Phase II Renovation	2002	456,101	15,203	30	15,203		139,368	2
3	Garage Doors	2002	1,166	117	10	117		1,063	3
4	Roof	2002	125,025	4,168	30	4,168		38,391	4
5	Stained Glass -Chapel	2002	1,063		7			1,063	5
6	Water Heater	2002	4,599		7			4,599	6
7	Generator	2002	1,565		7			1,565	7
8	Air Conditioner	2002	5,150		7			5,150	8
9	Air Conditioner	2002	1,495		7			1,495	9
10	Heating UN/Steam	2002	1,424		7			1,424	10
11	Air Hood	2002	4,970		7			4,970	11
12	Fire Protection System	2002	2,572		7			2,572	12
13	Nation Custom Vent Ducts	2002	830		7			830	13
14	New Road	2002	3,911	261	15	261		2,379	14
15	Sub Pump	2002	2,448		7			2,448	15
16	Sewage Pump Station	2002	1,906		20	95	95	890	16
17	Lift Station Eng	2002	1,860	266	20	93	(173)	863	17
18	Lift Station Eng	2002	1,674	239	20	84	(155)	773	18
19	Pump Station Eng	2002	1,169	167	20	58	(109)	529	19
20	Lift Station Eng Review	2002	720	103	20	36	(67)	325	20
21	Lift Station Eng	2002	950	136	20	48	(88)	452	21
22	Pump Station Eng	2002	1,603	229	20	80	(149)	749	22
23	Chiller Compressor Replacement	2002	2,418		7			2,418	23
24	Medline-Borders & Shades/ Dining Rm	2003	3,195		7			3,195	24
25	Phase II Renov Project	2003	244,941	8,165	30	8,165		71,449	25
26	Tile Specialists-Adm Bld Entry	2003	1,455	91	8	93	2	1,455	26
27	Tile Specialists-Adm Bldg Hallway	2003	9,350	390	8	338	(52)	9,350	27
28	Tile Specialists - Lounge Carpet	2003	2,950	123	8	105	(18)	2,950	28
29	Code Alert-Security System	2003	69,151	6,915	10	6,915		56,779	29
30	Jay's Plumbing - Hot Water Heater mixing valve	2003	2,980	298	10	298		2,405	30
31	New Lift Station	2003	97,919	4,896	20	4,896		42,454	31
32	Roof Repairs	2004	1,270	127	10	127		984	32
33	Electrical	2004	2,900	414	7	413	(1)	2,900	33
34	TOTAL (lines 1 thru 33)		\$ 11,867,911	\$ 330,488		\$ 321,306	\$ (9,182)	\$ 6,457,725	34

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

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,867,911	\$ 330,488		\$ 321,306	\$ (9,182)	\$ 6,457,725	1
2	Water Heaters	2004	12,523	1,252	10	1,252		9,680	2
3	Water Softner	2004	7,398	740	10	740		5,304	3
4	Asphalt Sealcoat	2004	22,833		3			22,833	4
5	Sidewalk	2005	2,450	123	20	123		795	5
6	Shingles	2005	21,650	1,083	20	1,083		6,717	6
7	Flooring/Carpet	2005	9,999	1,250	8	1,250		8,027	7
8	Brick Repairs	2005	2,230	223	10	223		1,386	8
9	Wall covering and modification	2005	28,744	4,020	7	4,106	86	27,719	9
10	Fire system and sprinkler	2005	6,238	624	10	624		4,009	10
11	A/C, Duct Htrs	2005	16,952	935	10	1,695	760	10,950	11
12	Generator	2005	1,191	79	15	79		549	12
13	Cooling tower refurbishment	2006	6,142	877	7	877		5,012	13
14	Air separator & fan coil units	2006	16,162	1,616	10	1,616		9,559	14
15	Window treatments	2006	3,385	484	7	484		2,835	15
16	Iron filters	2006	2,467	247	10	247		1,414	16
17	Chiller compressor	2006	9,294	929	10	929		4,910	17
18	HVAC Upgrade	2007	8,430	1,205	7	1,204	(1)	5,872	18
19	Shower room remodel	2007	5,873	587	10	587		2,398	19
20	Fire wall, sprinklers, risers	2007	18,535	1,765	10	1,854	89	8,543	20
21	Water treatment filters	2007	1,339	191	7	191		868	21
22	Upgrade sidewalk, road, fencing	2007	21,067	2,017	20	1,053	(964)	4,853	22
23	Asphalt project	2008	1,935	108	3	122	14	1,935	23
24	Trees	2008	7,509	501	15	501		1,629	24
25	Sanitation lift pump and tiling	2008	8,338	2,114	7	1,191	(923)	4,598	25
26	Station 1 & 2 shower and lounge remodel	2008	16,138	1,614	10	1,614		5,766	26
27	Elevator door detector	2008	5,330	533	10	533		1,933	27
28	Dbt entry door activity & dining	2008	19,373	1,292	15	1,292		4,102	28
29	Roof coating and repairs	2008	12,596	2,519	5	2,519		9,227	29
30	South and north hall carpeting	2008	14,669	1,834	8	1,834		6,883	30
31	Generator upgrade	2008	9,174	764	12	765	1	2,383	31
32	VAV system beauty shop	2008	5,708	571	10	571		1,755	32
33	St 4 humidifier	2008	9,264	926	10	926		2,834	33
34	TOTAL (lines 1 thru 33)		\$ 12,202,847	\$ 363,511		\$ 353,391	\$ (10,120)	\$ 6,645,003	34

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

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 12,202,847	\$ 363,511		\$ 353,391	\$ (10,120)	\$ 6,645,003	1
2	PT heating unit	2009	4,865	487	10	487		1,442	2
3	Fire dampers and access door	2009	4,164	595	7	595		1,661	3
4	HVAC Upgrade East entry	2009	2,116	302	7	302		807	4
5	Drain replace chapel	2009	1,001	100	10	100		264	5
6	Heating unit st 3	2009	1,208	173	7	173		420	6
7	Slider doors west entry	2009	2,278	325	7	325		745	7
8	Surge suppressor main panel	2009	11,998	1,200	10	1,200		2,617	8
9	Air handling unit st 4	2009	3,100	443	7	443		966	9
10	St 1 & 2 lounge tear out windows, fix sag wall, install windows, windo	2009	50,856	4,616	10	5,086	470	11,189	10
11	Entrance lights and waterline valve	2009	6,754	507	10	675	168	1,470	11
12	Lounge tear out windows, fix sag wall, install windows, chiller compre	2009	17,158	2,451	7	2,451		4,922	12
13	HVAC computer and sprinkler system	2009	30,416	4,496	10	3,042	(1,454)	6,251	13
14	PT shelving	2009	1,943	278	7	278		568	14
15	Cement work st 1 & 4	2009	15,545	1,036	15	1,036		2,796	15
16	East entrance sidewalk	2009	40,545	2,703	15	2,703		5,947	16
17	Iron filters	2009	2,673	535	5	535		1,432	17
18	Dining room roof and cabinetry	2010	7,422	1,389	5	1,484	95	2,838	18
19	Carpet & electric panel - chaplain & copier rm	2010	3,110	316	15	207	(109)	259	19
20	Roof & garbage disposal kitchen	2010	43,375	3,714	15	2,892	(822)	3,367	20
21	HVAC connection upgrade, mgmt controls	2010	12,070	2,943	7	1,724	(1,219)	3,297	21
22	PT rm walls, floor, ceiling, lights	2010	3,362	480	7	480		721	22
23	Carpet & ext. doors - St 1 & 2; west entry	2010	5,400	643	10	540	(103)	544	23
24	S. parking lot blacktop	2010	39,475	2,632	15	2,632		3,367	24
25	Fire hydrant admin bldg entrance way	2010	3,404	340	10	340		539	25
26	Retaining wall - St 1 & receiving	2010	15,013	1,501	10	1,501		1,624	26
27	Sidewalk - E. entrance	2010	3,615	362	10	362		383	27
28	HVAC upgrade and chimney repair	2011	37,751	2,464	10	3,124	660	3,124	28
29	Wiring for generator	2011	4,250	557	7	552	(5)	552	29
30	3 Exterior entrance doors	2011	13,334	1,000	10	1,001	1	1,001	30
31	Chiller compressor	2011	7,275	808	3	870	62	870	31
32	Fireproof walls and ceilings	2011	11,663		7	50	50	50	32
33	Water tower riser pipe repair	2011	22,061	1,103	15	1,144	41	1,144	33
34	TOTAL (lines 1 thru 33)		\$ 12,632,047	\$ 404,010		\$ 391,725	\$ (12,285)	\$ 6,712,180	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 12,632,047	\$ 404,010		\$ 391,725	\$ (12,285)	\$ 6,712,180	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 12,632,047	\$ 404,010		\$ 391,725	\$ (12,285)	\$ 6,712,180	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 12,632,047	\$ 404,010		\$ 391,725	\$ (12,285)	\$ 6,712,180	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 12,632,047	\$ 404,010		\$ 391,725	\$ (12,285)	\$ 6,712,180	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 12,632,047	\$ 404,010		\$ 391,725	\$ (12,285)	\$ 6,712,180	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 12,632,047	\$ 404,010		\$ 391,725	\$ (12,285)	\$ 6,712,180	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 274,344	\$ 49,518	\$ 49,518	\$	various	\$ 667,613	71
72	Current Year Purchases	42,135	3,888	3,888		various	3,888	72
73	Fully Depreciated Assets	470,982				various	470,982	73
74								74
75	TOTALS	\$ 787,461	\$ 53,406	\$ 53,406	\$		\$ 1,142,483	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Grounds Maintenance	1999 Dodge D350	1999	\$ 29,024	\$	\$	\$	5	\$ 29,024	76
77	Patient Transport	2004 Pontiac Montana	2004	10,609				5	10,609	77
78	Grounds Maintenance	JD 1420/Sno-way	2007	15,308	479	248	(231)	5	15,308	78
79	Grounds Maintenance	Other	Various	52,238	5,288	5,288		5	19,307	79
80	TOTALS			\$ 107,179	\$ 5,767	\$ 5,536	\$ (231)		\$ 74,248	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,568,785	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 463,183	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 450,667	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,516)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,928,911	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Residential Housing Units	\$ 1,503,796	\$ 41,251	\$ 973,629	86
87	Residential Vehicles	49,027		49,027	87
88	CEO House Remodeling	78,877	3,634	51,688	88
89	Land	158,040			89
90	Fellowship Center Land 2007	24,000			90
91	TOTALS	\$ 1,813,740	\$ 44,885	\$ 1,074,344	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	\$ 2,912	92
93			93
94			94
95		\$ 2,912	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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: \$ 6,447 Description: Copier

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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. _____ /2012	\$	_____
-----------------	----	-------

13. _____ /2013	\$	_____
-----------------	----	-------

14. _____ /2014	\$	_____
-----------------	----	-------

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 600	\$	\$ 600
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 600	\$	\$ 600
10	SUM OF line 9, col. 1 and 2 (e)	\$ 600			

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

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

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

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	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)					
					Units	Cost						
1	Licensed Occupational Therapist	10a.3	hrs	\$	2,936	\$ 245,030			\$	2,936	\$ 245,030	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		1,701	155,063				1,701	155,063	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs		4,146	345,346				4,146	345,346	4
5	Physician Care	39.3	visits									5
6	Dental Care	39.3	visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39.2	# of prescripts					55,265			55,265	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						1,912			1,912	13
14	TOTAL			\$	8,783	\$ 745,439		\$ 57,177		8,783	\$ 802,616	14

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

Facility Name & ID Number Meadows Mennonite Retirement Community Association, Inc. # 0011544 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 218,243	\$	1
2	Cash-Patient Deposits	15,105		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (56,000) )	1,348,246		3
4	Supply Inventory (priced at FIFO )			4
5	Short-Term Investments	40,083		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	60,284		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,681,961	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,368,212		12
13	Land	184,978		13
14	Buildings, at Historical Cost	8,798,894		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,986,484		16
17	Accumulated Depreciation (book methods)	(7,908,043)		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): <u>Construction in Process</u>	2,912		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 9,433,437	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 11,115,398	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 219,878	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,105		28
29	Short-Term Notes Payable	11,301		29
30	Accrued Salaries Payable	165,631		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,020		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<u>Accrued Expenses</u>	412,517		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 870,452	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	315,954		39
40	Mortgage Payable	3,833,558		40
41	Bonds Payable			41
42	Deferred Compensation	138,757		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 4,288,269	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 5,158,721	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 5,956,677	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 11,115,398	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,966,582	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(608,093)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,358,489	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	598,188	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)	\$ 598,188	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 5,956,677	24 *

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

Facility Name & ID Number Meadows Mennonite Retirement Community Associat # 0011544 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,496,428	1
2	Discounts and Allowances for all Levels	(1,738,330)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,758,098	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,850,547	6
7	Oxygen	8,101	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,858,648	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,888	13
14	Non-Patient Meals	2,376	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	110,506	17
18	Sale of Supplies to Non-Patients	415	18
19	Laboratory	39,365	19
20	Radiology and X-Ray	3,415	20
21	Other Medical Services	93,253	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 251,218	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	400,164	24
25	Interest and Other Investment Income***	14,053	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 414,217	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential Revenue	349,600	28
28a	Other Income	9,785	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 359,385	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,641,566	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,677,538	31
32	Health Care	3,650,491	32
33	General Administration	1,504,294	33
<b>B. Capital Expense</b>			
34	Ownership	741,885	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	169,453	35
36	Provider Participation Fee	233,062	36
<b>D. Other Expenses (specify):</b>			
37	Intercompany Support	66,655	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,043,378	40
41	Income before Income Taxes (line 30 minus line 40)**	598,188	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 598,188	43

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

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

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

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

Facility Name & ID Number Meadows Mennonite Retirement Community Association, Inc.

# 0011544

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,168	2,388	\$ 90,229	\$ 37.78	1
2	Assistant Director of Nursing	1,831	2,103	61,594	29.29	2
3	Registered Nurses	9,293	9,916	233,530	23.55	3
4	Licensed Practical Nurses	22,313	24,207	588,773	24.32	4
5	CNAs & Orderlies	109,340	117,853	1,561,663	13.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,544	1,686	24,785	14.70	8
9	Activity Director	1,366	1,392	21,962	15.78	9
10	Activity Assistants	5,587	5,899	67,498	11.44	10
11	Social Service Workers	5,130	5,559	99,783	17.95	11
12	Dietician					12
13	Food Service Supervisor	1,555	1,835	31,862	17.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,060	27,828	281,061	10.10	15
16	Dishwashers					16
17	Maintenance Workers	5,185	5,706	97,092	17.02	17
18	Housekeepers	19,845	21,855	239,525	10.96	18
19	Laundry	5,511	5,957	62,169	10.44	19
20	Administrator	1,896	2,056	136,535	66.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,897	2,116	104,269	49.28	23
24	Clerical	7,720	8,560	129,382	15.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	1,819	2,083	32,508	15.60	33
34	TOTAL (lines 1 - 33)	230,057	248,998	\$ 3,864,220 *	\$ 15.52	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	192	\$ 7,200	1.3	35
36	Medical Director	54	5,400	9.3	36
37	Medical Records Consultant	40	1,620	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	8	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			11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	294	\$ 14,820		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Certified Nurse Assistants/Aides			10.3	52
53	TOTAL (lines 50 - 52)		\$		53



Facility Name & ID Number Meadows Mennonite Retirement Community Association, Inc # 0011544

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network of IL 3,703
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,230 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. \$ 233,062  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.  
Hskpng & Laundry split on time spent.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,724
- (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 training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Phillips, Salmi & Associates, LLC
- (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.