

		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: <u>0023275</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Sheltered Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>600 Borden St</u> <u>Woodstock</u> <u>60098</u>																									
Number City Zip Code																									
County: <u>McHenry</u>																									
Telephone Number: <u>815-338-6440</u> Fax # <u>815-338-0124</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>Compilation Report Attached</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Robert F X Keeler</u> <u>CPA</u></td></tr><tr><td>(Firm Name & Address) <u>Siepert & Co., LLP</u> <u>2380 Bethany Road Sycamore, IL 60178</u></td></tr><tr><td>(Telephone) <u>815-787-7657</u> Fax # <u>815-787-6797</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>Compilation Report Attached</u>	Paid Preparer	(Print Name and Title) <u>Robert F X Keeler</u> <u>CPA</u>	(Firm Name & Address) <u>Siepert & Co., LLP</u> <u>2380 Bethany Road Sycamore, IL 60178</u>	(Telephone) <u>815-787-7657</u> Fax # <u>815-787-6797</u>	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												
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	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																								
Date of Initial License for Current Owners: <u>01/01/1977</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Robert Keeler</u> Telephone Number: <u>815-751-2080</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village# 0023275 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 96

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>96</u>	Intermediate/DD	<u>96</u>	<u>35,136</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>96</u>	TOTALS	<u>96</u>	<u>35,136</u>	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			<u>Hospice</u>		8
9	SNF/PED					9
10	ICF	<u>32,757</u>	<u>366</u>	<u>384</u>	<u>33,507</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,757</u>	<u>366</u>	<u>384</u>	<u>33,507</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.36%

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

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/AF. Does the facility maintain a daily midnight census? yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 01/01/1977

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

YES ☐ Date NO ☒

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

YES ☐ NO ☒ If YES, enter number
of beds certified and days of care provided Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: December 31 Fiscal Year: December 31

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

SEE ACCOUNTANTS' COMPILATION REPORT

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	175,756	19,692	6,979	202,427		202,427		202,427		1
2	Food Purchase		221,394		221,394		221,394	(429)	220,965		2
3	Housekeeping	67,723	23,798		91,521		91,521		91,521		3
4	Laundry	24,168	6,889		31,057		31,057		31,057		4
5	Heat and Other Utilities			71,942	71,942		71,942		71,942		5
6	Maintenance	130,933	26,898	12,724	170,555		170,555		170,555		6
7	Other (specify):*										7
8	TOTAL General Services	398,580	298,671	91,645	788,896		788,896	(429)	788,467		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,450,528	99,769	41,555	1,591,852		1,591,852		1,591,852		10
10a	Therapy										10a
11	Activities	132,433	2,440	120	134,993		134,993		134,993		11
12	Social Services	313,668	3,824	27,691	345,183	(12,535)	332,648		332,648		12
13	CNA Training	24,576			24,576	12,919	37,495		37,495		13
14	Program Transportation			23,279	23,279	(4,576)	18,703		18,703		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,921,205	106,033	92,645	2,119,883	(4,192)	2,115,691		2,115,691		16
	C. General Administration										
17	Administrative	270,767			270,767		270,767		270,767		17
18	Directors Fees			72,000	72,000		72,000		72,000		18
19	Professional Services			25,201	25,201		25,201		25,201		19
20	Dues, Fees, Subscriptions & Promotions			4,540	4,540		4,540	(130)	4,410		20
21	Clerical & General Office Expenses	98,796	9,466	23,220	131,482	(384)	131,098		131,098		21
22	Employee Benefits & Payroll Taxes			595,158	595,158		595,158		595,158		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,738	5,738		5,738		5,738		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,914	51,914		51,914		51,914		26
27	Other (specify):*										27
28	TOTAL General Administration	369,563	9,466	777,771	1,156,800	(384)	1,156,416	(130)	1,156,286		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,689,348	414,170	962,061	4,065,579	(4,576)	4,061,003	(559)	4,060,444		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			51,288	51,288	4,576	55,864	30,159	86,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,295	61,295		61,295	(211)	61,084			32
33	Real Estate Taxes			53,137	53,137		53,137		53,137			33
34	Rent-Facility & Grounds			228,000	228,000		228,000	(228,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			393,720	393,720	4,576	398,296	(198,052)	200,244			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			255,012	255,012							42
43	Other (specify):* Day Training	307,665		184,438	492,103			(492,103)				43
44	TOTAL Special Cost Centers	307,665		439,450	747,115			(492,103)				44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,997,013	414,170	1,795,231	5,206,414		4,459,299	(690,714)	4,260,688			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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				9
10	Interest and Other Investment Income	(211)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(429)	2		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	(130)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(720,103)	34/43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (720,873)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	30,159	30	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 30,159		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (690,714)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sheltered Village

ID#

0023275

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/12 Ending: 12/31/12

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(429)	0	0	0	0	0	0	0	0	0	0	(429)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(429)	0	0	0	0	0	0	0	0	0	0	(429)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(130)	0	0	0	0	0	0	0	0	0	0	(130)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(130)	0	0	0	0	0	0	0	0	0	0	(130)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(559)	0	0	0	0	0	0	0	0	0	0	(559)	29

STATE OF ILLINOIS

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	30,159	0	0	0	0	0	0	0	0	0	0	30,159	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(211)	0	0	0	0	0	0	0	0	0	0	(211)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	29,948	0	0	0	0	0	0	0	0	0	0	29,948	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	29,389	0	0	0	0	0	0	0	0	0	0	29,389	45

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
Forest Steel Company	100%					

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

YES

NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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	Robert R Bowman	President		**				Director Fees	\$ 12,000	18-3	1
2	Robert R Bowman	Physical Plant				35	80.00	Wage	156,000	17-1	2
3	Pamela S Bowman	Vice President		**				Director Fees	12,000	18-3	3
4	Edward A Rosenow	Secretary						Director Fees	12,000	18-3	4
5	Robert F X Keeler	Treasurer						Director Fees	12,000	18-3	5
6	Robb Bowman	Director						Director Fees	12,000	18-3	6
7	Amy McCue	Director						Director Fees	12,000	18-3	7
8	Amy McCue	Speech Therapist				16	40.00		20,600	12-1	8
9											9
10											10
11	** Robert & Pamela Bowman own 100% of Forest Steel Company which owns 100% of Dorr Wood Ltd.										11
12											12
13								TOTAL	\$ 248,600		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

SEE ACCOUNTANTS' COMPILATION REPORT

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													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Harris Bank		X	Working Capital		9/30/12	2,500,000	360,328	9/30/13	5.2500	51,555	6		
7	Robert Keeler		X	Working Capital		12/30/11	150,000	150,000	Demand	5.0000	7,500	7		
8	Interest on Trade payables										2,240	8		
9	TOTAL Facility Related						\$ 2,650,000	\$ 510,328			\$ 61,295	9		
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	\$			\$	14		
15	TOTALS (line 9+line14)						\$ 2,650,000	\$ 510,328			\$ 61,295	15		

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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 2011 report.		\$	54,100	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.)		\$	52,957	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,143)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	54,280	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.		\$	53,137	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	45,307	8	
		2008	48,350	9	
		2009	49,425	10	
		2010	52,026	11	
		2011	52,957	12	
Accrual @ 12/31/12				13	FOR BHF USE ONLY
52957@ 1.025% = 54280.				14	FROM R. E. TAX STATEMENT FOR 2011 \$
				15	PLUS APPEAL COST FROM LINE 5 \$
				16	LESS REFUND FROM LINE 6 \$
				17	AMOUNT TO USE FOR RATE CALCULATION \$

- 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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Sheltered Village</u>	COUNTY	<u>McHenry</u>
---------------	--------------------------	--------	----------------

FACILITY IDPH LICENSE NUMBER 0023275

CONTACT PERSON REGARDING THIS REPORT Robert Norris

TELEPHONE 815-338-6440 FAX #: 815-338-0124

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 13 06 326 001	600 Borden Street	\$ 52,957.00	\$ 52,957.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
	TOTALS	\$ 52,957.00	\$ 52,957.00

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,800

B. General Construction Type: Exterior Brick Frame Wood

Number of Stories One

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Residential Care	4.9 Acres	1991	\$ 50,000	1
2					2
3	TOTALS	#VALUE!		\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	96		1991		\$ 950,000	\$	31.5	\$ 30,159	\$ 30,159	\$ 662,237
5										
6										
7										
8										
	Improvement Type**									
9	Blacktop		1995		8,986		15			8,986
10	Concrete Sidewalk & Patio		2000		3,851	257	15	257		3,252
11	90 x 40 Building Addition & Remodel		2003		629,115	16,131	39	16,131		148,541
12	Remodel Shower Area		2004		27,050	694	39	694		6,040
13	Blacktop Walkway		2006		11,675	778	15	778		5,059
14	Replace Resident Room Doors		2006		11,614	290	39	290		1,875
15	Attic Fire Walls		2011		9,743	244	39	244		375
16	Roof Work		2011		18,691	467	39	467		565
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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
SEE ACCOUNTANTS' COMPILATION REPORT

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,670,725	\$ 18,861		\$ 49,020	\$ 30,159	\$ 836,930	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$219,482	\$30,944	\$30,944	\$	5 to 7	\$100,872	71
72	Current Year Purchases	18,587	1,483	1,483		5 to 7	1,483	72
73	Fully Depreciated Assets	412,404					412,404	73
74								74
75	TOTALS	\$650,473	\$32,427	\$32,427	\$		\$514,759	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	Resident Transportation	2005 Chevy G35 Van	2006	\$23,394	\$	\$	\$	5	\$23,394	76
77	Resident Transportation	2009 Chevy Impala	2010	30,180	2,950	2,950		5	9,135	77
78	Resident Transportation	2012 Dodge Van	2012	16,264	1,626	1,626		5	1,626	78
79										79
80	TOTALS			\$69,838	\$4,576	\$4,576	\$		\$34,155	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)	\$2,441,036	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$55,864	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$86,023	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$30,159	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,385,844	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	Day Training Assets	\$99,835	\$9,141	\$53,644	86
87					87
88					88
89					89
90					90
91	TOTALS	\$99,835	\$9,141	\$53,644	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Trust 134-1435 (Controlled by Robert & Pamela Bowman)
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:	1969	96	01/01/1991	\$ 228,000			3
4	Additions							4
5								5
6								6
7	TOTAL		96		\$ 228,000			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: \$ Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 01/01/12
Ending 12/31/12

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/13	\$ 228,000
13.	12/31/14	\$ not started
14.	12/31/15	\$ not started

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 CNA76

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA92

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		384		384
3	Classroom Wages (a)		11,059		11,059
4	Clinical Wages (b)		13,517		13,517
5	In-House Trainer Wages (c)		12,535		12,535
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 37,495	\$	\$ 37,495
10	SUM OF line 9, col. 1 and 2 (e)	\$ 37,495			

COMPLETED	
1. From this facility	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

(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.

SEE ACCOUNTANTS' COMPILATION REPORT

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		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$ None	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 87,800	\$	1
2	Cash-Patient Deposits	6,258		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	790,256		3
4	Supply Inventory (priced at)	6,258		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,462		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 919,034	\$	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	720,725		15
16	Equipment, at Historical Cost	720,311		16
17	Accumulated Depreciation (book methods)	(723,608)		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): Day Training Equipment Net	46,191		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 763,619	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,682,653	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 97,030	\$	26
27	Officer's Accounts Payable	7,164		27
28	Accounts Payable-Patient Deposits	6,258		28
29	Short-Term Notes Payable	510,328		29
30	Accrued Salaries Payable	73,600		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,280		32
33	Accrued Interest Payable	1,875		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)	\$ 750,535	\$	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)	\$ 750,535	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 932,118	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,682,653	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,122,470	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,122,470	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(190,353)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (190,352)	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)	\$ 932,118	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village# 0023275Report Period Beginning: 01/01/12Ending: 12/31/12**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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,285,753	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,285,753	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	36,471	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)	\$ 36,471	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	211	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 211	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Commissary Income Net	2,147	28
28a	Day Training Income	691,479	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 693,626	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,016,061	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	788,896	31
32	Health Care	2,119,883	32
33	General Administration	1,156,800	33
	B. Capital Expense		
34	Ownership	393,720	34
	C. Ancillary Expense		
35	Special Cost Centers	492,103	35
36	Provider Participation Fee	255,012	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,206,414	40
41	Income before Income Taxes (line 30 minus line 40)**	(190,353)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (190,353)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,437,679	44
45	Private Pay - Net Inpatient Revenue	61,550	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Social Security & VA</u>	784,804	47
48	Other-(specify) <u>State of Illinois - Transportation</u>	1,720	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,285,753	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? _____ 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	1,912	2,080	\$ 97,000	\$ 46.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,728	12,391	327,501	26.43	3
4	Licensed Practical Nurses	5,912	6,785	174,051	25.65	4
5	CNAs & Orderlies					5
6	CNA Trainees	2,533	2,533	24,576	9.70	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,056	2,227	32,311	14.51	9
10	Activity Assistants	10,188	10,328	100,122	9.69	10
11	Social Service Workers	1,918	2,135	48,411	22.67	11
12	Dietician					12
13	Food Service Supervisor	2,044	2,228	42,399	19.03	13
14	Head Cook	1,796	1,964	27,719	14.11	14
15	Cook Helpers/Assistants	4,392	4,569	53,053	11.61	15
16	Dishwashers	5,692	5,840	52,585	9.00	16
17	Maintenance Workers	6,449	7,246	130,933	18.07	17
18	Housekeepers	6,759	7,326	67,723	9.24	18
19	Laundry	2,414	2,510	24,168	9.63	19
20	Administrator	2,040	2,080	114,767	55.18	20
21	Assistant Administrator					21
22	Other Administrative	1,820	2,080	156,000	75.00	22
23	Office Manager					23
24	Clerical	3,527	4,052	98,796	24.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,240	11,991	204,372	17.04	28
29	Resident Services Coordinator	1,973	2,139	60,885	28.46	29
30	Habilitation Aides (DD Homes)	62,326	66,346	820,769	12.37	30
31	Medical Records	1,856	2,089	31,207	14.94	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Day Training</u>	22,641	25,013	307,665	12.30	33
34	TOTAL (lines 1 - 33)	173,216	185,952	\$ 2,997,013 *	\$ 16.12	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	145	\$ 6,960	1-3	35
36	Medical Director	96	24,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,097	10-3	39
40	Physical Therapy Consultant	26	2,267	10-3	40
41	Occupational Therapy Consultant	16	825	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	370	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	48	3,264	12-3	45
46	Other(specify) <u>Psychiatrist</u>	48	3,600	12-3	46
47	<u>Behavioral Consultant</u>	971	21,363	12-3	47
48	<u>Dental Consultant</u>	52	1,735	10-3	48
49	TOTAL (lines 35 - 48)	1,507	\$ 65,481		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 325	10-3	50
51	Licensed Practical Nurses	8	135	10-3	51
52	Certified Nurse Assistants/Aides	201	1,660	10-3	52
53	TOTAL (lines 50 - 52)	225	\$ 2,120		53

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID NumberSheltered Village# 0023275Report Period Beginning: 01/01/12Ending: 12/31/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Norris	Administration	0	\$ 114,767
Robert Bowman	Physical Plant	100	156,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 270,767

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
Siepert & Co., LLP	CPA	\$ 19,165
McHenry County Health Dept.	Health Permis	300
Fauago & Gorman	Legal	1,200
Jay Filler PC	Legal	242
Orchard Trust LLC	401k Fee	325
Illinois Depart of Human Services		200
Access I Source	ELEC Time Clock	3,035
Payroll	Payroll	734
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 25,201

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 195,645	
Unemployment Compensation Insurance	25,823	
FICA Taxes	221,460	
Employee Health Insurance	221,132	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Less DT Program Fringes	(68,902)	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 595,158

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	3,116	
Health Care Worker Background Check (Indicate # of checks performed 24)	923	
Patient Background Checks 6	96	
Other Advertising	130	
Dues	275	
Less: Public Relations Expense	()	
Non-allowable advertising	(130)	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,410

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	1,522
Seminar Expense	4,216
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 5,738

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

IL Nursing Home Admin (\$100) MES/HSPI of IL (\$175)
- (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 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 0

Line
- (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.

\$ 225,012

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

Yes

If YES, attach an explanation of the allocation.

- (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.

\$ None

Has any meal income been offset against related costs?

None

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?

Yes

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ 1,720

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

Yes

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ 0 Vehicle not in report
- (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?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT