

		FOR BHT 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.

I. IDPH License ID Number: 0021766

Facility Name: Meadows Sheltered Care, Inc.

Address: 3250 South Plum Grove Road Rolling Meadows 60008
Number City 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

☒ PROPRIETARY

☐ GOVERNMENTAL

☐ Charitable Corp.

☐ Individual

☐ State

☐ Trust

☐ Partnership

☐ County

IRS Exemption Code

☒ "Sub-S" Corp.

Other

☐ 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 01/01/2011 to 12/31/2011 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)

(Type or Print Name) Robin Witt

(Title) Administrator

Paid Preparer

(Signed)

(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: 01/01/2011 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	Skilled (SNF)			1
2	Skilled Pediatric (SNF/PED)			2
3	Intermediate (ICF)			3
4	99 Intermediate/DD	99	36,135	4
5	Sheltered Care (SC)			5
6	ICF/DD 16 or Less			6
7	99 TOTALS	99	36,135	7

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
8 SNF	-	-	-		8
9 SNF/PED					9
10 ICF	-	-			10
11 ICF/DD	30,276	730		31,006	11
12 SC	-	-			12
13 DD 16 OR LESS	-	-			13
14 TOTALS	30,276	730		31,006	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 0.858060053

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

ACCRAUAL x MODIFIED CASH* CASH*

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

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

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 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	
	A. General Services											
1	Dietary	230,206	22,865	4,266	257,337	-	257,337	-	257,337			1
2	Food Purchase		177,171		177,171	-	177,171	1,429	178,600			2
3	Housekeeping	83,534	29,234	-	112,768	-	112,768	-	112,768			3
4	Laundry	118,383	24,056	-	142,439	-	142,439	-	142,439			4
5	Heat and Other Utilities			94,679	94,679	-	94,679	-	94,679			5
6	Maintenance	144,496	14,355	66,182	225,033	-	225,033	-	225,033			6
7	Other (specify):*	-	-	-	-	-	-	-	-			7
8	TOTAL General Services	576,619	267,681	165,127	1,009,427	-	1,009,427	1,429	1,010,856			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	1,171,300	58,811	14,992	1,245,103		1,245,103		1,245,103			10
10a	Therapy	14,011		7,785	21,796	5,139	26,935		26,935			10a
11	Activities	31,681	4,667		36,348	976	37,324		37,324			11
12	Social Services	133,845		24,057	157,902	(6,115)	151,787		151,787			12
13	CNA Training				-		-		-			13
14	Program Transportation			94	94		94		94			14
15	Other (specify):*				-		-		-			15
16	TOTAL Health Care and Programs	1,350,837	63,478	63,728	1,478,043	(13,440)	1,464,603	-	1,464,603			16
	C. General Administration											
17	Administrative	123,924	-	-	123,924	-	123,924	(6,196)	117,728			17
18	Directors Fees			-	-	-	-	-	-			18
19	Professional Services			42,786	42,786	(2,309)	40,477	-	40,477			19
20	Dues, Fees, Subscriptions & Promotions			7,825	7,825	720	8,545	-	8,545			20
21	Clerical & General Office Expenses	103,055	17,313	9,585	129,953	(269)	129,684	28,261	157,945			21
22	Employee Benefits & Payroll Taxes			443,674	443,674	2,005	445,679	(3,063)	442,616			22
23	Inservice Training & Education			350	350	-	350	-	350			23
24	Travel and Seminar			204	204	-	204	-	204			24
25	Other Admin. Staff Transportation		-	-	-	-	-	-	-			25
26	Insurance-Prop.Liab.Malpractice			26,079	26,079	-	26,079	20,155	46,234			26
27	Other (specify):*		-	-	-	-	-	-	-			27
28	TOTAL General Administration	226,979	17,313	530,503	774,795	147	774,942	39,157	814,099			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,154,435	348,472	759,358	3,262,265	(13,293)	3,248,972	40,586	3,289,558			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			3,261	3,261	-	3,261	48,646	51,907			30
31	Amortization of Pre-Op. & Org.			-	-	-	-	-	-			31
32	Interest			-	-	-	-	156,662	156,662			32
33	Real Estate Taxes			-	-	-	-	148,687	148,687			33
34	Rent-Facility & Grounds			729,600	729,600	-	729,600	(729,600)	-			34
35	Rent-Equipment & Vehicles			10,212	10,212	(147)	10,065	-	10,065			35
36	Other (specify):*			-	-	-	-	-	-			36
37	TOTAL Ownership			743,073	743,073	(147)	742,926	(375,605)	367,321			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	-	-	-	-	-			38
39	Ancillary Service Centers	-	-	9,807	9,807	13,440	23,247	-	23,247			39
40	Barber and Beauty Shops	-	-	-	-	-	-	-	-			40
41	Coffee and Gift Shops	-	-	-	-	-	-	-	-			41
42	Provider Participation Fee	-	-	251,233	251,233	-	251,233	-	251,233			42
43	Other (specify):*	-	-	-	-	-	-	-	-			43
44	TOTAL Special Cost Centers	-	-	261,040	261,040	13,440	274,480	-	274,480			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,154,435	348,472	1,763,471	4,266,378	-	4,266,378	(335,019)	3,931,359			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.)

	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	1,458	30.3		9
10	Interest and Other Investment Income	(39)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	9,559			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 10,978		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(345,997)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (345,997)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (335,019)		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

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%	Zachary House	Streamwood			
Barbara S. Witt	50%	Zachary House	Streamwood			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	\$ 729,600	Byrn T. Witt & Barbara S. Witt	100%	\$ -	\$ (729,600)	1
2	V	17	Management Fee	-	Byrn T. Witt & Barbara S. Witt	100%	-	-	2
3	V	30	Depreciation	-	Byrn T. Witt & Barbara S. Witt	100%	48,253	48,253	3
4	V	32	Interest	-	Byrn T. Witt & Barbara S. Witt	100%	156,701	156,701	4
5	V	17		-			-	-	5
6	V	33	Real Estate Taxes	-	Byrn T. Witt & Barbara S. Witt	100%	148,687	148,687	6
7	V	17	Administration	117,728	Robin Witt		117,728	-	7
8	V	26	Property Insurance	-	Byrn T. Witt & Barbara S. Witt	100%	29,962	29,962	8
9	V			-			-	-	9
10	V			-			-	-	10
11	V			-			-	-	11
12	V			-			-	-	12
13	V			-			-	-	13
14	Total			\$ 847,328			\$ 501,331	\$ * (345,997)	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: 01/01/2011 Ending: 12/31/2011

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	Robin Witt	Administrator	Administration			38	0.95	Salary	117,728	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	\$ 117,728		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: 01/01/2011 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 ☒

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2	HUD		X	Debt Refinance / Bldg Constructio	Varies	2006	2,700,000	2,599,895	2046	0.0600	156,701		2
3													3
4										Interest Income Adju		(39)	4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$ 2,700,000	\$ 2,599,895			\$ 156,662		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	\$ 2,599,895			\$ 156,662		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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	260,921	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.)		\$	204,804	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(56,117)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	204,804	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.		\$	148,687	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	214,214	8	
		2007	223,540	9	
		2008	229,505	10	
		2009	260,921	11	
		2010	204,804	12	
Accrual based on current year assessment.		13	FROM R. E. TAX STATEMENT FOR 2010 \$	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: 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 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 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. <u>02-35-100-016-0000</u>	<u>3250 South Plum Grove Road</u>	\$ <u>204,804</u>	\$ <u>204,804</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>204,804</u>	\$ <u>204,804</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	587,838	5
6	1		1996	1996	15,000		39	385	385	5,857	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		266	30
31	Garage Door			1996	385		10			385	31
32	Parking Lot Repair			1996	6,655		20	333	333	5,163	32
33	Driveway			1996	22,572		20	1,129	1,129	17,504	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	6,034	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:

01/01/2011 Ending: 12/31/2011

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	
37 Fencing	1997	\$ 8,090	\$ 207	39	\$ 207	\$	\$ 3,003	37
38 Windows & Doors	1997	2,128		39	55	55	798	38
39 New Building Addition	1998	7,500		39	192	192	2,688	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	1,235	44
45 Window Screens	2001	1,400		39	36	36	379	45
46 Draperies	2001	4,118		39	106	106	1,152	46
47 Magnetic Door Holders	2002	1,350		7			1,350	47
48 6 Air Conditioner Units	2002	4,671		39	120	120	969	48
49 12 Resident Room Closet Doors	2002	2,346		39	60	60	495	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	240	240	1,698	52
53 Flooring	2002	1,731		10	173	173	1,280	53
54 Draperies	2003	1,052		7	150	150	1,050	54
55 Windows	2003	710		39	18	18	126	55
56 HVAC Units	2003	3,813		5			3,813	56
57 Carpeting	2003	10,994		10	1,099	1,099	7,693	57
58 Parking Lot	2004	26,879		15	1,792	1,792	12,544	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	1,263	66
67 Security System	2006	3,590	313	7	513	200	2,649	67
68 Draperies	2006	1,610		7	230	230	1,379	68
69 Toilets	2006	1,295		39	33	33	198	69
70 TOTAL (lines 4 thru 69)		\$ 3,380,147	\$ 701		\$ 45,572	\$ 44,871	\$ 2,417,604	70

**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 Totals from Page 12A, Carried Forward		\$ 3,380,147	\$ 701		\$ 45,572	\$ 44,871	\$ 2,417,604	1
2 Interior doors	2006	2,200		39	56	56	327	2
3 Double egress doors	2006	5,908		39	151	151	866	3
4 Bathroom vanities	2006	1,104		39	28	28	157	4
5 Payroll time clock	2006	6,440		7	920	920	4,998	5
6 Telephone system	2006	669		7	96	96	514	6
7 Air conditioning units	2007	555	52	7	79	27	355	7
8 Generator & electrical panel	2008	2,500	156	7	357	201	1,161	8
9 Handrails	2008	1,864	48	39	48		176	9
10 HVAC Units	2008	1,096		7	157	157	616	10
11 Replacement Doors	2008	2,859		39	73	73	274	11
12 Fire Alarm System	2008	17,084		39	438	438	1,393	12
13 HVAC Units	2008	791		7	113	113	344	13
14 HVAC Units	2009	4,209		7	601	601	1,524	14
15 Fire door hinges	2009	1,338		7	191	191	552	15
16 Fire alarm system	2009	6,108		39	157	157	353	16
17 Wall guards	2009	1,553		7	222	222	475	17
18 Driveway repair	2010	4,604		15	307	307	359	18
19 Heat/AC units in rooms	2010	4,453		7	636	636	1,218	19
20 Kitchen roof exhaust vent	2010	1,430		7	204	204	358	20
21 Resident and interior doors - 12	2011	4,343		39	47	47	47	21
22 Wheelchair guards, kitchen disposal, vanities, toilets, 2 HVAC	2011	5,977		7	215	215	215	22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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	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 12B, Carried Forward		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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	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 12C, Carried Forward		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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	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 12D, Carried Forward		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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	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 12E, Carried Forward		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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	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 12F, Carried Forward		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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	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 12G, Carried Forward		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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	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 12H, Carried Forward		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,457,232	\$ 957		\$ 50,668	\$ 49,711	\$ 2,433,886	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	\$ 57,609	\$ 966	\$ 966	\$	Various	\$ 53,965	71
72	Current Year Purchases	273	273	273		Various	273	72
73	Fully Depreciated Assets	131,753					131,753	73
74								74
75	TOTALS	\$ 189,635	\$ 1,239	\$ 1,239	\$		\$ 185,991	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)	\$ 3,671,867	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,196	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,907	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 49,711	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,619,877	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 10,065
- Description: Copier: \$7,881; 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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		173	7,785		173	7,785	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		98	9,807		98	9,807	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2								13
14	TOTAL			\$	405	\$ 31,032	\$	405	\$ 31,032	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.

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	\$ 76,325	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,656,460		3
4	Supply Inventory (priced at FIFO)	6,943		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,962		7
8	Accounts Receivable (owners or related parties)	(665,000)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,092,690	\$	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)	(237,140)		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)	\$ 58,284	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,150,974	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 91,659	\$	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)	\$ 91,659	\$	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)	\$ 91,659	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,059,315	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,150,974	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,010,971	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(15,288)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 995,683	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(31,597)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	95,229	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)	\$ 63,632	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,059,315	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,234,742	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,234,742	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***	39	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39	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)	\$ 4,234,781	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,009,427	31
32	Health Care	1,478,043	32
33	General Administration	774,795	33
	B. Capital Expense		
34	Ownership	743,073	34
	C. Ancillary Expense		
35	Special Cost Centers	9,807	35
36	Provider Participation Fee	251,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,266,378	40
41	Income before Income Taxes (line 30 minus line 40)**	(31,597)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (31,597)	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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,844	2,080	\$ 68,000	\$ 32.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,579	5,943	152,552	25.67	3
4	Licensed Practical Nurses	8,232	8,680	213,557	24.60	4
5	CNAs & Orderlies	53,251	56,927	680,791	11.96	5
6	CNA Trainees					6
7	Licensed Therapist	590	590	5,940	10.07	7
8	Rehab/Therapy Aides	492	492	8,071	16.40	8
9	Activity Director					9
10	Activity Assistants	2,319	2,509	31,681	12.63	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,878	2,080	35,094	16.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,501	18,009	195,112	10.83	15
16	Dishwashers					16
17	Maintenance Workers	8,282	9,037	144,496	15.99	17
18	Housekeepers	7,500	8,125	83,534	10.28	18
19	Laundry	10,574	11,678	118,383	10.14	19
20	Administrator	1,976	1,976	117,728	59.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,614	5,132	94,444	18.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,112	4,416	91,448	20.71	28
29	Resident Services Coordinator	1,734	1,798	42,397	23.58	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Behavior Dev'l	2,517	2,765	56,400	20.40	33
34	TOTAL (lines 1 - 33)	131,995	142,237	\$ 2,139,628 *	\$ 15.04	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	158	\$ 4,266	1.3	35
36	Medical Director	34	3,360	9.3	36
37	Medical Records Consultant	25	1,250	10.3	37
38	Nurse Consultant	74	3,688	10.3	38
39	Pharmacist Consultant	39	3,910	10.3	39
40	Physical Therapy Consultant	47	3,221	10a.3	40
41	Occupational Therapy Consultant	13	941	10a.3	41
42	Respiratory Therapy Consultant			10a.3	42
43	Speech Therapy Consultant	12	977	10a.3	43
44	Activity Consultant	16	976	11.3	44
45	Social Service Consultant			12.3	45
46	Other(specify) Psychologist	69	5,815	12.3	46
47					47
48	Psychiatrist	49	12,125	12.3	48
49	TOTAL (lines 35 - 48)	535	\$ 40,529		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Robin Witt	Administrator	-0-	123,924	Workers' Compensation Insurance		90,808	IDPH License Fee				
				Unemployment Compensation Insurance		32,164	Advertising: Employee Recruitment		250		
				FICA Taxes		158,743	Health Care Worker Background Check		1,050		
				Employee Health Insurance		155,085	(Indicate # of checks performed 28)				
				Employee Meals			Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			IARF Membership Dues		5,617		
				Staff Appreciation		6,045	Other Dues & Licenses		535		
				Employee Life/Disability		829	Sec of State/City of Rolling Meadows		1,093		
				Employee Physicals		2,005	Subscriptions				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)						\$ 123,924					
B. Administrative - Other											
Description			Amount	Allocation of Benefits		(3,063)	Less: Public Relations Expense		()		
			\$	Rounding			Non-allowable advertising		()		
							Yellow page advertising		()		
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 442,616	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 8,545		
TOTAL (agree to Schedule V, line 17, col. 3)											
(Attach a copy of any management service agreement)											
C. Professional Services						E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Clifton Gunderson	Accounting		\$ 7,177				Out-of-State Travel		\$		
Dukes Consulting	Consulting		1,100								
Robert Rein CPA	Consulting		3,200								
Christenson Computer	Computer		4,387				In-State Travel		204		
ADP	Payroll		10,843								
Achieve Health	Computer		5,712								
Reclassification			2,309								
Dac Easy	Consulting						Seminar Expense				
Duane Morris	Legal		2,680								
Warren Burke	Legal		4,265								
Fox Law Office	Legal		1,113								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense		()		
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)				
							TOTAL		\$ 204		

* Attach copy of IMRF notifications

**See instructions.

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. IARF Membership Dues 5,617

(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.

\$ 12,615

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.

\$ 251,233

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.