FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0023275

Facility Name: Sheltered Village

Address: 600 Borden Street (Number) Woodstock (City) 60098 (Zip Code)

County: McHenry

Telephone Number: 815-338-6440 **Fax #** 815-338-0124

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1977

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: Robert Keeler **Telephone Number:** 815-787-7657
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 01/01/10 to 12/31/10 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)
(Title)

Paid Preparer

(Signed) Compilation Report Attached (Date)
(Print Name and Title) Robert F. X. Keeler, CPA
(Firm Name & Address) Siepert & Co., LLP, 2380 Bethany Road Sycamore, IL 60178
(Telephone) 815-787-7657 Fax # 815-787-6797

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	96	Intermediate/DD	96	35,040	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	31,670	365		32,035	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,670	365		32,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.42%

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

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 [X]

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

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

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	167,334	17,641	7,660	192,635		192,635		192,635			1
2	Food Purchase		192,839		192,839		192,839	(342)	192,497			2
3	Housekeeping	107,443	21,414		128,857		128,857		128,857			3
4	Laundry	26,855	3,810		30,665		30,665		30,665			4
5	Heat and Other Utilities			78,227	78,227		78,227		78,227			5
6	Maintenance	64,887	17,683	11,719	94,289		94,289		94,289			6
7	Other (specify):*											7
8	TOTAL General Services	366,519	253,387	97,606	717,512		717,512	(342)	717,170			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,198,289	72,257	15,801	1,286,347	(4,822)	1,281,525		1,281,525			10
10a	Therapy											10a
11	Activities	210,782	2,804		213,586		213,586		213,586			11
12	Social Services	252,490	2,412	27,998	282,900		282,900		282,900			12
13	CNA Training	24,866			24,866	5,258	30,124		30,124			13
14	Program Transportation			24,943	24,943	(9,989)	14,954		14,954			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,686,427	77,473	92,742	1,856,642	(9,553)	1,847,089		1,847,089			16
	C. General Administration											
17	Administrative	266,915			266,915		266,915		266,915			17
18	Directors Fees			72,000	72,000		72,000		72,000			18
19	Professional Services			23,814	23,814		23,814		23,814			19
20	Dues, Fees, Subscriptions & Promotions			4,270	4,270		4,270	(1,641)	2,629			20
21	Clerical & General Office Expenses	100,449	15,209	7,717	123,375	(436)	122,939		122,939			21
22	Employee Benefits & Payroll Taxes			550,612	550,612		550,612		550,612			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,477	6,477		6,477		6,477			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,103	52,103		52,103		52,103			26
27	Other (specify):* Contribution			95	95		95	(95)				27
28	TOTAL General Administration	367,364	15,209	717,088	1,099,661	(436)	1,099,225	(1,736)	1,097,489			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,420,310	346,069	907,436	3,673,815	(9,989)	3,663,826	(2,078)	3,661,748			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 Sheltered Village #0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,366	41,366	9,989	51,355	39,159	90,514			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,005	24,005		24,005	(14,277)	9,728			32
33	Real Estate Taxes			50,025	50,025		50,025		50,025			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**			343,396	343,396	9,989	353,385	(203,118)	150,267			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			216,814	216,814		216,814		216,814			42
43	Other (specify):* **Day Training**	297,113	11,262	173,760	482,135		482,135	(482,135)				43
44	**TOTAL Special Cost Centers**	297,113	11,262	390,574	698,949		698,949	(482,135)	216,814			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,717,423	357,331	1,641,406	4,716,160		4,716,160	(687,331)	4,028,829			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 Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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				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	(14,277)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(342)	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	(95)	27		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	(1,641)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(710,135)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (726,490)		$	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)			34
35	Other- Attach Schedule	39,159		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 39,159		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (687,331)		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						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

Sheltered Village

ID# 0023275

Report Period Beginning: 01/01/10

Ending: 12/31/10

	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:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(342)	0	0	0	0	0	0	0	0	0	0	(342)	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**	(342)	0	0	0	0	0	0	0	0	0	0	(342)	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	(1,641)	0	0	0	0	0	0	0	0	0	0	(1,641)	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):*	(95)	0	0	0	0	0	0	0	0	0	0	(95)	27
28	**TOTAL General Administration**	(1,736)	0	0	0	0	0	0	0	0	0	0	(1,736)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,078)	0	0	0	0	0	0	0	0	0	0	(2,078)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheltered Village # 0023275 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,277)	0	0	0	0	0	0	0	0	0	0	(14,277)	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**	(14,277)	0	0	0	0	0	0	0	0	0	0	(14,277)	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(16,355)	0	0	0	0	0	0	0	0	0	0	(16,355)	45

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 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			$			$	$	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.**

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Robert R. Bowman	President		**				Director Fee	$ 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 Fee	12,000	18-3	3
4	Edward A. Rosenow	Secretary						Director Fee	12,000	18-3	4
5	Robert F.X. Keeler	Treasurer						Director Fee	12,000	18-3	5
6	Robb Bowman	Director						Director Fee	12,000	18-3	6
7	Amy McCue	Director						Director Fee	12,000	18-3	7
8	Amy McCue	Speech Therapist				16	40.00	Wage	16,346	12-1	8
9											9
10											10
11	** Robert and Pamela Bowman own 100% of Forest Steel Company which owns 100% of Dorr Wood Ltd.										11
12											12
13								TOTAL	$ 244,346		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 Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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												2
3												3
4												4
5												5
	Working Capital											
6	Harris Bank N.A.		X	Working Capital		10/2010	1,500,000	26,350	10/2010	5.2500	24,005	6
7				Line of Credit						Prime plus 2%		7
8												8
9	TOTAL Facility Related						$ 1,500,000	$ 26,350			$ 24,005	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,500,000	$ 26,350			$ 24,005	15

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

*** 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 Sheltered Village # 0023275 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 49,800	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.)		$ 49,425	2
3. Under or (over) accrual (line 2 minus line 1).		$ (375)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 50,400	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.		$ 50,025	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	42,437	8
	2006	43,637	9
	2007	45,307	10
	2008	48,350	11
	2009	49,425	12

2010 Accrual $49,425 @ 1.02% = 50,400 Rounded

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheltered Village COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0023275

CONTACT PERSON REGARDING THIS REPORT Robert Keeler

TELEPHONE 815-787-7657 FAX #: 815-787-6797

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13 06 326 001	600 Borden Street	$ 49,425.00	$ 49,425.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,425.00	$ 49,425.00

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,800 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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 [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	96		1991		$ 950,000	$	31.5	$ 30,159	$ 30,159	$ 601,919	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Blacktop			1995	8,986	548	15	548		8,986	9
10	Concrete Sidewalk and Patio			2000	3,851	257	15	257		2,738	10
11	90 x 40 Building Addition an Remodel			2003	629,115	16,131	39	16,131		116,279	11
12	Remodel Shower Area			2004	27,050	694	39	694		4,653	12
13	Blacktop Walkway			2006	11,675	778	15	778		3,503	13
14	Replace Resident Room Doors			2006	11,614	290	39	290		1,295	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

*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 Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)		$ 1,642,291	$ 18,698		$ 48,857	$ 30,159	$ 739,373	70

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 162,519	$ 20,334	$ 20,334	$	5 to 7	$ 106,287	71
72	Current Year Purchases	32,673	2,334	2,334		5 to 7	2,334	72
73	Fully Depreciated Assets	346,802					346,802	73
74								74
75	TOTALS	$ 541,994	$ 22,668	$ 22,668	$		$ 455,423	75

D. Vehicle Depreciation (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	Res Trans	2004 Chev G35 Van	2005	$ 22,501	$ 2,250	$ 2,250	$	5	$ 22,501	76
77	Res Trans	2005 Chev G35 Van	2006	23,395	4,679	4,679		5	21,055	77
78	Res Trans	2009 Chev Impala	2010	30,180	1,285	1,285		5	1,285	78
79	Res Trans	2002 Buick Traded	2002		1,775	1,775				79
80	TOTALS			$ 76,076	$ 9,989	$ 9,989	$		$ 44,841	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)	$ 2,310,361	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,355	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 81,514	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)	$ 1,239,637	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	$ 80,685	$ 7,913	$ 47,251	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 80,685	$ 7,913	$ 47,251	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 Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Trust 134-1435 (Controlled by Robert 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. [X] 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	01/01/91	$ 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 [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 01/01/10
    Ending 12/31/10

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2011	$ 228,000
13.	12/31/2012	$ not stated
14.	12/31/2013	$ not stated

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

* 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 Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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?
   [X] 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 [X]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA 80

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	26	410		436
3	Classroom Wages (a)	212	11,834		12,046
4	Clinical Wages (b)		12,820		12,820
5	In-House Trainer Wages (c)		4,822		4,822
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 238	$ 29,886	$	$ 30,124
10	SUM OF line 9, col. 1 and 2 (e)	$ 30,124			

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	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	17

(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 Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

STATE OF ILLINOIS

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$ 134,338	$	1
2	Cash-Patient Deposits	5,090		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	506,977		3
4	Supply Inventory (priced at Cost)	7,393		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,430		6
7	Other Prepaid Expenses	15,365		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 722,593	$	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	692,291		15
16	Equipment, at Historical Cost	618,069		16
17	Accumulated Depreciation (book methods)	(637,717)		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 Equip Net	33,434		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 706,077	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,428,670	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 155,746	$	26
27	Officer's Accounts Payable	7,375		27
28	Accounts Payable-Patient Deposits	5,090		28
29	Short-Term Notes Payable	26,350		29
30	Accrued Salaries Payable	46,950		30
31	Accrued Taxes Payable (excluding real estate taxes)	50,400		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 291,911	$	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)**	$ 291,911	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,136,759	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,428,670	$	48

*(See instructions.)

Facility Name & ID Number Sheltered Village # 0023275 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,200,384	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,200,384	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(63,620)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) **Rounding**	(5)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (63,625)	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)**	$ 1,136,759	24 *

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,971,610	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,971,610	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***	14,277	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,277	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Commissary net of expenses	3,702	28
28a	Day Training Income	662,951	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 666,653	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,652,540	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	717,512	31
32	Health Care	1,856,642	32
33	General Administration	1,099,661	33
	B. Capital Expense		
34	Ownership	343,396	34
	C. Ancillary Expense		
35	Special Cost Centers	482,135	35
36	Provider Participation Fee	216,814	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,716,160	40
41	**Income before Income Taxes (line 30 minus line 40)****	(63,620)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (63,620)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

50% of meals = 502

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

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1,902	2,080	$ 72,800	$ 35.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,025	10,348	270,422	26.13	3
4	Licensed Practical Nurses	7,162	7,849	191,690	24.42	4
5	CNAs & Orderlies					5
6	CNA Trainees	2,580	2,580	24,866	9.64	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,130	47,985	22.53	9
10	Activity Assistants	14,197	14,460	158,269	10.95	10
11	Social Service Workers	1,893	2,182	30,775	14.10	11
12	Dietician					12
13	Food Service Supervisor	1,930	2,150	39,177	18.22	13
14	Head Cook	1,702	1,902	26,629	14.00	14
15	Cook Helpers/Assistants	3,842	4,092	46,729	11.42	15
16	Dishwashers	5,864	6,073	54,799	9.02	16
17	Maintenance Workers	3,053	3,261	64,887	19.90	17
18	Housekeepers	8,200	9,943	107,443	10.81	18
19	Laundry	2,181	2,251	26,855	11.93	19
20	Administrator	1,960	2,080	110,915	53.32	20
21	Assistant Administrator					21
22	Other Administrative	1,820	2,080	156,000	75.00	22
23	Office Manager					23
24	Clerical	3,756	4,112	100,449	24.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,547	12,576	201,175	16.00	28
29	Resident Services Coordinator	1,956	2,138	54,031	25.27	29
30	Habilitation Aides (DD Homes)	49,423	53,223	604,959	11.37	30
31	Medical Records	1,772	2,004	29,454	14.70	31
32	Other Health Care(specify)					32
33	Other(specify) DT Program	18,947	21,414	297,113	13.87	33
34	TOTAL (lines 1 - 33)	157,618	170,928	$ 2,717,422 *	$ 15.90	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	150	$ 7,660	1-3	35
36	Medical Director	96	24,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,081	10-3	39
40	Physical Therapy Consultant	16	1,378	10-3	40
41	Occupational Therapy Consultant	23	1,994	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	13	500	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	40	2,600	12-3	45
46	Other(specify) Psychiatrist	48	3,600	12-3	46
47	Behavior Consultant	1,016	21,835	12-3	47
48	Dental Consultant	12	1,316	10-3	48
49	TOTAL (lines 35 - 48)	1,510	$ 65,964		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 320	10-3	50
51	Licensed Practical Nurses	25	459	10-3	51
52	Certified Nurse Assistants/Aides	160	1,323	10-3	52
53	TOTAL (lines 50 - 52)	201	$ 2,102		53

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Norris	Administrator		$ 110,915
Robert Bowman	Physical Plant	100	156,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 266,915

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	$ 23,000
McHenry County Health Dept.	Food License	300
Payroll Service	Payroll fees	514
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 23,814

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 164,326
Unemployment Compensation Insurance	14,207
FICA Taxes	198,402
Employee Health Insurance	241,090
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	(67,413)
Less DT Program Fringes	
TOTAL (agree to Schedule V, line 22, col.8)	$ 550,612

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,414
Health Care Worker Background Check	860
(Indicate # of checks performed 29)	
Patient Background Checks 7	
Other Advertising	1,641
Dues - See below	
MES/HSPI of Illinois Dues	175
CPE Dues	100
DDNA	80
Less: Public Relations Expense	( )
Non-allowable advertising	(1,641)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,629

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,003
Seminar Expense	5,474
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,477

**See instructions.

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

Facility Name & ID Number Sheltered Village **#** 0023275 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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? **355**
If YES, give association name and amount. **Dues detail on page 21**

(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? **5-7 year**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** 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. $ **216,814**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** 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. $ **1,567**
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? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES, Personal use credited to vehicle expense**
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.

Dorr Wood Ltd.

Detail of Seminars

Date	Sponsor	Title	Location	
2/2/10	CPI J. Collins - QMRP	Profeciency Plus	Northbrook	$549.00
2/17/10	Phoenix A. Kumm - Aide	Pren of health and Wellness	On-line	$240.00
5/19/10	PESI T. Miller - LPN J. Esposito - LPN	Acute Renal Failure	Schaumburg	$348.00
4/28/10	PESI T. Miller - LPN J. Esposito - LPN	P T Crisis	Illinois	$348.00
3/5/10	PESI In House Seminar	Crisis Prevention	Woodstock	$662.00
3/24/10	PESI A. McCue - Speech		Illinois	$199.00
5/15/10	DDNA C. Couris - DON	DDNA Conference	Illinois	$395.00
7/20/10	Safe Food Handelers D. Pena - Cook	Safe Food Handling	Crystal Lake	$170.00
5/4/10	Phoenix EDU A. Kumm - Aide	Communication	On-line	$240.00
5/20/10	IL Nurse Home Assn. R. Bowman	IL Nursing Home Admin.	Lake Carroll	$95.00
6/18/10	PESI T. Miller - LPN J. Esposito - LPN	Nursing Documentation	Illinois	$348.00

7/15/10	INR R. Bowman R. Norris L. Marsh	Food Addictions	Crystal Lake	$243.00
7/20/10	Phoenix EDU A. Kumm - Aide	Psychology	On-line	$240.00
8/12/2010	AZER C. Lockenger - Hab Tech B Hathaway - Hab Tech	Restorative Nursing	Galesburg	$240.00
9/9/2010	Illinois Dept. Public health		Illinois	$35.00
12/8/2010	INR R. Bowman R. Norris L. Marsh	Arthritis/Bone Disease	Crystal Lake	$258.00
	Health Education network		Illinois	$338.00
11/4/2010	NIDBA C. Couris - DON T. Miller - LPN	What's New DD Nursing	Illinois	$250.00
11/15/2010	Illinois Nursing Home Admin Association		Illinois	$100.00
11/8/2010	 B. Hathcock - RN		Illinois	$176.00
		TOTAL		**$5,474.00**

Dorr-Wood Ltd.
Reclassifications
12/31/2010

Reclassifications - Sch V

		DR	CR
30-3	Depreciation	9,989	
14-3	Program Transportation		9,989
Reclassify Vehicle Depreciation			
13-2	CNA Training	436	
21-2	Clerical & General Office		436
Reclassify Training and Supplies			
13-1	CNA Traning	4,822	
10-1	Nursing and Medical Records		4,822
Reclassify Trainer Wages			

Reclassifications - Sch VI

Line		Reference	Amount
29	Related Party Rent	34	$228,000.00
	Day Training Program Expense	43	$482,135.00
	Total Line 29		**$710,135.00**
35	Building Depreciation	30	$39,159.00

Dorr-Wood Ltd.
d/b/a Sheltered Village
Detail of Travel
12/31/2010

3/4/2010	Business	Meeting Sorrento's Ranch	Sycamore, IL	$99.00
3/13/2010	Business	Meeting Rosita's Restaurant	DeKalb, IL	$103.00
5/11/2010	Business	Meeting Sorrento's Ranch	Sycamore, IL	$225.00
6/8/2010	Business	Meeting Sorrento's Ranch	Sycamore, IL	$226.00
8/4/2010	Business	Meeting Washington Street Station	Woodstock, IL	$129.00
9/15/2010	Business	Meeting Sorrento's Ranch	Sycamore, IL	$141.00
12/10/2010	Business	Meeting Village Square	Crystal Lake, IL	$80.00
			TOTAL	**$1,003.00**