

		FOR BHF USE					

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**2016**  
 STATE OF ILLINOIS  
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
 FOR LONG-TERM CARE FACILITIES  
 (FISCAL YEAR 2016)

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.

<p>I. IDPH License ID Number: <u>0021766</u></p> <p>Facility Name: <u>Meadows</u></p> <p>Address: <u>3250 S Plum Grove Rd</u> <u>Rolling Meadows</u> <u>60008</u>  <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 397-0055</u> Fax # <u>(847) 397-0477</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/1975</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input checked="" type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p>In the event there are further questions about this report, please contact:        Name: <u>Robin Witt</u> Telephone Number: <u>(847) 397-0055</u>        Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Robin Witt</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Administrator</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name &amp; Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p align="right">       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     </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Robin Witt</u>		(Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____																
Officer or Administrator of Provider	(Signed) _____ (Date) _____																	
	(Type or Print Name) <u>Robin Witt</u>																	
	(Title) <u>Administrator</u>																	
Paid Preparer	(Signed) _____ (Date) _____																	
	(Print Name and Title) _____																	
	(Firm Name & Address) _____																	
	(Telephone) <u>( )</u> Fax # ( )																	

Facility Name & ID Number Meadows Sheltered Care, Inc.

# 0021766 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>99</u>	Intermediate/DD	<u>99</u>	<u>36,234</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>33,233</u>	<u>763</u>		<u>33,996</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>33,233</u>	<u>763</u>		<u>33,996</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.82%

D. How many bed-hold days during this year were paid by the Department? 259 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 08/1975

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 08/1975 NO

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	166,620	19,569	4,771	190,960		190,960		190,960		1
2	Food Purchase		227,712		227,712		227,712		227,712		2
3	Housekeeping	86,994	36,322		123,316		123,316		123,316		3
4	Laundry	60,340	41,453		101,793		101,793		101,793		4
5	Heat and Other Utilities			115,846	115,846		115,846		115,846		5
6	Maintenance	127,920	8,947	47,785	184,652		184,652		184,652		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	441,874	334,003	168,402	944,279		944,279		944,279		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,800	16,800	(16,128)	672		672		9
10	Nursing and Medical Records	1,414,798	117,483	4,521	1,536,802		1,536,802		1,536,802		10
10a	Therapy	11,498		9,846	21,344	3,068	24,412		24,412		10a
11	Activities	46,735	5,180		51,915	260	52,175		52,175		11
12	Social Services	160,569		15,445	176,014	(3,328)	172,686		172,686		12
13	CNA Training										13
14	Program Transportation			48	48		48		48		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,633,600	122,663	46,660	1,802,923	(16,128)	1,786,795		1,786,795		16
	<b>C. General Administration</b>										
17	Administrative	61,000			61,000		61,000		61,000		17
18	Directors Fees										18
19	Professional Services			53,413	53,413	(1,044)	52,369		52,369		19
20	Dues, Fees, Subscriptions & Promotions			8,343	8,343	666	9,009		9,009		20
21	Clerical & General Office Expenses	192,521	12,876	(26,344)	179,053	(666)	178,387	28,434	206,821		21
22	Employee Benefits & Payroll Taxes			324,123	324,123	1,044	325,167	(1,817)	323,350		22
23	Inservice Training & Education										23
24	Travel and Seminar			551	551		551		551		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			25,245	25,245		25,245	22,089	47,334		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	253,521	12,876	385,331	651,728		651,728	48,706	700,434		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,328,995	469,542	600,393	3,398,930	(16,128)	3,382,802	48,706	3,431,508		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 &amp; ID Number

Meadows Sheltered Care, Inc.

#0021766

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			22,327	22,327		22,327	47,133	69,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							149,177	149,177			32
33	Real Estate Taxes							263,684	263,684			33
34	Rent-Facility & Grounds			729,600	729,600		729,600	(729,600)				34
35	Rent-Equipment & Vehicles			6,550	6,550		6,550		6,550			35
36	Other (specify):*											36
37	TOTAL Ownership			758,477	758,477		758,477	(269,606)	488,871			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			8,290	8,290	16,128	24,418		24,418			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			268,284	268,284		268,284		268,284			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			276,574	276,574	16,128	292,702		292,702			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,328,995	469,542	1,635,444	4,433,981		4,433,981	(220,900)	4,213,081			45

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(113)	30.3		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	13,756			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 13,643		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(234,543)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (234,543)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (220,900)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39	Physician Care	x		16,128	9.3	39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44			x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 16,128		47

Facility Name & ID Number

Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility Rent	\$ 729,600	Byrn T. Witt & Barbara S. Witt	100.00%	\$	\$ (729,600)	1
2	V							2
3	V	30 Depreciation		Byrn T. Witt & Barbara S. Witt	100.00%	49,021	49,021	3
4	V	32 Interest		Byrn T. Witt & Barbara S. Witt	100.00%	149,177	149,177	4
5	V	17						5
6	V	33 Real Estate Taxes		Byrn T. Witt & Barbara S. Witt	100.00%	263,684	263,684	6
7	V							7
8	V	26 Property Insurance		Byrn T. Witt & Barbara S. Witt	100.00%	33,175	33,175	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 729600			\$ 495,057	\$ * (234,543)	14

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

Facility Name &amp; ID Number

Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robin Witt	Administrator	Administration			40	100%	Salary	\$ 61,000	17.1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 61,000		13

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

# 0021766 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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



Facility Name & ID Number

Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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																				
2	HUD	X	Debt Refinance / Bldg Constructio	Varies	2006	\$ 2,700,000	\$ 2,470,382	2046	0.0600	\$ 149,177										
3				-																
4				-																
5				-																
Working Capital																				
6				-																
7				-						-										
8				-																
9	TOTAL Facility Related					\$ 2,700,000	\$ 2,470,382			\$ 149,177										
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$	\$			\$										
15	TOTALS (line 9+line14)					\$ 2,700,000	\$ 2,470,382			\$ 149,177										

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

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number Meadows Sheltered Care, Inc.

# 0021766 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

**Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 report.		\$	<u>252,888</u>	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.)		\$	<u>258,286</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,398	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>258,286</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>263,684</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	<u>210,832</u>	8	
	2012	<u>221,997</u>	9	
	2013	<u>246,370</u>	10	
	2014	<u>252,888</u>	11	
	2015	<u>258,286</u>	12	
<u>Accrual based on current year assessment.</u>				

	<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2015	\$		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.**

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Meadows Sheltered Care, Inc. COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0021766  
 CONTACT PERSON REGARDING THIS REPORT Robin Witt  
 TELEPHONE (847) 397-0055 FAX #: (847) 397-0477

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. <u>02-35-100-016-0000</u>	<u>3250 South Plum Grove Road</u>	\$ <u>258,286.00</u>	\$ <u>258,286.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>258,286.00</u>	\$ <u>258,286.00</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>52,300</u>	<u>1986</u>	<u>\$ 25,000</u>	1
2					2
3	<b>TOTALS</b>	<b>52,300</b>		<b>\$ 25,000</b>	<b>3</b>

Facility Name &amp; ID Number Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

## XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98		1986	1975	\$ 1,500,000	\$	30	\$		\$ 1,500,000	4
5			1996	1996	1,478,674		39	37,915	37,915	777,413	5
6	1		1996	1996	15,000		39	385	385	7,782	6
7											7
8											8
	Improvement Type**										
9	Remodeling			1976	3,548		10			3,548	9
10				1977	21,344		10			21,344	10
11				1979	169		10			169	11
12				1980	9,111		10			9,111	12
13				1981	3,203		10			3,203	13
14				1983	7,355		10			7,355	14
15				1984	11,356		10			11,356	15
16	Garage			1985	3,165		10			3,165	16
17	Remodeling			1986	2,386		10			2,386	17
18	Water Heater & Fire Alarm System			1987	3,199		15			3,199	18
19	Roof			1988	40,520		20			40,520	19
20	Heat Pump			1988	1,900		15			1,900	20
21	Roof			1990	3,527		20			3,527	21
22	Kitchen			1990	2,319		10			2,319	22
23	Heater Repairs			1991	840		7			840	23
24	Improvements			1993	737	4	10		(4)	737	24
25	Water Heater			1995	3,000		7			3,000	25
26	Exterior Doors			1995	628	16	39	16		346	26
27	Garage Door			1996	385		10			385	27
28	Parking Lot Repair			1996	6,655		20	160	160	6,655	28
29	Driveway			1996	22,572		20	552	552	22,572	29
30	Walk-in Freezer & Cooler			1996	12,333		10			12,333	30
31	Draperies			1997	16,239		39	416	416	8,114	31
32	Fencing			1997	8,090	207	39	207		4,038	32
33	Windows & Doors			1997	2,128		39	55	55	1,073	33
34	New Building Addition			1998	7,500		39	192	192	3,648	34
35	Telephone Equipment			2001	1,850		5			1,850	35
36	Air Conditioning Units			2001	4,568		39	117	117	1,820	36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

## XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Window Screens	2001	\$ 1,400	\$	39	\$ 36	\$ 36	\$ 559	37
38 Draperies	2001	4,118		39	106	106	1,682	38
39 Magnetic Door Holders	2002	1,350		7			1,350	39
40 6 Air Conditioner Units	2002	4,671		39	120	120	1,569	40
41 12 Resident Room Closet Doors	2002	2,346		39	60	60	795	41
42 Nurse Call System	2002	38,000		5			38,000	42
43 Magnetic Door Holders	2002	3,696		5			3,696	43
44 Signage	2003	1,698		7			1,698	44
45 Flooring	2002	1,731		10			1,731	45
46 Draperies	2003	1,052		7			1,052	46
47 Windows	2003	710		39	18	18	216	47
48 HVAC Units	2003	3,813		5			3,813	48
49 Carpeting	2003	10,994		10			10,994	49
50 Parking Lot	2004	26,879		15	1,792	1,792	21,504	50
51 HVAC Units	2004	5,825		5			5,825	51
52 Security System	2004	18,600		5			18,600	52
53 HVAC Units	2005	484		5			484	53
54 Nurse call system	2005	6,231		5			6,231	54
55 Electrical cabling	2005	1,450		5			1,450	55
56 HVAC Units	2005	281		5			281	56
57 Security System	2006	3,590		7			3,590	57
58 Double egress doors	2006	5,908		39	151	151	1,621	58
59 Generator & electrical panel	2008	2,500		7			2,500	59
60 Replacement Doors	2008	2,859		39	73	73	639	60
61 Fire Alarm System	2008	17,084		39	438	438	3,583	61
62 HVAC Units	2009	4,209		7	281	281	4,209	62
63 Fire alarm system	2009	6,108		39	157	157	1,138	63
64 Driveway repair	2010	4,604		15	307	307	1,894	64
65 Heat/AC units in rooms	2010	4,453		7	636	636	4,398	65
66 Resident and interior doors - 12	2011	4,343		39	111	111	602	66
67 Wheelchair guards, kitchen disposal, vanities, toilets, 2 HVAC	2011	2,876		7	411	411	2,159	67
68 HVAC Units	2012	2,549		7	364	364	1,533	68
69 Cooling compressor	2012	2,627		7	375	375	1,683	69
70 TOTAL (lines 4 thru 69)		\$ 3,393,340	\$ 227		\$ 45,451	\$ 45,224	\$ 2,616,787	70

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,393,340	\$ 227		\$ 45,451	\$ 45,224	\$ 2,616,787	1
2	2012	3,452		7	493	493	2,156	2
3	2013	4,310		7	616	616	2,287	3
4	2014	80,327		39	2,060	2,060	5,841	4
5	2014	3,549		5	710	710	1,784	5
6	2015	3,765		39	97	97	193	6
7	2015	3,488		39	89	89	178	7
8	2015	20,274		39	520	520	704	8
9	2015	6,478		39	166	166	252	9
10	2016	2,586	1,358	5		(1,358)		10
11	2016	5,500	2,773	15	60	(2,713)	60	11
12	2016	3,830	1,931	15	42	(1,889)	42	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	TOTAL (lines 1 thru 33)	\$ 3,530,899	\$ 6,289		\$ 50,304	\$ 44,015	\$ 2,630,284	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 79,674	\$ 2,530	\$ 2,530	\$	Various	\$ 72,747	71
72	Current Year Purchases	15,451	8,683	8,683		Various	8,683	72
73	Fully Depreciated Assets	87,385					87,385	73
74								74
75	TOTALS	\$ 182,510	\$ 11,213	\$ 11,213	\$		\$ 168,815	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Mini Van	Dodge, 2014	2014	\$ 39,713	\$ 3,050	\$ 7,943	\$ 4,893	5	\$ 23,828	76
77										77
78										78
79										79
80	TOTALS			\$ 39,713	\$ 3,050	\$ 7,943	\$ 4,893		\$ 23,828	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,778,122	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,552	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,460	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 48,908	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,822,927	85

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

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

G. Construction-in-Progress

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

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

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



**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

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

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

\*\*

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 6,550 Description: Copier: \$6,056; Mailing Machine: \$494

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		141	9,846		141	9,846	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39.3	visits		200	16,128		200	16,128	5
6	Dental Care	39.3	visits		83	8,290		83	8,290	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			\$	424	\$ 34,264	\$	424	\$ 34,264	14

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

Facility Name &amp; ID Number Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 459,022	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	153,391		3
4	Supply Inventory (priced at FIFO )	6,693		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	38,797		7
8	Accounts Receivable (owners or related parties)	49,813		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 707,716	\$	10
	<b>B. Long-Term Assets</b>			
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	26,429		15
16	Equipment, at Historical Cost	328,264		16
17	Accumulated Depreciation (book methods)	(270,872)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 83,821	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 791,537	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 43,917	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,757		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	A/P Other			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 46,674	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
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)	\$ 46,674	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 744,863	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 791,537	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 597,227	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(76,059)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 521,168	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	223,695	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)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 223,695	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 744,863	24 *

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

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

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,657,676	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,657,676	3
<b>B. Ancillary Revenue</b>			
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
<b>C. Other Operating Revenue</b>			
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
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,657,676	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	944,279	31
32	Health Care	1,802,923	32
33	General Administration	651,728	33
<b>B. Capital Expense</b>			
34	Ownership	758,477	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	8,290	35
36	Provider Participation Fee	268,284	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,433,981	40
41	Income before Income Taxes (line 30 minus line 40)**	223,695	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 223,695	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,492,876	44
45	Private Pay - Net Inpatient Revenue	164,800	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,657,676	49

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

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 60,872	\$ 29.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,633	2,642	82,532	31.24	3
4	Licensed Practical Nurses	11,904	12,200	320,193	26.25	4
5	CNAs & Orderlies	55,972	58,943	865,115	14.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	700	700	11,498	16.43	8
9	Activity Director	645	800	14,615	18.27	9
10	Activity Assistants	2,183	2,344	32,120	13.70	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,480	13,344	166,620	12.49	15
16	Dishwashers					16
17	Maintenance Workers	7,411	7,610	127,920	16.81	17
18	Housekeepers	6,917	7,136	86,994	12.19	18
19	Laundry	4,943	5,096	60,340	11.84	19
20	Administrator	1,710	1,872	61,000	32.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,000	6,455	179,507	27.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,112	4,160	89,584	21.53	28
29	Resident Services Coordinator	1,595	2,080	70,985	34.13	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	2,705	2,864	86,086	30.06	33
34	TOTAL (lines 1 - 33)	123,990	130,326	\$ 2,315,981 *	\$ 17.77	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	184	\$ 4,771	1.3	35
36	Medical Director	8	672	9.3	36
37	Medical Records Consultant	11	550	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	40	3,971	10.3	39
40	Physical Therapy Consultant	42	2,898	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	170	10a.3	43
44	Activity Consultant	4	260	11.3	44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	13	1,148	12.3	46
47					47
48	<u>Psychiatrist</u>	35	10,500	12.3	48
49	TOTAL (lines 35 - 48)	338	\$ 24,940		49

C. CONTRACT NURSES

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

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

\*\* See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Robin Witt	Administrator	-0-	61,000	Workers' Compensation Insurance	105,351	IDPH License Fee		
				Unemployment Compensation Insurance	7,424	Advertising: Employee Recruitment	1,264	
				FICA Taxes	175,882	Health Care Worker Background Check	385	
				Employee Health Insurance	32,668	(Indicate # of checks performed <u>11</u> )		
				Employee Meals		IARF Membership Dues	5,916	
				Illinois Municipal Retirement Fund (IMRF)*		Other Dues & Licenses	1,244	
				Staff Appreciation	2,694	Sec of State/City of Rolling Meadows	200	
				Employee Life/Disability	104			
				Employee Physicals	1,044			
				Allocation of Benefits	(1,817)	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 323,350	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,009	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	551
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 551
C. Professional Services								
Vendor/Payee	Type		Amount					
Robert Rein CPA	Consulting		3,200					
Christenson Computer	Computer		9,952					
ADP	Payroll		13,074					
Achieve Health	Computer		5,826					
Reclassification			1,044					
Dac Easy	Computer		1,221					
Duane Morris	Legal		19,096					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 53,413					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Meadows Sheltered Care, Inc.

# 0021766

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IARF Membership Dues 5,916
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,966 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 268,284  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 100%
  - d. Have vehicle usage logs been maintained? Yes
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ Zero
- (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 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. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.