

		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 0019356

Facility Name: Meadowood

Address: 320 South Second Street Grayville 62844
Number City Zip Code

County: White

Telephone Number: (618) 375-2171 **Fax #** (618) 375-7756

HFS ID Number: _____

Date of Initial License for Current Owners: 06/05/1975

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Curt Benson, CPA **Telephone Number:** (812) 882-7730
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2018 to 12/31/2018 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) _____	<u>4/30/19</u>
	(Type or Print Name) <u>Michael A. Cunningham</u>	(Date)
Paid Preparer	(Title) <u>Administrator</u>	
	(Signed) _____	<u>4/30/19</u>
	(Print Name and Title) <u>Curt Benson, CPA</u> <u>Partner</u>	(Date)
	(Firm Name & Address) <u>Kemper CPA Group LLP</u> <u>802 Old Wheatland Rd, PO Box 297, Vincennes, IN</u>	
	(Telephone) <u>(812) 882-7730</u>	Fax # <u>(812) 882-7778</u>

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**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowood

0019356 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1	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	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,156	2,555	1,611	12,322	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,156	2,555	1,611	12,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.62%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES 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 06/01/1975

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 74 and days of care provided 1,008

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowood # 0019356 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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
	A. General Services										
1	Dietary	119,381	956	6,292	126,629		126,629		126,629		1
2	Food Purchase		153,413		153,413		153,413	(4,107)	149,306		2
3	Housekeeping	67,673	9,877		77,550		77,550		77,550		3
4	Laundry	17,790	8,330		26,120		26,120		26,120		4
5	Heat and Other Utilities			48,415	48,415		48,415	(7,930)	40,485		5
6	Maintenance	29,910	76,000	4,308	110,218		110,218	(213)	110,005		6
7	Other (specify):*										7
8	TOTAL General Services	234,754	248,576	59,015	542,345		542,345	(12,250)	530,095		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	773,490	60,646	203,527	1,037,663		1,037,663		1,037,663		10
10a	Therapy										10a
11	Activities	20,819		1,570	22,389		22,389		22,389		11
12	Social Services	23,642		1,570	25,212		25,212		25,212		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	817,951	60,646	206,667	1,085,264		1,085,264		1,085,264		16
	C. General Administration										
17	Administrative	72,000			72,000		72,000		72,000		17
18	Directors Fees										18
19	Professional Services			13,205	13,205		13,205		13,205		19
20	Dues, Fees, Subscriptions & Promotions			5,800	5,800		5,800	(2,071)	3,729		20
21	Clerical & General Office Expenses	32,866	5,239	15,099	53,204		53,204		53,204		21
22	Employee Benefits & Payroll Taxes			117,412	117,412		117,412		117,412		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,723	1,723		1,723		1,723		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	104,866	5,239	153,239	263,344		263,344	(2,071)	261,273		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,157,571	314,461	418,921	1,890,953		1,890,953	(14,321)	1,876,632		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			30,928	30,928		30,928	10,930	41,858			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			23,337	23,337		23,337		23,337			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Disposal of Assets			3,611	3,611		3,611		3,611			36
37	TOTAL Ownership			57,876	57,876		57,876	10,930	68,806			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			603	603		603		603			41
42	Provider Participation Fee			110,608	110,608		110,608		110,608			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			111,211	111,211		111,211		111,211			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,157,571	314,461	588,008	2,060,040		2,060,040	(3,391)	2,056,649			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(3,948)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,930)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	34,407	30		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	(159)	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	(2,071)	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 See Pg 5A	(23,690)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,391)		\$	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,391)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Meadowood

ID# 0019356

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Care Asset Depreciation	\$ (23,477)	30	1
2	Non-Care Supplies - Apt Bldg	(213)	6	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	(23,690)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meadowood# 0019356

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	(4,107)	0	0	0	0	0	0	0	0	0	0	(4,107)	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	(7,930)	0	0	0	0	0	0	0	0	0	0	(7,930)	5
6	Maintenance	(213)	0	0	0	0	0	0	0	0	0	0	(213)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,250)	0	0	0	0	0	0	0	0	0	0	(12,250)	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	(2,071)	0	0	0	0	0	0	0	0	0	0	(2,071)	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	(2,071)	0	0	0	0	0	0	0	0	0	0	(2,071)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,321)	0	0	0	0	0	0	0	0	0	0	(14,321)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meadowood

0019356

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	10,930	0	0	0	0	0	0	0	0	0	0	10,930	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	10,930	0	0	0	0	0	0	0	0	0	0	10,930	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)	(3,391)	0	0	0	0	0	0	0	0	0	0	(3,391)	45

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
Roscoe D. Cunningham	100	Rest Haven	Albion			

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		\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowood

0019356

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Michael A. Cunningham	Administrator	Administrator	0.00	0	40	100.00	Administrator	\$ 72,000	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	\$ 72,000		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowood

0019356

Report Period Beginning:

01/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowood

0019356

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	Michael A. Cunningham	X		Operations			\$ 211,045	\$ 116,220			\$	1								
2	J.C. Cunningham Estate	X		Operations			34,000	34,000				2								
3	Madelyn Cunningham	X		Operations			44,000	44,000				3								
4	Roscoe Cunningham	X		Operations			679,672	679,672				4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 968,717	\$ 873,892			\$	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 968,717	\$ 873,892			\$	15								

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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 2017 report.	\$		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.)	\$	23,337	2
3. Under or (over) accrual (line 2 minus line 1).	\$	23,337	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		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.	\$	23,337	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>24,193</u>	8
	2014	<u>24,112</u>	9
	2015	<u>25,472</u>	10
	2016	<u>26,555</u>	11
	2017	<u>21,422</u>	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meadowood COUNTY White

FACILITY IDPH LICENSE NUMBER 0019356

CONTACT PERSON REGARDING THIS REPORT Curt Benson, CPA

TELEPHONE (812) 882-7730 FAX #: (812) 882-7778

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-20-254-001</u>	<u>PT NE S20 T3 R14W (24A)</u>	\$ <u>23,337.00</u>	\$ <u>23,337.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>23,337.00</u></u>	\$ <u><u>23,337.00</u></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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Meadowood

0019356

Report Period Beginning:

01/01/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,000 B. General Construction Type: Exterior Brick Frame Concrete Block Number of Stories 1

C. Does the Operating Entity? [X] (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? [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).

N/A

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Rows include Facility (130,680 sq ft, 1975, \$2,050), Facility (7,950), and TOTALS (130,680, \$10,000).

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	74	1975	1975	\$ 376,698	\$	30	\$	\$	\$ 376,698
5									
6									
7									
8									
Improvement Type**									
9	Fully Depreciated Assets Thru 2018			192,165					192,165
10	Roof Coating		2009	86,340	8,634	10	8,634		61,375
11	Dividing Sliding Doors		2011	790	79	10	79		450
12	Fire Doors		2011	1,092	109	10	109		494
13	Fire Sprinkler System		2011	82,294	8,229	10	8,229		22,628
14	Carport		2014	717	48	15	48		336
15	Boiler		2014	6,000	400	15	400		2,000
16	Roof		2015	30,938	3,094	10	3,094		12,376
17	Seamless Roof		2016	35,227	3,523	10	3,523		7,633
18	Middle Nursing Station - Carpentry		2018	3,098	69	15	69		69
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$	\$		\$	\$	\$	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)	\$	\$ 815,359		\$ 24,185	\$ 24,185	\$ 676,224	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Meadowood

0019356

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	\$ 174,587	\$ 17,673	\$ 17,673	\$	Various	\$ 137,265	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	200,083					200,083	73
74								74
75	TOTALS	\$ 374,670	\$ 17,673	\$ 17,673	\$		\$ 337,348	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,200,029	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,858	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,858	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,013,572	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	Land	\$ 58,247	\$	\$	86
87	Building - Apartments	329,958	11,701	206,253	87
88	Building - Medical	328,302	10,944	154,050	88
89	Improvements - Apts & Medical	18,158	832	10,946	89
90	Equipment - Apts	7,785		7,785	90
91	TOTALS	\$ 742,450	\$ 23,477	\$ 379,034	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowood

0019356

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10-3	hrs	\$	1,267	\$ 75,090	\$	1,267	\$ 75,090	1
2	Licensed Speech and Language Development Therapist	10-3	hrs		302	20,539		302	20,539	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs		1,507	88,532		1,507	88,532	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			\$	3,076	\$ 184,161	\$	3,076	\$ 184,161	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 40,886	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	298,157		3
4	Supply Inventory (priced at cost)	7,207		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	196,901		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 543,151	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	492,099		12
13	Land	68,247		13
14	Buildings, at Historical Cost	1,491,778		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	382,454		16
17	Accumulated Depreciation (book methods)	(1,460,911)		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)	\$ 973,667	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,516,818	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 125,473	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,427		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,759		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 179,659	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	873,892		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)	\$ 873,892	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,053,551	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 463,267	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,516,818	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 750,669	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 750,669	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(287,405)	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) Rounding	3	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (287,402)	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)	\$ 463,267	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowood

0019356

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,797,761	1
2	Discounts and Allowances for all Levels	(47,385)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,750,376	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,454	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,948	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)	\$ 7,402	23
D. Non-Operating Revenue			
24	Contributions	100	24
25	Interest and Other Investment Income***	1,020	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,120	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apartment Rental Income</u>	12,500	28
28a	<u>Miscellaneous</u>	1,237	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,737	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,772,635	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	542,345	31
32	Health Care	1,085,264	32
33	General Administration	263,344	33
B. Capital Expense			
34	Ownership	57,876	34
C. Ancillary Expense			
35	Special Cost Centers	603	35
36	Provider Participation Fee	110,608	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,060,040	40
41	Income before Income Taxes (line 30 minus line 40)**	(287,405)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (287,405)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 794,976	44
45	Private Pay - Net Inpatient Revenue	379,880	45
46	Medicare - Net Inpatient Revenue	575,520	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,750,376	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowood

0019356

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

12/31/2018

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	1,913	1,953	\$ 43,662	\$ 22.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,959	6,119	127,695	20.87	3
4	Licensed Practical Nurses	13,543	13,823	257,682	18.64	4
5	CNAs & Orderlies	33,042	33,722	344,450	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,217	2,257	20,819	9.22	9
10	Activity Assistants					10
11	Social Service Workers	1,822	1,942	23,642	12.17	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,004	20,920	10.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,085	7,445	65,544	8.80	15
16	Dishwashers	3,745	3,785	32,917	8.70	16
17	Maintenance Workers	1,833	1,873	29,910	15.97	17
18	Housekeepers	7,090	7,338	67,673	9.22	18
19	Laundry	1,561	1,641	17,790	10.84	19
20	Administrator	2,000	2,080	72,000	34.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,990	2,110	32,867	15.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	85,764	88,092	\$ 1,157,571 *	\$ 13.14	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	122	\$ 6,292	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,570	11-3	44
45	Social Service Consultant	26	1,570	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	174	\$ 9,432		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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Michael A. Cunningham	Administrator	0	\$ 72,000	Workers' Compensation Insurance	\$ 17,951	IDPH License Fee	\$	
				Unemployment Compensation Insurance	6,587	Advertising: Employee Recruitment	72	
				FICA Taxes	86,767	Health Care Worker Background Check (Indicate # of checks performed <u>6</u>)	270	
				Employee Health Insurance	1,053	Patient Background Checks <u>8</u>	80	
				Employee Meals		Licenses & Fees	3,072	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	235	
				Insurance Admin Fees	3,745	Advertising	2,071	
				Employee Vaccines	1,309			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,000	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising (2,071)	
			\$				Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8) \$ 3,729	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Terry L. Harper, CPA	Accounting Services		\$ 13,205				Out-of-State Travel	\$
							In-State Travel	1,261
							Seminar Expense	462
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 13,205	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8) \$ 1,723	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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? No
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? 7-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,672 Line 10
- (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. \$ 110,608
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? N/A
- (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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,948
- (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. \$ N/A
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees

Attachment to Schedule XIII, Page 15.

Expenses Related to Certified Nurses Aid Training Programs

Item A, #1

The facility only hires fully-trained Certified Nurses Aides.

SEE ACCOUNTANTS' COMPILATION REPORT