		FOR BHF USE			

LL1

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.

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

I. IDPH License ID Number: 0023275

Facility Name: Sheltered Village

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

County: McHenry

Telephone Number: 815-338-6440 **Fax #** 815-338-6803

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
			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

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 ______ to ______ 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) ______ (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: 1/1/2016 Ending: ########

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 NA

	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	96	Intermediate/DD	96	35,136	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,136	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	31,513		5	31,518	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,513		5	31,518	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.70%

D. How many bed-hold days during this year were paid by the Department?
0 (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)
NA

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ______ NO [X]

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

Medicare Intermediary ______

IV. ACCOUNTING BASIS

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

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

Tax Year: December Fiscal Year: December

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

STATE OF ILLINOIS

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

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	178,902	30,465	6,336	215,703		215,703		215,703			1
2	Food Purchase		216,115		216,115		216,115	(413)	215,702			2
3	Housekeeping	97,739	24,362		122,101		122,101		122,101			3
4	Laundry	32,438	3,888		36,326		36,326		36,326			4
5	Heat and Other Utilities			81,161	81,161		81,161		81,161			5
6	Maintenance	100,497	17,219	21,329	139,045		139,045		139,045			6
7	Other (specify):*											7
8	**TOTAL General Services**	409,576	292,049	108,826	810,451		810,451	(413)	810,038			8
	B. Health Care and Programs											
9	Medical Director			29,500	29,500		29,500		29,500			9
10	Nursing and Medical Records	1,536,124	122,481	25,886	1,684,491		1,684,491		1,684,491			10
10a	Therapy											10a
11	Activities	177,017	4,428	183	181,628		181,628		181,628			11
12	Social Services	344,740	1,230	23,430	369,400	(8,357)	361,043		361,043			12
13	CNA Training	12,996			12,996	8,613	21,609		21,609			13
14	Program Transportation			28,913	28,913	(9,530)	19,383		19,383			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,070,877	128,139	107,912	2,306,928	(9,274)	2,297,654		2,297,654			16
	C. General Administration											
17	Administrative	126,465			126,465		126,465		126,465			17
18	Directors Fees			17,250	17,250		17,250		17,250			18
19	Professional Services			23,155	23,155		23,155		23,155			19
20	Dues, Fees, Subscriptions & Promotions			32,556	32,556		32,556	(6,912)	25,644			20
21	Clerical & General Office Expenses	138,675	12,890	21,438	173,003	(256)	172,747		172,747			21
22	Employee Benefits & Payroll Taxes			526,526	526,526		526,526		526,526			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,445	6,445		6,445		6,445			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,464	63,464		63,464		63,464			26
27	Other (specify):*											27
28	**TOTAL General Administration**	265,140	12,890	690,834	968,864	(256)	968,608	(6,912)	961,696			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,745,593	433,078	907,572	4,086,243	(9,530)	4,076,713	(7,325)	4,069,388			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: Ending:

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			51,694	51,694	9,530	61,224	30,159	91,383			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,661	22,661		22,661	(44)	22,617			32
33	Real Estate Taxes			67,751	67,751		67,751		67,751			33
34	Rent-Facility & Grounds			264,000	264,000		264,000	(264,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			406,106	406,106	9,530	415,636	(233,885)	181,751			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			256,324	256,324		256,324		256,324			42
43	Other (specify):*	342,858	22,933	169,543	535,334		535,334	(535,334)				43
44	TOTAL Special Cost Centers	342,858	22,933	425,867	791,658		791,658	(535,334)	256,324			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,088,451	456,011	1,739,545	5,284,007		5,284,007	(776,544)	4,507,463			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: Ending:

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	(44)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(413)	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	(6,912)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(799,334)	34/43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (806,703)		$	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))**	$ (776,544)		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

STATE OF ILLINOIS

Sheltered Village

ID# 0023275

Report Period Beginning:

Ending:

	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: Ending:

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	(413)	0	0	0	0	0	0	0	0	0	0	(413)	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**	(413)	0	0	0	0	0	0	0	0	0	0	(413)	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	(6,912)	0	0	0	0	0	0	0	0	0	0	(6,912)	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**	(6,912)	0	0	0	0	0	0	0	0	0	0	(6,912)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,325)	0	0	0	0	0	0	0	0	0	0	(7,325)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

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

	Capital Expense D. Ownership	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)	
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	(44)	0	0	0	0	0	0	0	0	0	0	(44)	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**	30,115	0	0	0	0	0	0	0	0	0	0	30,115	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)**	22,790	0	0	0	0	0	0	0	0	0	0	22,790	45

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

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					
As of 12/31/2016 Pamela Bowman controls 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.

STATE OF ILLINOIS

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

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: Ending:

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Pamela Bowman	President		**				Directors Fee	$ 9,000	18-3	1
2	Robert R Bowman	Deceased 11/28/16						Director Fee	8,250	18-3	2
3											3
4	Robert FX Keeler	Treasurer				5	12.00	Wage	10,800	17-1	4
5											5
6	Amy McCue	Secretary									6
7	Amy McCue	Speech Therapist				900	40.00	Wage	30,769	12-1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,819		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: Ending:

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]

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

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

	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: Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Harris BMO		X	Working Capital		9/30/16	2,500,000	664,688	9/30/18	5.0000	22,540	6
7	Interest on late 401K payment									*		7
8	prime plus 2%										121	8
9	TOTAL Facility Related						$ 2,500,000	$ 664,688			$ 22,661	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	$ 664,688			$ 22,661	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: Ending:

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2015 report.	$	70,555	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.)	$	67,806	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,749)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	70,500	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.	$	67,751	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2011	52,957	8
2012	60,169	9
2013	64,639	10
2014	67,149	11
2015	67,806	12

FOR BHF USE ONLY

Line	Item		Line
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

Accrual at 12/31/16 67806@ 104%=70518 round to 70500

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 Sheltered Village COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0023275

CONTACT PERSON REGARDING THIS REPORT Robert Norris

TELEPHONE 8153386440 ex112 FAX #: 8153386803

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 Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	13 06 326 001	600 Borden St	$ 67,805.00	$ 67,805.00
2.		Woodstock IL	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,805.00	$ 67,805.00

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 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 Sheltered Village # 0023275 Report Period Beginning: Ending:

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

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	$ 782,873	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		15			3,851	10
11	90X40 addition and remodel			2003	629,115	16,131	39	16,131		213,065	11
12	Remodel shower area			2004	27,050	694	39	694		8,814	12
13	blacktop walkway			2006	11,675	778	15	778		8,172	13
14	Replace resident room doors			2006	11,614	290	39	290		3,037	14
15	Attic fire walls			2011	9,743	244	39	244		1,350	15
16	Roof Work			2011	18,691	467	39	467		2,434	16
17	Widen Resident Doors			2013	7,580	189	39	189		615	17
18	Roof Work			2014	13,100	1,120	15	1,120		3,020	18
19	New enry door			2016	9,250	200	39	200		200	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: Ending:

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)		$ 1,700,655	$ 20,113		$ 50,272	$ 30,159	$ 1,036,417	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: Ending:

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	$ 220,617	$ 29,599	$	$ (29,599)	5to7	$ 174,219	71
72	Current Year Purchases	26,398	1,981		(1,981)	5to7	1,981	72
73	Fully Depreciated Assets	472,685				5to7	472,685	73
74								74
75	TOTALS	$ 719,700	$ 31,580	$	$ (31,580)		$ 648,885	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 Imala	2010	$ 30,180	$ 1,775	$ 1,775	$	5	$ 16,235	76
77	Resident Transport	2012 Doge Caravan	2012	16,264	1,875	1,875		5	11,779	77
78	Resident Transport	2014 Chevy 3500 Van	2015	29,402	5,881	5,881		5	8,821	78
79										79
80	TOTALS			$ 75,846	$ 9,531	$ 9,531	$		$ 36,835	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)	$ 2,546,201	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 61,224	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 59,803	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,421)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,722,137	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	$ 8,187	$ 92,428	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 106,588	$ 8,187	$ 92,428	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	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: Ending:

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	$ 264,000			3
4	Additions							4
5								5
6								6
7	TOTAL		96		$ 264,000 **			7

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.	12/31/2017	$ 180,000
13.	12/31/2018	$ open
14.	12/31/2019	$ open

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 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.

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

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 50

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA 86

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		256		256
3	Classroom Wages (a)		4,778		4,778
4	Clinical Wages (b)		8,218		8,218
5	In-House Trainer Wages (c)		8,357		8,357
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 21,609	$	$ 21,609
10	SUM OF line 9, col. 1 and 2 (e)	$ 21,609			

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

(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: Ending:

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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			$		$	$		$	14

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

XV. BALANCE SHEET - Unrestricted Operating Fund. As of (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	$ 369,856	$	1
2	Cash-Patient Deposits	20,363		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	624,303		3
4	Supply Inventory (priced at)	6,796		4
5	Short-Term Investments			5
6	Prepaid Insurance	74,393		6
7	Other Prepaid Expenses	7,220		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,102,931	$	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	750,655		15
16	Equipment, at Historical Cost	795,547		16
17	Accumulated Depreciation (book methods)	(939,264)		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):	14,160		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 621,098	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,724,029	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 110,365	$	26
27	Officer's Accounts Payable	1,671		27
28	Accounts Payable-Patient Deposits	20,363		28
29	Short-Term Notes Payable	664,688		29
30	Accrued Salaries Payable	127,134		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,500		32
33	Accrued Interest Payable	1,000		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)**	$ 995,721	$	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)**	$ 995,721	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 728,308	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,724,029	$	48

*(See instructions.)

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 846,040	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 846,040	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(117,732)	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)**	$ (117,732)	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)**	$ 728,308	24 *

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

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	$ 4,276,586	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,276,586	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	32,130	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)**	$ 32,130	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Day Training Program	860,839	28
28a	Net Commisary Income (Loss)	(3,325)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 857,514	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,166,274	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	810,451	31
32	Health Care	2,306,928	32
33	General Administration	968,864	33
	B. Capital Expense		
34	Ownership	406,106	34
	C. Ancillary Expense		
35	Special Cost Centers	535,334	35
36	Provider Participation Fee	256,324	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,284,007	40
41	**Income before Income Taxes (line 30 minus line 40)****	(117,733)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (117,733)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,441,484	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Social Security and VA	833,325	47
48	Other-(specify) state of Il Transportation	1,777	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,276,586	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 Sheltered Village # 0023275 Report Period Beginning: Ending:

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 87,809	$ 42.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,792	16,973	464,136	27.35	3
4	Licensed Practical Nurses	7,592	8,204	216,164	26.35	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,360	1,360	12,996	9.56	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,054	2,277	36,816	16.17	9
10	Activity Assistants	13,467	14,342	140,201	9.78	10
11	Social Service Workers	1,899	2,099	49,504	23.58	11
12	Dietician					12
13	Food Service Supervisor	2,216	2,388	48,522	20.32	13
14	Head Cook	2,110	2,325	29,852	12.84	14
15	Cook Helpers/Assistants	5,006	5,515	66,651	12.09	15
16	Dishwashers	3,410	2,305	33,877	14.70	16
17	Maintenance Workers	5,657	6,407	100,497	15.69	17
18	Housekeepers	8,369	9,315	97,739	10.49	18
19	Laundry	2,071	2,361	32,438	13.74	19
20	Administrator	1,960	2,080	115,665	55.61	20
21	Assistant Administrator			10,800		21
22	Other Administrative	260	260	138,675	533.37	22
23	Office Manager			233,028		23
24	Clerical	4,890	5,991	62,208	10.38	24
25	Vocational Instruction			738,747		25
26	Academic Instruction			29,268		26
27	Medical Director			342,858		27
28	Qualified MR Prof. (QMRP)	9,865	10,742		0.00	28
29	Resident Services Coordinator	1,840	2,098		0.00	29
30	Habilitation Aides (DD Homes)	54,890	58,900		0.00	30
31	Medical Records	1,710	1,937		0.00	31
32	Other Health Care(specify)	23,728	25,683		0.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,106	185,642	$ 3,088,451 *	$ 16.64	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	132	$ 6,336	1-3	35
36	Medical Director	96	29,500	10-3	36
37	Medical Records Consultant	96	1,101	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	102	2,393	10-3	39
40	Physical Therapy Consultant	27	2,314	10-3	40
41	Occupational Therapy Consultant	83	663	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	480	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	408	3,264	12-3	45
46	Other(specify) Psychiatrist	39	3,600	12-3	46
47	Behavior Consultant	1,040	18,945	10-3	47
48	Dentl Consultant	165	11,063		48
49	TOTAL (lines 35 - 48)	2,203	$ 79,659		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	159	1,310	10-3	52
53	TOTAL (lines 50 - 52)	159	$ 1,310		53

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: Ending:

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Norris	Administrator	0	$ 115,665
Robert Keler	Treasurer	0	10,800
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 126,465

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/Surce	Timekeeing	$ 4,351
Sitberger Hau & Co	401 K audit	6,500
Pro Data	Payroll Service	5,912
Siepert&Co LLP	CPA Service	2,410
Filler & Associates	Legal	2,300
Wessels and Pautsch	Legal	273
Monahan Law Group	Legal	1,409
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 23,155

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 132,460
Unemployment Compensation Insurance	18,935
FICA Taxes	230,391
Employee Health Insurance	198,826
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Dental	5,089
Group Term Life Insurance	3,043
Less Day Training Fringes	(62,218)
TOTAL (agree to Schedule V, line 22, col.8)	$ 526,526

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	$ 70
Advertising: Employee Recruitment	23,636
Health Care Worker Background Check (Indicate # of checks performed 12)	453
Patient Background Checks 7	112
Other Advertising	6,912
Website	720
Dues	353
McHenry Health Department	300
Less: Public Relations Expense	( )
Non-allowable advertising	(6,912)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,644

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,553
Seminar Expense	4,892
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,445

**See instructions.

Facility Name & ID Number **Sheltered Village** # **0023275** **Report Period Beginning:** **Ending:**

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? If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **5-7yr**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

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

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **264,324**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes *** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **none** Has any meal income been offset against related costs? **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. $ **1,777**

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

12 page 22-Aide Training portion of wages re-classified

Reclassifications

Line			
30-3	Depreciation	9530	
14-3	Program Transportation Reclassify Vehicle Depreciation		9530
13-2	CNA Training	256	
	Re-classify aide training suplies		256
13-1	CNATRAINING	8357	
	Social Services		8357
	Reclassify Aide Trainer Wages		

Adjustments Scheduled		ScheduleV	
Line 29	Related Party Rent	34	264000
	Day Training Program Expense	43	535334
	Total Line 29		799334
line 35	Depreciation Adjustment	30	30159

DORR-WOOD LTD

Detail of Travel and Meetings 2016 Cost Report

1/23/2016	Business Meeting Rosata's De Kalb, IL	$138.00
1/29/2016	Business Meeting Ellwood Steak House DeKalb IL	$106.00
1/30/2016	Business Meeting Basils Grek, Aurora IL	$94.00
4/23/2016	Seminar Atendees, Village Inn Crystal Lake IL	$80.00
7/26/2016	Business Meeting Szechwan Rest. St Charles IL	$101.00
6/28/2016	Secretaries Lunch, Corner Pub and Grill, Woodstock IL	$31.00
8/23/2016	Business Meeting Sorrentos Ranch, Sycamore IL	$206.00
8/25/2016	Secretary Meeting. Public House Woodstock IL	$47.00
10/4/2016	Business Meeting Sorentos Ranch Sycamore IL	$165.00
10/17/2016	Business Meeting Beehive Restaurant St Charles IL	$108.00
10/21/2016	Business Meeting Sharon Restaurant St Charles IL	$132.00
10/30/20161	Board of Director Meetning Colemand woodstock IL	$211.00
11/2/2016	Business Meeting Public House Woodstock IL	$86.00
11/16/2016	Business Meeting Public House Woodstock IL	$48.00
		$1,553.00

DORR-WOOD LTD
SCHEDULE OF DUES
2016

Crisis Preventin Institute	$150.00
American Speech, Language Hearing Association	$203.00
	$353.00

DORR-WOOD LTD
Detail of Seminars
2016

Seminar Name	Cost	Attendees	Job Title	Date	Place	Sponsor
CPR Training	$270.00	6Staff	DSP's	12/29/2015	Woodstock IL	A TEC Ambulance
Human Development	$909.00	Kayla Goss	DSP'	1/16/2016	Crystal Lake IL	MCC College
Inflamation,Chronic Illiness&Brain	$162.00	M Mac	DON			
		T Miller	LPN	2/25/2016	Crystal Lake IL	INR
Leadership, Team building skills	$498.00	C Ostrow	DT Dir			
		L Schlendorf	DSP	1/20/2016	OakBrook IL	Fred Pryor Seminars
Creative Leadership	$199.00	C Ostrow	DT Dir	3/22/2016	Oak Brook IL	Fred Pryor Seminars
Transition from staff to supervisor	$99.00	L Schlendorf	DSP	3/23/2016	ElkGrove Village IL	Fred Pryor Seminars
Understanding Addictions	$324.00	R Norris	Admin			
		L Marsh	Asst Admin			
		L Smith	RN			
		E Conley	RN	4/28/2016	Crystal Lake IL	INR
CPR Training	$180.00	6 Staff	DSP's	4/18-4/28/16	Woodstock IL	ATEC Ambulance
Food Sewage Sanitation	$375.00	S Auvenshine	Cook			
		G Shafer	Cook	5/11/2016	New Berlin IL	Safety Handler Corp
Transition from staff to supervisor	$99	N Robey	DSP	7/19/2016	Rockford IL	Fed Pryor Seminars
Psychopharmachology	$325.00	C Woolford	RN	5/11/2016	Downers Grove IL	PESI
End Stage Diseases	$400.00	M Mac	DON			
		T Miller	LPN	9/16/2016	Arlington Heights IL	PESI
Basic Nursing Assistant	$312.00	K Harter	DSP	Fall 2016	Schaumberg IL	JCM Institute
Transition from staff to supervisor	$398.00	M Kilbane	DSP			
		K Holola	QIDP	11/1/2016	Rockford IL	Fred Pryor
CPR Training	$180	6 Staff	DSP's	12/8/2016	Woodstock IL	ATEC Ambulance
Memory, Forgetfullness and Brain	$162.00	R Norris	Adm			
		L Marsh	Asst Adm	3/17/2016	Crystal lake, IL	INR

INR-Institute for Natural Resources
DSP-Direct Service Professional
DT DIR-Developmental Teraining Director