FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 8153386440 **Fax #** 815 3386803

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
			"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:** 815-751-2080
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 01/01/2015 to 12/31/2015 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) Robert Norris
(Title) Administrator

Paid Preparer

(Signed) _____ 04/25/2016 (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 n/a

	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	30,930	395	332	31,657	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,930	395	332	31,657	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.35%

D. How many bed-hold days during this year were paid by the Department?
1,052 (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 01/01/1997

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: December Fiscal Year: December

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

Facility Name & ID Number Sheltered Village # 0023275 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	196,941	31,462	6,912	235,315		235,315		235,315			1
2	Food Purchase		226,048		226,048		226,048	(565)	225,483			2
3	Housekeeping	61,382	25,465		86,847		86,847		86,847			3
4	Laundry	27,831	4,101		31,932		31,932		31,932			4
5	Heat and Other Utilities			69,454	69,454		69,454		69,454			5
6	Maintenance	95,110	17,792	26,816	139,718		139,718		139,718			6
7	Other (specify):*											7
8	**TOTAL General Services**	381,264	304,868	103,182	789,314		789,314	(565)	788,749			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,573,338	121,079	47,318	1,741,735		1,741,735		1,741,735			10
10a	Therapy											10a
11	Activities	159,031	4,416	200	163,647		163,647		163,647			11
12	Social Services	310,987	1,955	27,750	340,692		340,692		340,692			12
13	CNA Training	13,893			13,893	306	14,199		14,199			13
14	Program Transportation			28,488	28,488	(6,590)	21,898		21,898			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,057,249	127,450	103,756	2,288,455	(6,284)	2,282,171		2,282,171			16
	C. General Administration											
17	Administrative	137,143			137,143		137,143		137,143			17
18	Directors Fees			18,000	18,000		18,000		18,000			18
19	Professional Services			11,107	11,107		11,107		11,107			19
20	Dues, Fees, Subscriptions & Promotions			14,922	14,922		14,922		14,922			20
21	Clerical & General Office Expenses	105,983	10,009	20,142	136,134	(2,442)	133,692		133,692			21
22	Employee Benefits & Payroll Taxes			419,432	419,432		419,432		419,432			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,814	6,814		6,814		6,814			24
25	Other Admin. Staff Transportation			57,673	57,673		57,673		57,673			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	243,126	10,009	548,090	801,225	(2,442)	798,783		798,783			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,681,639	442,327	755,028	3,878,994	(8,726)	3,870,268	(565)	3,869,703			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:** 01/01/2015 **Ending:** 12/31/2015

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			52,960	52,960	6,590	59,550	30,159	89,709			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,540	25,540	2,136	27,676	(41)	27,635			32
33	Real Estate Taxes			69,879	69,879		69,879		69,879			33
34	Rent-Facility & Grounds			195,000	195,000		195,000	(195,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			343,379	343,379	8,726	352,105	(164,882)	187,223			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			250,076	250,076		250,076		250,076			42
43	Other (specify):* **Day Training**	335,684	13,078	158,572	507,334		507,334	(507,334)				43
44	**TOTAL Special Cost Centers**	335,684	13,078	408,648	757,410		757,410	(507,334)	250,076			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,017,323	455,405	1,507,055	4,979,783		4,979,783	(672,781)	4,307,002			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: 01/01/2015 Ending: 12/31/2015

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	(41)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(565)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 see schedule	(702,334)	34/43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (702,940)		$	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	30,159	30	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 30,159		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (672,781)		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: 01/01/2015

Ending: 12/31/2015

	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:** 01/01/2015 **Ending:** 12/31/2015

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	(565)	0	0	0	0	0	0	0	0	0	0	(565)	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**	(565)	0	0	0	0	0	0	0	0	0	0	(565)	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(565)	0	0	0	0	0	0	0	0	0	0	(565)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheltered Village # 0023275 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	30,159	0	0	0	0	0	0	0	0	0	0	30,159	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(41)	0	0	0	0	0	0	0	0	0	0	(41)	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**	30,118	0	0	0	0	0	0	0	0	0	0	30,118	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)**	29,553	0	0	0	0	0	0	0	0	0	0	29,553	45

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Forest Steel Company	100					
Robert and Pamela Bowman own 100% of Forest Steel Company						

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 [x] 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: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 9,000	18-3	1
2	Pamela S Bowman	Vice-President		**				Director Fee	9,000	18-3	2
3	Robert F Keeler	Treasurer				4	10.00	Wage	9,000	17-1	3
4	Edward Rosenow	Secretary									4
5	Robb Bowman	Director									5
6	Amy McCue	Speech Therapist				20	45.00	Wage	25,571	12-1	6
7											7
8											8
9											9
10	Robert And Pamela Bowman own 100% of Forest Steel Company which owns 100% of DORR-WOOD LTD										10
11											11
12											12
13								TOTAL	$ 52,571		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: 01/01/2015 Ending: 2/31/2015

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: 01/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BMO Harris		x	Working Capital		9/30/2016	2,500,000	496,725	9/30/2017	4.7500	27,327	6
7	Interest On trade payables										349	7
8												8
9	TOTAL Facility Related						$ 2,500,000	$ 496,725			$ 27,676	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,500,000	$ 496,725			$ 27,676	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** n/a **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:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 67,870	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.)		$ 67,194	2
3. Under or (over) accrual (line 2 minus line 1).		$ (676)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,555	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.		$ 69,879	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	52,026	8
	2011	52,957	9
	2012	60,169	10
	2013	64,639	11
	2014	67,194	12

Accrual @ 12/31/2015

67194 @105%=70554 Rounded to 70555

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheltered Village COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0023275

CONTACT PERSON REGARDING THIS REPORT Robert Norris

TELEPHONE 815-338-6440 FAX #: 815-338-6803

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13 06 326 001	600 Borden St	$ 33,597.00	$ 33,597.00
2.		Woodstock Illinois	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 33,597.00	$ 33,597.00

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,500 B. General Construction Type: Exterior brick Frame Wood 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 [ ] (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: 01/01/2015 Ending: 12/31/2015

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	96		1991		$ 950,000	$	31.5	$ 30,159	$ 30,159	$ 752,714	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Blacktop			1995	8,986		15			8,986	9
10	Concrete sidewalk and patio			2000	3,851	86	15		(86)	3,851	10
11	90X40 Addition and Remodeling			2003	629,115	16,131	39		(16,131)	196,935	11
12	Remodel shower area			2004	27,050	694	39		(694)	8,121	12
13	Blacktop Walkway			2006	11,675	778	15		(778)	7,394	13
14	Replace Residential room doors			2006	11,614	290	39		(290)	2,746	14
15	Attach fire walls			2011	9,743	244	39		(244)	1,106	15
16	Roof Work			2011	18,691	467	37		(467)	1,966	16
17	Widen Resident Doors			2013	7,580	189	39		(189)	425	17
18	Roof work			2014	13,100	1,245	15		(1,245)	1,900	18
19	Deposit on New entry door			2015	4,053						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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,695,458	$ 20,124		$ 30,159	$ 10,035	$ 986,144	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: 01/01/2015 Ending: 12/31/2015

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	$ 223,794	$ 32,578	$	$ (32,578)	5 to 7	$ 151,147	71
72	Current Year Purchases	3,608	258		(258)	5 to 7	258	72
73	Fully Depreciated Assets	465,900					465,900	73
74								74
75	TOTALS	$ 693,302	$ 32,836	$	$ (32,836)		$ 617,305	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	resident transport	2009 Chevy Impala	2010	$ 30,180	$ 1,775	$ 1,775	$	5	$ 14,460	76
77	resident transport	2012 Dodge Caravan	2012	16,264	1,875	1,875		5	9,904	77
78	resident transport	2014 Chevy C3500Van	2015	29,402	2,940	2,940		5	2,940	78
79										79
80	TOTALS			$ 75,846	$ 6,590	$ 6,590	$		$ 27,304	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)	$ 2,514,606	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 59,550	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,749	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,801)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,630,753	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	$ 106,588	$ 9,906	$ 84,242	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 106,588	$ 9,906	$ 84,242	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: 01/01/2015 Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1969	96	01/01/1991	$ 195,000			3
4	Additions		Full rent not paid for 2015					4
5								5
6								6
7	TOTAL		96		$ 195,000 **			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 september 2013
    Ending open

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2016	$ 264,000
13.	12/31/2017	$ 264,000
14.	12/31/2018	$ 264,000

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: $ 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: 01/01/2015 Ending: 12/31/2015

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	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		306		306
3	Classroom Wages (a)		4,622		4,622
4	Clinical Wages (b)		9,271		9,271
5	In-House Trainer Wages (c)		10,027		10,027
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 24,226	$	$ 24,226
10	SUM OF line 9, col. 1 and 2 (e)	$ 24,226			

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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 225,937	$	1
2	Cash-Patient Deposits	20,667		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	596,547		3
4	Supply Inventory (priced at)	5,405		4
5	Short-Term Investments			5
6	Prepaid Insurance	81,174		6
7	Other Prepaid Expenses	8,295		7
8	Accounts Receivable (owners or related parties)	13,086		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 951,111	$	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	741,405		15
16	Equipment, at Historical Cost	773,202		16
17	Accumulated Depreciation (book methods)	(878,039)		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): DT Training net	22,346		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 658,914	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,610,025	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 77,978	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,667		28
29	Short-Term Notes Payable	496,725		29
30	Accrued Salaries Payable	97,250		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,555		32
33	Accrued Interest Payable	810		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)**	$ 763,985	$	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)**	$ 763,985	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 846,040	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,610,025	$	48

***(See instructions.)**

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 712,935	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 712,935	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	133,107	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	(2)	14
15	Other (describe) **rounding**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 133,105	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)**	$ 846,040	24 *

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,317,878	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,317,878	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	18,900	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)**	$ 18,900	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	41	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training Program	775,465	28
28a	Commisary Income Net	606	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 776,071	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,112,890	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	789,314	31
32	Health Care	2,288,455	32
33	General Administration	801,225	33
	B. Capital Expense		
34	Ownership	343,379	34
	C. Ancillary Expense		
35	Special Cost Centers	507,334	35
36	Provider Participation Fee	250,076	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,979,783	40
41	**Income before Income Taxes (line 30 minus line 40)****	133,107	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 133,107	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,462,109	44
45	Private Pay - Net Inpatient Revenue	13,353	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)	841,096	47
48	Other-(specify)	1,320	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,317,878	49

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

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

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

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	2,040	2,080	$ 91,870	$ 44.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,104	18,453	434,674	23.56	3
4	Licensed Practical Nurses	6,473	6,995	181,036	25.88	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,440	1,440	13,893	9.65	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,101	2,293	36,363	15.86	9
10	Activity Assistants	12,204	12,539	122,668	9.78	10
11	Social Service Workers	1,939	2,106	48,845	23.19	11
12	Dietician					12
13	Food Service Supervisor	2,078	2,309	47,951	20.77	13
14	Head Cook	2,062	2,270	32,167	14.17	14
15	Cook Helpers/Assistants	5,303	5,842	69,455	11.89	15
16	Dishwashers	4,318	4,534	47,368	10.45	16
17	Maintenance Workers	5,186	5,494	95,110	17.31	17
18	Housekeepers	5,873	6,391	61,382	9.60	18
19	Laundry	2,390	2,508	27,831	11.10	19
20	Administrator	1,960	2,080	128,143	61.61	20
21	Assistant Administrator					21
22	Other Administrative	180	180	9,000	50.00	22
23	Office Manager					23
24	Clerical	3,396	4,132	105,983	25.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,921	8,402	200,139	23.82	28
29	Resident Services Coordinator	1,880	2,101	62,003	29.51	29
30	Habilitation Aides (DD Homes)	64,908	68,710	834,745	12.15	30
31	Medical Records	1,571	1,829	31,013	16.96	31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	22,437	24,653	335,684	13.62	33
34	TOTAL (lines 1 - 33)	175,764	187,341	$ 3,017,323 *	$ 16.11	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	144	$ 6,912	1-3	35
36	Medical Director	96	27,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	117	3,421	10-3	39
40	Physical Therapy Consultant	22	1,919	10-3	40
41	Occupational Therapy Consultant	16	800	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	204	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	48	3,264	12-3	45
46	Other(specify) Psychiatrist	39	3,600	12-3	46
47	Behavior Consultant	1,040	18,945	12-3	47
48	Dental Consultant	50	3,349	10-3	48
49	TOTAL (lines 35 - 48)	1,579	$ 69,414		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	8	167	10-3	51
52	Certified Nurse Assistants/Aides	118	971	10-3	52
53	TOTAL (lines 50 - 52)	126	$ 1,138		53

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Norris	Administrator	0	$ 128,143
Robert Keeler	CPA Treasurer	0	9,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 137,143

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
Access 1 Source	Timekeeping	$ 1,881
McHenry County	Kitchen Permit	300
Fed Ex	Payroll Services	806
B M Redlin CPA	401k Audit	6,500
Siepert & Co. LLP	CPA	1,620
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 11,107

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 151,750
Unemployment Compensation Insurance	17,875
FICA Taxes	228,062
Employee Health Insurance	75,676
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	1,397
Less Day Training Fringes	(55,328)
TOTAL (agree to Schedule V, line 22, col.8)	$ 419,432

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	12,319
Health Care Worker Background Check	549
(Indicate # of checks performed)	
Patient Background Checks	48
Dues and Subscriptions	635
Website	1,220
Paper Subscription	151
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,922

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,843
Seminar Expense	4,971
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,814

**See instructions.

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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:** **01/01/2015** **Ending:** **12/31/2015**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See schedule**

(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? **7yr**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **none** 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. $ **250,076**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **n/a** 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. $ **1,320**
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? **Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **Vehicles in DT assets**

(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) 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. **No Legal Fees**
Attach invoices and a summary of services for all architect and appraisal fees.

DORR-WOOD LTD | COST REPORT | Detail of Seminars | SUPPORTING DATA 2015

DATE	TITLE	NAME	TITLE	LOCATION	SPONSOR	COST
02 11 15	Discover Path to Successful Restorative Programs	3 staff	3 RNA	Schaumburg	Cross County Education	$ 567.00
03 10 15	SAFE FOOD HANDLING	Elijah Roberts	cook	Crystal Lake	Safe Food Handlers Corp	$ 190.00
03 12 15	His Health/Her Health	2 nurses	DON, Infectn Control Nurse	Crystal Lake	INR	$ 162.00
03 12 15	His Health/Her Health	Laura Marsh	Asst.Admin	Crystal Lake	INR	$ 81.00
03 20 15	First Aid & CPR	7 staff	1 QIDP & 6 DSP	Woodstock	A-Tec Ambulance Service	$ 180.00
04 06 15	First Aid & CPR	3 staff	DSP	Woodstock	A-Tec Ambulance Service	$ 90.00
05 14 15	Understanding Relationships	3 staff	Admin, Owner, RN	Crystal Lake	INR	$ 228.00
06 10 15	Wound Care Essentials	2 staff	DON, Infect'n. Control Nurse	Schaumburg	PESI	$ 740.00
08 24 15	CPR	4 nurses	3 RN 1 LPN	Woodstock	A-Tec Ambulance Service	$ 90.00
08 31 15	CPR	4 nurses	1LPN, 3RN	Woodstock	A-Tec Ambulance Service	$ 90.00
09 04 15	CPR	4 staff	2 DSP, MTC, cook	Woodstock	A-Tec Ambulance Service	$ 90.00
09 28 15	First Aid	7 staff	5 DSP, MTC, cook,1RNA	Woodstock	A-Tec Ambulance Service	$ 90.00
09 29 15	First Aid	8 staff	1QIDP,2cook,4DSP,1RNA	Woodstock	A-Tec Ambulance Service	$ 90.00
09 29 15	First Aid	4 staff	4 DSP	Woodstock	A-Tec Ambulance Service	$ 90.00
09 30 15	First Aid	4 staff	1 DSP, 3 Activity Aides	Woodstock	A-Tec Ambulance Service	$ 90.00
10 01 15	First Aid	9 staff	3DSP,2Act,2cook,1Q,1dishes	Woodstock	A-Tec Ambulance Service	$ 90.00
10 01 15	First Aid	9 staff	4DSP,3Act,2Q	Woodstock	A-Tec Ambulance Service	$ 90.00
10 24 15	Therapeutic Strategies for .Degenerative Joint Disease	3 staff	3 RNA	Gurnee	PESI	$ 600.00
10 29 15	Understanding Diabetes	3 staff	Admin, Owner, Asst. Admin	Crystal Lake	INR	$ 228.00
11 04 15	Viruses and Germs	2 staff	DON, Infect'n. Control Nurse	Skokie	INR	$ 162.00
11 11 15	Phlebotomy Technician	K Harter	DSP	Schaumburg	JCM Institute	$ 303.00
11 11 15	CPR	6 staff	DSP	Woodstock	A-Tec Ambulance Service	$ 90.00
11 11 15	First Aid	7 staff	DSP	Woodstock	A-Tec Ambulance Service	$ 90.00
11 12 15	CPR	2 staff	1 Act Aid, 1 RNA	Woodstock	A-Tec Ambulance Service	$ 90.00
11 16 15	CPR	Holly Pietrzak	Activity Aid	Woodstock	A-Tec Ambulance Service	$ 90.00
11 20 15	CPR	2 staff	2 DSP	Woodstock	A-Tec Ambulance Service	$ 90.00
11 20 15	First Aid	5 staff	DSP	Woodstock	A-Tec Ambulance Service	$ 90.00
12 15 15	First Aid	2 staff	1 DSP, 1 RNA	Woodstock	A-Tec Ambulance Service	$ 90.00
						$4,971.00

DORR-WOOD LTD
COST REPORT
SUPPORTING DATA Detail of Travel

1/15/2015	Staff meeting, Off The Rail, Woodstock Illinois	$220
2/19/2015	Business meeting sorento's Ranch, Sycamore, Illinois	$289
5/8/2015	Business meeting Front Street Cantina, Geneva, Illinois	$252
5/14/2015	Business meeting Village Squire, Crystal Lake, Illininois	$102
5/15/2015	Business meeting Sorrento Ranch,Sycamore	$103
6/1/2015	Business meeting Szechwan Restalurant, St. Charles Illinois	$77
6/12/2015	Business meeting Kishwaukee Country Club, DeKalb Illinois	$61
8/11/2015	Business meeting shaws Crabhouse Schaumburg, Illinois	$101
8/25/2015	Business meeting Hanks, Sycamore, Illinois	$64
3/11/1900	L Marsh Reimbursed expenses	$71
10/24/2015	Business meeting Roseta's DeKalb, Illinois	$173
10/29/2015	Seminar Meal Thunder Bay Grill, Rockford, Illinois	$60
11/13/2015	Business meeting Szechwan Restaurant, St Charles Illinois	$117
11/16/2015	Business meeting Hugo's bar and Grill, Napervile, Illinois	$97
12/5/2015	Business meetingSorrento's Ranch ,Sycamore, Illinois	$56
	Total	$1,843

DORR-WOOD LTD
COST REPORT
SUPPORTING DATA
Reclassifications and Adjustments

Reclassifications		DR	DR	CR
30-3 Depreciation			6590	
14-3 Program Transportation Reclassify Vehicle Depreciation				6590
13-2 c	CNA Training		306	
	Clerical and general office			
	Reclasify Aide Training suupplies			306
21-2	Interest Expense		2136	
	Clerical and general office			
	Reclassify CR 48644 To BMO Harris Bank			2136

Adjustments		Schedule V Line	
Line 29	Related party Rent	34	195000
	Day Training Program Expense	43	507334
	Total Line 29		702334
Line 35			
	Depreciation Adjustment	30	30159

Illinois Nursing Home Administrators Association	200
Crisis Prevention Institute	150
American speech language Hearing Association	285
Total	635