FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0021766

Facility Name: Meadows

Address: 3250 South Plum Grove Road (Number) Rolling Meadows (City) 60008 (Zip Code)

County: Cook

Telephone Number: (847) 397-0055 Fax # (847) 397-0477

HFS ID Number:

Date of Initial License for Current Owners: 08/1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Robin Witt Telephone Number: (847) 397-0055
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Robin Witt
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)		-	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)		-	3
4	99	Intermediate/DD	99	36,234	4
5		Sheltered Care (SC)		-	5
6		ICF/DD 16 or Less		-	6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	-	-	-		8
9	SNF/PED					9
10	ICF	-	-			10
11	ICF/DD	30,075	640		30,715	11
12	SC	-	-			12
13	DD 16 OR LESS	-	-			13
14	TOTALS	30,075	640		30,715	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.847684495

D. How many bed-hold days during this year were paid by the Department? 133 (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 [X] NO [ ]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided -

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	226,185	23,750	2,538	252,473		252,473		252,473			1
2	Food Purchase		175,885		175,885		175,885		175,885			2
3	Housekeeping	72,979	30,173		103,152		103,152		103,152			3
4	Laundry	96,115	16,074		112,189		112,189		112,189			4
5	Heat and Other Utilities			88,534	88,534		88,534		88,534			5
6	Maintenance	116,313	12,045	43,749	172,107		172,107		172,107			6
7	Other (specify):*											7
8	TOTAL General Services	511,592	257,927	134,821	904,340		904,340		904,340			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800	(13,440)	3,360		3,360			9
10	Nursing and Medical Records	1,131,256	61,044	18,942	1,211,242		1,211,242		1,211,242			10
10a	Therapy	15,252		4,015	19,267	4,233	23,500		23,500			10a
11	Activities	39,003	5,874	6,626	51,503	234	51,737		51,737			11
12	Social Services	137,354		21,820	159,174	(4,467)	154,707		154,707			12
13	CNA Training											13
14	Program Transportation			159	159		159		159			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,322,865	66,918	68,362	1,458,145	(13,440)	1,444,705		1,444,705			16
	C. General Administration											
17	Administrative	125,001			125,001		125,001		125,001			17
18	Directors Fees											18
19	Professional Services			43,060	43,060	(837)	42,223		42,223			19
20	Dues, Fees, Subscriptions & Promotions			10,860	10,860	148	11,008		11,008			20
21	Clerical & General Office Expenses	106,741	13,887	(38,278)	82,350	(148)	82,202	53,622	135,824			21
22	Employee Benefits & Payroll Taxes			410,178	410,178	837	411,015	(1,781)	409,234			22
23	Inservice Training & Education											23
24	Travel and Seminar			63	63		63		63			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,407	18,407		18,407	20,738	39,145			26
27	Other (specify):*											27
28	TOTAL General Administration	231,742	13,887	444,290	689,919		689,919	72,579	762,498			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,066,199	338,732	647,473	3,052,404	(13,440)	3,038,964	72,579	3,111,543			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Meadows Sheltered Care, Inc. #0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			2,829	2,829		2,829	49,961	52,790			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							155,373	155,373			32
33	Real Estate Taxes							216,860	216,860			33
34	Rent-Facility & Grounds			729,600	729,600		729,600	(729,600)				34
35	Rent-Equipment & Vehicles			10,785	10,785		10,785		10,785			35
36	Other (specify):*											36
37	TOTAL Ownership			743,214	743,214		743,214	(307,406)	435,808			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,488	7,488	13,440	20,928		20,928			39
40	Barber and Beauty Shops			20	20		20		20			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			263,882	263,882		263,882		263,882			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			271,390	271,390	13,440	284,830		284,830			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,066,199	338,732	1,662,077	4,067,008		4,067,008	(234,827)	3,832,181			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 Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,505	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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees		13		27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	41,114			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ 42,619		$	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 Amount	2 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)	(277,446)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (277,446)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (234,827)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39	Physician Care	x		13,440	9.3	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)			$ 13,440		47

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
Byrn T. Witt	50.00%	Zachary House	Streamwood			
Barbara S. Witt	50.00%	Zachary House	Streamwood			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 729,600	Byrn T. Witt & Barbara S. Witt	100.00%	$	$ (729,600)	1
2	V								2
3	V	30	Depreciation		Byrn T. Witt & Barbara S. Witt	100.00%	49,521	49,521	3
4	V	32	Interest		Byrn T. Witt & Barbara S. Witt	100.00%	155,373	155,373	4
5	V	17							5
6	V	33	Real Estate Taxes		Byrn T. Witt & Barbara S. Witt	100.00%	216,860	216,860	6
7	V								7
8	V	26	Property Insurance		Byrn T. Witt & Barbara S. Witt	100.00%	30,400	30,400	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 729600			$ 452,154	$ * (277,446)	14

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robin Witt	Administrator	Administration			40	100%	Salary	$ 65,001	17.1	1
2	Robin Witt	CFO / HR	Administration			34	100%	Salary	60,000	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 125,001		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 Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 [x]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	HUD		X	Debt Refinance / Bldg Constructi	Varies	2006	2,700,000	2,576,997	2046	0.0600	155,373	2
3												3
4										Interest Income		4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,700,000	$ 2,576,997			$ 155,373	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,700,000	$ 2,576,997			$ 155,373	15

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.	$ 204,804	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 210,832	2
3. Under or (over) accrual (line 2 minus line 1).		$ 6,028	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 210,832	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 216,860	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	223,540	8
	2008	229,505	9
	2009	260,921	10
	2010	204,804	11
	2011	210,832	12

Accrual based on current year assessment.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2011 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 2011 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2011.

Please complete the Real Estate Tax Statement below and include it in the 2012 cost report along with a copy of your 2011 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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meadows Sheltered Care, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0021766

CONTACT PERSON REGARDING THIS REPORT Robin Witt

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-35-100-016-0000	3250 South Plum Grove Road	$ 210,832	$ 210,832
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 210,832.00	$ 210,832.00

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 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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? [x] (a) Own the Equipment [x] (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 [x] NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	52,300	1986	$ 25,000	1
2					2
3	TOTALS	52300		$ 25000	3

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1986	1975	$ 1,500,000	$	30	$	$	$ 1,500,000	4
5			1996	1996	1,478,674		39	37,915	37,915	625,753	5
6	1		1996	1996	15,000		39	385	385	6,242	6
7											7
8											8
	Improvement Type**										
9	Remodeling			1976	3,548		10			3,548	9
10				1977	21,344		10			21,344	10
11				1979	169		10			169	11
12				1980	9,111		10			9,111	12
13				1981	3,203		10			3,203	13
14				1983	7,355		10			7,355	14
15				1984	11,356		10			11,356	15
16	Garage			1985	3,165		10			3,165	16
17	Remodeling			1986	2,386		10			2,386	17
18	Water Heater & Fire Alarm System			1987	3,199		15			3,199	18
19	Roof			1988	40,520		20			40,520	19
20	Heat Pump			1988	1,900		15			1,900	20
21	Carpeting			1988	10,119		5			10,119	21
22	Carpeting			1989	4,185		5			4,185	22
23	Roof			1990	3,527		20			3,527	23
24	Kitchen			1990	2,319		10			2,319	24
25	Heater Repairs			1991	840		7			840	25
26	Improvements			1993	737	19	10		(19)	737	26
27	Water Heater			1995	3,000		7			3,000	27
28	Air Conditioners			1995	5,627		5			5,627	28
29	Unit Heaters			1995	737		5			737	29
30	Exterior Doors			1995	628	16	39	16		282	30
31	Garage Door			1996	385		10			385	31
32	Parking Lot Repair			1996	6,655		20	333	333	5,496	32
33	Driveway			1996	22,572		20	1,129	1,129	18,633	33
34	Walk-in Freezer & Cooler			1996	12,333		10			12,333	34
35	Air Conditioning Units			1996	3,554		5			3,554	35
36	Draperies			1997	16,239		39	416	416	6,450	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 Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fencing	1997	$ 8,090	$ 207	39	$ 207	$	$ 3,210	37
38	Windows & Doors	1997	2,128		39	55	55	853	38
39	New Building Addition	1998	7,500		39	192	192	2,880	39
40	Time Clock System	1999	8,785		5			8,785	40
41	Air Conditioning Units	1999	7,589		5			7,589	41
42	Time Clock System	2001	1,452		5			1,452	42
43	Telephone Equipment	2001	1,850		5			1,850	43
44	Air Conditioning Units	2001	4,568		39	117	117	1,352	44
45	Window Screens	2001	1,400		39	36	36	415	45
46	Draperies	2001	4,118		39	106	106	1,258	46
47	Magnetic Door Holders	2002	1,350		7			1,350	47
48	6 Air Conditioner Units	2002	4,671		39	120	120	1,089	48
49	12 Resident Room Closet Doors	2002	2,346		39	60	60	555	49
50	Nurse Call System	2002	38,000		5			38,000	50
51	Magnetic Door Holders	2002	3,696		5			3,696	51
52	Signage	2003	1,698		7			1,698	52
53	Flooring	2002	1,731		10	173	173	1,453	53
54	Draperies	2003	1,052		7	2	2	1,052	54
55	Windows	2003	710		39	18	18	144	55
56	HVAC Units	2003	3,813		5			3,813	56
57	Carpeting	2003	10,994		10	1,099	1,099	8,792	57
58	Parking Lot	2004	26,879		15	1,792	1,792	14,336	58
59	HVAC Units	2004	5,825		5			5,825	59
60	Signage	2004	318		5			318	60
61	Security System	2004	18,600		5			18,600	61
62	HVAC Units	2005	484		5			484	62
63	Nurse call system	2005	6,231		5			6,231	63
64	Electrical cabling	2005	1,450		5			1,450	64
65	HVAC Units	2005	281		5			281	65
66	Air conditioning units	2006	1,656	146	7	237	91	1,500	66
67	Security System	2006	3,590	313	7	513	200	3,162	67
68	Draperies	2006	1,610		7	230	230	1,609	68
69	Toilets	2006	1,295		39	33	33	231	69
70	TOTAL (lines 4 thru 69)		$ 3,380,147	$ 701		$ 45,184	$ 44,483	$ 2,462,788	70

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,380,147	$ 701		$ 45,184	$ 44,483	$ 2,462,788	1
2	Interior doors	2006	2,200		39	56	56	383	2
3	Double egress doors	2006	5,908		39	151	151	1,017	3
4	Bathroom vanities	2006	1,104		39	28	28	185	4
5	Payroll time clock	2006	6,440		7	920	920	5,918	5
6	Telephone system	2006	669		7	96	96	610	6
7	Air conditioning units	2007	555	49	7	79	30	434	7
8	Generator & electrical panel	2008	2,500	112	7	357	245	1,518	8
9	Handrails	2008	1,864	48	39	48		224	9
10	HVAC Units	2008	1,096		7	157	157	773	10
11	Replacement Doors	2008	2,859		39	73	73	347	11
12	Fire Alarm System	2008	17,084		39	438	438	1,831	12
13	HVAC Units	2008	791		7	113	113	457	13
14	HVAC Units	2009	4,209		7	601	601	2,125	14
15	Fire door hinges	2009	1,338		7	191	191	743	15
16	Fire alarm system	2009	6,108		39	157	157	510	16
17	Wall guards	2009	1,553		7	222	222	697	17
18	Driveway repair	2010	4,604		15	307	307	666	18
19	Heat/AC units in rooms	2010	4,453		7	636	636	1,854	19
20	Kitchen roof exhaust vent	2010	1,430		7	204	204	562	20
21	Resident and interior doors - 12	2011	4,343		39	111	111	158	21
22	Wheelchair guards, kitchen disposal, vanities, toilets, 2 HVAC	2011	5,977		7	854	854	1,069	22
23	HVAC Units	2012	2,549		7	77	77	77	23
24	Cooling compressor	2012	2,627		7	183	183	183	24
25	Toilets, bath cabinets, sinks	2012	3,452		7	184	184	184	25
26	Communication sys, hot water booster, generator	2012	4,349		7	509	509	509	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,470,209	$ 910		$ 51,936	$ 51,026	$ 2,485,822	34

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 57,882	$ 854	$ 854	$	Various	$ 55,092	71
72	Current Year Purchases					Various		72
73	Fully Depreciated Assets	131,753					131,753	73
74								74
75	TOTALS	$ 189,635	$ 854	$ 854	$		$ 186,845	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,684,844	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,764	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,790	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 51,026	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,672,667	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 10,785 Description: Copier: $8,601; Mailing Machine: $2,184
(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.

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [x] NO

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		73	4,015		73	4,015	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits		134	13,440		134	13,440	5
6	Dental Care	39.3	visits		75	7,488		75	7,488	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Exceptional Care	39.2								12
13	Other (specify): Medical Supplies	39.2								13
14	TOTAL			$	282	$ 24,943	$	282	$ 24,943	14

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 727,124	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	617,398		3
4	Supply Inventory (priced at FIFO)	6,693		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(1,572)		7
8	Accounts Receivable (owners or related parties)	(802,792)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 546,851	$	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	15,923		15
16	Equipment, at Historical Cost	279,501		16
17	Accumulated Depreciation (book methods)	(239,969)		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)	$ 55,455	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 602,306	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 103,831	$	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)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 103,831	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ 103,831	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 498,475	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 602,306	$	48

*(See instructions.)

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 1,059,315	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(190,458)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 868,857	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	95,703	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	(466,085)	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)	$ (370,382)	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)	$ 498,475	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,162,711	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 4,162,711	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 4,162,711	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	904,340	31
32	Health Care	1,458,145	32
33	General Administration	689,919	33
	B. Capital Expense		
34	Ownership	743,214	34
	C. Ancillary Expense		
35	Special Cost Centers	7,508	35
36	Provider Participation Fee	263,882	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 4,067,008	40
41	Income before Income Taxes (line 30 minus line 40)**	95,703	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 95,703	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,053,871	44
45	Private Pay - Net Inpatient Revenue	108,840	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Rounding		47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,162,711	49

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

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	653	693	$ 27,272	$ 39.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,191	4,784	133,832	27.97	3
4	Licensed Practical Nurses	9,604	9,989	255,603	25.59	4
5	CNAs & Orderlies	50,563	53,217	655,451	12.32	5
6	CNA Trainees					6
7	Licensed Therapist	548	573	5,896	10.29	7
8	Rehab/Therapy Aides	549	570	9,356	16.41	8
9	Activity Director					9
10	Activity Assistants	2,982	3,157	39,003	12.35	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,009	2,080	35,094	16.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,593	15,657	191,091	12.20	15
16	Dishwashers					16
17	Maintenance Workers	6,399	6,710	116,313	17.33	17
18	Housekeepers	6,246	6,635	72,979	11.00	18
19	Laundry	7,647	8,177	96,115	11.75	19
20	Administrator	1,929	2,000	65,001	32.50	20
21	Assistant Administrator					21
22	Other Administrative	1,600	1,680	60,000	35.71	22
23	Office Manager					23
24	Clerical	4,751	5,111	97,788	19.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,885	4,000	87,695	21.92	28
29	Resident Services Coordinator	1,578	1,634	49,659	30.39	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	2,540	2,668	59,098	22.15	33
34	TOTAL (lines 1 - 33)	122,267	129,335	$ 2,057,246 *	$ 15.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	94	$ 2,538	1.3	35
36	Medical Director	34	3,360	9.3	36
37	Medical Records Consultant	21	1,025	10.3	37
38	Nurse Consultant	61	3,025	10.3	38
39	Pharmacist Consultant	48	4,803	10.3	39
40	Physical Therapy Consultant	50	3,489	10a.3	40
41	Occupational Therapy Consultant	12	744	10a.3	41
42	Respiratory Therapy Consultant			10a.3	42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	3	234	11.3	44
45	Social Service Consultant			12.3	45
46	Other(specify) Psychologist	72	5,040	12.3	46
47				12.3	47
48	Psychiatrist	49	12,312	12.3	48
49	TOTAL (lines 35 - 48)	444	$ 36,570		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Certified Nurse Assistants/Aides	239	9,779	10.3	52
53	TOTAL (lines 50 - 52)	239	$ 9,779		53

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robin Witt	Administrator		$ 65,001
Robin Witt	CFO / HR		60,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,001

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson	Accounting	$ 7,300
Robert Rein CPA	Consulting	3,200
Christenson Computer	Computer	5,589
ADP	Payroll	10,841
Achieve Health	Computer	5,712
Reclassification		837
Dac Easy	Consulting	491
Duane Morris	Legal	3,441
Burke, Warren, MacKay & Serritella	Legal	4,729
Ellen E. Douglas	Legal	920
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 43,060

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,123
Unemployment Compensation Insurance	32,220
FICA Taxes	153,253
Employee Health Insurance	133,034
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Appreciation	3,940
Employee Life/Disability	609
Employee Physicals	837
Allocation of Benefits	(1,782)
Rounding	
TOTAL (agree to Schedule V, line 22, col.8)	$ 409,234

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,555
Health Care Worker Background Check	455
(Indicate # of checks performed 13)	
Patient Background Checks	
IARF Membership Dues	6,409
Other Dues & Licenses	1,486
Sec of State/City of Rolling Meadows	1,103
Subscriptions	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,008

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	63
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 63

**See instructions.

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IARF Membership Dues 6,409

(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? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 12,713 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. $ 263,882
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.