FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0021766

Facility Name: Meadows

Address: 3250 S Plum Grove Rd (Number) Rolling Meadows (City) 60008 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 08/1975

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Doreatha Norris 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 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Doreatha Norris
(Title) Administrator

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)		-	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	99	Intermediate/DD	99	36,135	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.

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	9
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	30,064							30,064	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	30,064							30,064	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 83.20%

D. How many bed reserve days during this year were paid by the Department?
104 (Do not include bed reserve 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 certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
1	Dietary	231,980	20,328	8,010	260,318		260,318		260,318			1
2	Food Purchase		296,897		296,897		296,897		296,897			2
3	Housekeeping	115,198	16,526		131,724		131,724		131,724			3
4	Laundry		32,924		32,924		32,924		32,924			4
5	Heat and Other Utilities			156,341	156,341		156,341		156,341			5
6	Maintenance	59,100	19,712	187,468	266,280		266,280		266,280			6
7	Other (specify):*											7
8	TOTAL General Services	406,278	386,387	351,819	1,144,484		1,144,484		1,144,484			8
	B. Health Care and Programs											
9	Medical Director			21,900	21,900	(21,058)	842		842			9
10	Nursing and Medical Records	2,063,303	162,828	258,059	2,484,190		2,484,190	(1,662)	2,482,528			10
10a	Therapy											10a
11	Activities	116,892	6,065	770	123,727		123,727		123,727			11
12	Social Services	146,900		17,235	164,135	(292)	163,843		163,843			12
13	CNA Training											13
14	Program Transportation			8	8		8		8			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,327,095	168,893	297,972	2,793,960	(21,350)	2,772,610	(1,662)	2,770,948			16
	C. General Administration											
17	Administrative	162,469			162,469		162,469	(65,811)	96,658			17
18	Directors Fees											18
19	Professional Services			77,271	77,271	(2,136)	75,135		75,135			19
20	Dues, Fees, Subscriptions & Promotions			1,600	1,600	(443)	1,157		1,157			20
21	Clerical & General Office Expenses	194,163	15,795	27,987	237,945	2,938	240,883	(37,643)	203,240			21
22	Employee Benefits & Payroll Taxes			388,751	388,751		388,751	(10,066)	378,685			22
23	Inservice Training & Education			1,450	1,450		1,450		1,450			23
24	Travel and Seminar			930	930		930		930			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			133,000	133,000		133,000	257,514	390,514			26
27	Other (specify):*											27
28	TOTAL General Administration	356,632	15,795	630,989	1,003,416	359	1,003,775	143,994	1,147,769			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,090,005	571,075	1,280,780	4,941,860	(20,991)	4,920,869	142,332	5,063,201			29

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. #0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			5,635	5,635	(67)	5,568	60,410	65,978			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							48,522	48,522			32
33	Real Estate Taxes							392,578	392,578			33
34	Rent-Facility & Grounds			855,000	855,000		855,000	(855,000)				34
35	Rent-Equipment & Vehicles			6,753	6,753		6,753		6,753			35
36	Other (specify):* Income Tax			52,360	52,360		52,360		52,360			36
37	TOTAL Ownership			919,748	919,748	(67)	919,681	(353,490)	566,191			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			4,098	4,098	21,058	25,156		25,156			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			385,234	385,234		385,234		385,234			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			389,332	389,332	21,058	410,390		410,390			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,090,005	571,075	2,589,860	6,250,940		6,250,940	(211,158)	6,039,782			45

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	16,597	30.3		9
10	Interest and Other Investment Income	(45)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees		13		27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(191,794)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (175,242)		$	30

BHF USE ONLY								
48		49		50		51	52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,916)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (35,916)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (211,158)		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		21,058	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)			$ 21,058		47

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Byrn T. Witt	50.00%	Zachary House	Streamwood			
Barbara S. Witt	50.00%	Zachary House	Streamwood			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 855,000	Byrn T. Witt & Barbara S. Witt	100.00%	$	$ (855,000)	1
2	V								2
3	V	30	Depreciation		Byrn T. Witt & Barbara S. Witt	100.00%	45,588	45,588	3
4	V	32	Interest		Byrn T. Witt & Barbara S. Witt	100.00%	48,567	48,567	4
5	V	17							5
6	V	33	Real Estate Taxes		Byrn T. Witt & Barbara S. Witt	100.00%	392,578	392,578	6
7	V								7
8	V	26	Property Insurance		Byrn T. Witt & Barbara S. Witt	100.00%	332,351	332,351	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 855000			$ 819,084	$ * (35,916)	14

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

STATE OF ILLINOIS — Ownership Listing-1

Meadows Sheltered Care, Inc.

ID# 0021766

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	*Place of Residence* City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Byrn	T	Witt	Arlington Heights	IL	50.00000			1
2	Barbara	S	Witt	Arlington Heights	IL	50.00000			2
3									3
4									4
5									5
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75									75

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	HUD		X	Debt Refinance / Bldg Constructi	Varies	2006	2,700,000	1,992,216	2046	0.0239	48,567	2
3					-							3
4					-					Interest Income	-45	4
5					-							5
	Working Capital											
6					-							6
7					-						-	7
8					-							8
9	TOTAL Facility Related						$ 2,700,000	$ 1,992,216			$ 48,522	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	$ 1,992,216			$ 48,522	15

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.	$ 386,934	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.)		$ 389,756	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,822	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 389,756	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.		$ 392,578	7

Assessed Value from Real Estate Tax Bill: 2024 1,173,927 (8)

Real Estate Tax Bill for Calendar Year:

2020	267,916	9
2021	271,960	10
2022	352,719	11
2023	386,934	12
2024	389,756	13

Accrual based on current year assessment.

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13	FROM R. E. TAX STATEMENT FOR 2024	$	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.

2024 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 Doreatha Norris

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 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-35-100-016-0000		$ 389,756.00	$ 389,756.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 389,756.00	$ 389,756.00

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numbe Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. 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.

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	1,118,648	5
6	1		1996	1996	15,000		39	385	385	11,247	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	Roof			1990	3,527		20			3,527	21
22	Kitchen			1990	2,319		10			2,319	22
23	Heater Repairs			1991	840		7			840	23
24	Improvements			1993	737		10			737	24
25	Water Heater			1995	3,000		7			3,000	25
26	Exterior Doors			1995	628	16	39	16		490	26
27	Garage Door			1996	385		10			385	27
28	Parking Lot Repair			1996	6,655		20			6,655	28
29	Driveway			1996	22,572		20			22,572	29
30	Walk-in Freezer & Cooler			1996	12,333		10			12,333	30
31	Draperies			1997	16,239		39	416	416	11,858	31
32	Fencing			1997	8,090	207	39	207		5,901	32
33	Windows & Doors			1997	2,128		39	55	55	1,568	33
34	New Building Addition			1998	7,500		39	192	192	5,376	34
35	Telephone Equipment			2001	1,850		5			1,850	35
36	Air Conditioning Units			2001	4,568		39	117	117	2,873	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: 01/01/2025 Ending: 12/31/2025

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	Window Screens	2001	$ 1,400	$	39	$ 36	$ 36	$ 883	37
38	Draperies	2001	4,118		39	106	106	2,636	38
39	Magnetic Door Holders	2002	1,350		7			1,350	39
40	6 Air Conditioner Units	2002	4,671		39	120	120	2,649	40
41	12 Resident Room Closet Doors	2002	2,346		39	60	60	1,335	41
42	Nurse Call System	2002	38,000		5			38,000	42
43	Magnetic Door Holders	2002	3,696		5			3,696	43
44	Signage	2003	1,698		7			1,698	44
45	Flooring	2002	1,731		10			1,731	45
46	Draperies	2003	1,052		7			1,052	46
47	Windows	2003	710		39	18	18	378	47
48	HVAC Units	2003	3,813		5			3,813	48
49	Carpeting	2003	10,994		10			10,994	49
50	Parking Lot	2004	26,879		15			26,879	50
51	HVAC Units	2004	5,825		5			5,825	51
52	Security System	2004	18,600		5			18,600	52
53	HVAC Units	2005	484		5			484	53
54	Nurse call system	2005	6,231		5			6,231	54
55	Electrical cabling	2005	1,450		5			1,450	55
56	HVAC Units	2005	281		5			281	56
57	Security System	2006	3,590		7			3,590	57
58	Double egress doors	2006	5,908		39	151	151	2,980	58
59	Generator & electrical panel	2008	2,500		7			2,500	59
60	Replacement Doors	2008	2,859		39	73	73	1,296	60
61	Fire Alarm System	2008	17,084		39	438	438	7,525	61
62	HVAC Units	2009	4,209		7			4,209	62
63	Fire alarm system	2009	6,108		39	157	157	2,551	63
64	Driveway repair	2010	4,604		15	254	254	4,604	64
65	Heat/AC units in rooms	2010	4,453		7			4,453	65
66	Resident and interior doors - 12	2011	4,343		39	111	111	1,601	66
67	Wheelchair guards, kitchen disposal, vanities, toilets, 2 HVAC	2011	2,876		7			2,876	67
68	HVAC Units	2012	2,549		7			2,549	68
69	Cooling compressor	2012	2,627		7			2,627	69
70	TOTAL (lines 4 thru 69)		$ 3,393,340	$ 223		$ 40,827	$ 40,604	$ 2,992,761	70

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,393,340	$ 223		$ 40,827	$ 40,604	$ 2,992,761	1
2	Toilets, bath cabinets, sinks	2012	3,452		7			3,452	2
3	Replacement Water Heater	2013	4,310		7			4,310	3
4	New flooring main hallways	2014	80,327		39	2,060	2,060	24,381	4
5	Door alarm replacement panel	2014	3,549		5			3,549	5
6	Exterior Door & Locking system	2015	3,765		39	97	97	1,066	6
7	Activity Flooring	2015	3,488		39	89	89	979	7
8	Sprinkler System	2015	20,274		39	520	520	5,384	8
9	5 ton condenser unit & HVAC unit	2015	6,478		39	166	166	1,746	9
10	Staff lounge flooring	2016	2,586		5			2,586	10
11	Exterior fencing	2016	5,500		15	367	367	3,363	11
12	New driveway by dumpster	2016	3,830		15	255	255	2,337	12
13	100 amp electrical panel	2017	9,000		7			9,000	13
14	Resident room flooring all rooms 1 - 49	2017	63,720	1,634	39	1,634		13,341	14
15	Direct Supply Flooring all rooms 1 - 49	2017	27,513		39	705	705	5,698	15
16	Electrical cabling entire building	2017	3,483		7			3,483	16
17	Plank Flooring all rooms 1 - 49	2018	10,634		39	273	273	2,183	17
18	Furnace/AC-Hallway D:Activities & Office	2021	13,037		7	1,862	1,862	8,494	18
19	Heater/AC wall units in rooms 26, 39, 40, 44	2022	3,102		7	443	443	1,365	19
20	HVAC rooftop and grnd condensing units-common areas	2022	16,303		39	418	418	1,671	20
21	Camera System whole building security & resident safety	2024	4,357		7	622	622	905	21
22	A/C compressor kitchen HVAC unit	2024	4,050		39	104	104	159	22
23	Hot water heater	2025	16,685		7	1,979	1,979	1,979	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)		$ 3,702,783	$ 1,857		$ 52,421	$ 50,564	$ 3,094,192	34

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	$ 173,823	$ 61	$ 83	$ 22	Various	$ 145,205	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	76,653					76,653	73
74								74
75	TOTALS	$ 250,476	$ 61	$ 83	$ 22		$ 221,858	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	Mini Van	Dodge, 2014	2014	$ 39,713	$ 1,875	$	$ (1,875)	5	$ 39,713	76
77	Lift for Dodge		2017	8,749				5	8,749	77
78	Van	Ford 2021	2021	67,368		13,474	13,474	5	60,947	78
79										79
80	TOTALS			$ 115,830	$ 1,875	$ 13,474	$ 11,599		$ 109,409	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)	$ 4,094,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 3,793	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,978	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 62,185	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,425,459	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.

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

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

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.	/2026	$
13.	/2027	$
14.	/2028	$

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

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

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

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

16. Rental Amount for movable equipment: $ 6,753 Description: Copier: $5,852; Mailing Machine: $901
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits		261	21,058		261	21,058	5
6	Dental Care	39.3	visits		41	4,098		41	4,098	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Exceptional Care	39.2								12
13	Other (specify): Medical Supplies	39.2								13
14	TOTAL			$	302	$ 25,156	$	302	$ 25,156	14

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2025 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 660,514	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	342,523		3
4	Supply Inventory (priced at FIFO)	6,693		4
5	Short-Term Investments			5
6	Prepaid Insurance	271,354		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	43,339		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 1,324,423	$	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	119,658		15
16	Equipment, at Historical Cost	411,081		16
17	Accumulated Depreciation (book methods)	(447,346)		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)	$ 83,393	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 1,407,816	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 197,982	$	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	A/P Other			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ 197,982	$	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)	$ 197,982	$	46
47	TOTAL EQUITY(page 18, line 24)	$ 1,209,834	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 1,407,816	$	48

*(See instructions.)

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 1,934,807	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments		4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 1,934,807	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	166,837	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	(891,810)	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)	$ (724,973)	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)	$ 1,209,834	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,399,667	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 6,399,667	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***	45	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 45	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Period Adjustment		28
28a	Miscellaneous Income	18,065	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 18,065	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 6,417,777	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,144,484	31
32	Health Care	2,793,960	32
33	General Administration	1,003,416	33
	B. Capital Expense		
34	Ownership	919,748	34
	C. Ancillary Expense		
35	Special Cost Centers	4,098	35
36	Provider Participation Fee	385,234	36
	D. Other Expenses (specify):		
37	Miscellaneous		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 6,250,940	40
41	Income before Income Taxes (line 30 minus line 40)**	166,837	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 166,837	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 6,399,667	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	-	45
46	MMAI-Medicaid is the Primary Payer	-	46
47	MMAI-Medicare is the Primary Payer	-	47
48	Private Pay	-	48
49	Mediciare Part A	-	49
50	Other-(specify)	-	50
51	Other-(specify)	-	51
52	Other-(specify)	-	52
53	Other-(specify)	-	53
54	Other-(specify) Rounding	-	54
55	Other-(specify)	-	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,399,667	56

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,974	2,051	$ 138,150	$ 67.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,669	4,826	266,610	55.24	3
4	Licensed Practical Nurses	7,712	8,123	434,780	53.52	4
5	CNAs & Orderlies	37,435	39,320	1,037,129	26.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,197	5,295	116,892	22.08	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,038	10,636	231,980	21.81	15
16	Dishwashers					16
17	Maintenance Workers	2,799	2,964	59,100	19.94	17
18	Housekeepers	5,672	5,846	115,198	19.71	18
19	Laundry					19
20	Administrator	1,151	1,222	96,658	79.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,207	6,780	181,626	26.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	4,048	4,120	146,900	35.66	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Behavior Dev'l	4,235	4,591	184,972	40.29	33
34	TOTAL (lines 1 - 33)	91,137	95,774	$ 3,009,995 *	$ 31.43	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	178	$ 8,010	1.3	35
36	Medical Director	10	842	9.3	36
37	Medical Records Consultant			10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	82	8,204	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant			10a.3	42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	11	770	11.3	44
45	Social Service Consultant			12.3	45
46	Other(specify) Psychologist	26	2,318	12.3	46
47					47
48	Psychiatrist	49	14,625	12.3	48
49	TOTAL (lines 35 - 48)	356	$ 34,769		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	129	$ 12,948	10.3	50
51	Licensed Practical Nurses	977	79,099	10.3	51
52	Certified Nurse Assistants/Aides	3,840	155,186	10.3	52
53	TOTAL (lines 50 - 52)	4,945	$ 247,232		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
See schedule			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 162,469

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
		$
See schedule		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 77,271

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,026
Unemployment Compensation Insurance	18,294
FICA Taxes	228,781
Employee Health Insurance	87,788
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Appreciation	1,623
Employee Life/Disability	239
Employee Physicals	
Allocation of Benefits	(10,066)
Rounding	
TOTAL (agree to Schedule V, line 22, col.8)	$ 378,685

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	280
(Indicate # of checks performed 8)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	
Other Dues & Licenses	
Sec of State/City of Rolling Meadows	877
Subscriptions	
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,157

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	930
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 930

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
Other, please specify	-
Other, please specify	
	- Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

Other, please specify	-
Other, please sp	
	- Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

Other, please specify	-
Other, please sp	-
	-
	-
	- Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 53,292 Line 10.2

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 385,234
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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

(10) 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.

(11) 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. $ -

(12) 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. $ Zero

(13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name:

(14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.