FOR BHF USE

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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: 0023275

Facility Name: Sheltered Village

Address: 600 Borden St (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
  - ☐ Charitable Corp.
  - ☐ Trust
- ☐ PROPRIETARY
  - ☐ Individual
  - ☐ Partnership
  - ☐ Corporation
  - ☐ "Sub-S" Corp.
  - ☐ Limited Liability Co.
  - ☐ Trust
  - ☐ Other
- ☐ GOVERNMENTAL
  - ☐ State
  - ☐ County
  - ☐ 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 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) _____ (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: 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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	96	Intermediate/DD	96	35,040	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	32,367	275		32,642	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,367	275		32,642	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.16%

D. How many bed reserve days during this year were paid by the Department?
447 (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)
n/a

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

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

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

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	MODIFIED CASH*	CASH*
[x]	[ ]	[ ]

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

Tax Year: December31 Fiscal Year: December

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 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	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	208,594	33,570	6,318	248,482		248,482		248,482			1
2	Food Purchase		219,894		219,894		219,894	(1,646)	218,248			2
3	Housekeeping	161,627	17,724	845	180,196		180,196		180,196			3
4	Laundry		6,951		6,951		6,951		6,951			4
5	Heat and Other Utilities			74,910	74,910		74,910		74,910			5
6	Maintenance	59,334	36,204	26,937	122,475		122,475		122,475			6
7	Other (specify):*											7
8	TOTAL General Services	429,555	314,343	109,010	852,908		852,908	(1,646)	851,262			8
	B. Health Care and Programs											
9	Medical Director			33,000	33,000		33,000		33,000			9
10	Nursing and Medical Records	1,637,953	178,719	29,782	1,846,454		1,846,454		1,846,454			10
10a	Therapy											10a
11	Activities	194,672	2,754	468	197,894		197,894		197,894			11
12	Social Services	277,629	927	28,461	307,017		307,017		307,017			12
13	CNA Training	12,951			12,951	256	13,207		13,207			13
14	Program Transportation			40,467	40,467	(18,281)	22,186		22,186			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,123,205	182,400	132,178	2,437,783	(18,025)	2,419,758		2,419,758			16
	C. General Administration											
17	Administrative	127,665			127,665		127,665		127,665			17
18	Directors Fees			9,000	9,000		9,000		9,000			18
19	Professional Services			40,372	40,372		40,372		40,372			19
20	Dues, Fees, Subscriptions & Promotions			31,914	31,914		31,914	(100)	31,814			20
21	Clerical & General Office Expenses	138,540		29,203	178,830	(256)	178,574		178,574			21
22	Employee Benefits & Payroll Taxes			589,856	589,856		589,856	(1,383)	588,473			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,303	15,303		15,303		15,303			24
25	Other Admin. Staff Transportation		11,087									25
26	Insurance-Prop.Liab.Malpractice			61,484	61,484		61,484		61,484			26
27	Other (specify):*											27
28	TOTAL General Administration	266,205	11,087	777,132	1,054,424	(256)	1,054,168	(1,483)	1,052,685			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,818,965	507,830	1,018,320	4,345,115	(18,281)	4,326,834	(3,129)	4,323,705			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheltered Village #0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			41,066	41,066	18,281	59,347	30,159	89,506			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,527	29,527		29,527	(47)	29,480			32
33	Real Estate Taxes			54,167	54,167		54,167		54,167			33
34	Rent-Facility & Grounds			171,000	171,000		171,000	(171,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			295,760	295,760	18,281	314,041	(140,888)	173,153			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			265,720	265,720		265,720		265,720			42
43	Other (specify):* **Day Training**	444,257	17,180	213,413	674,850		674,850	(674,850)				43
44	**TOTAL Special Cost Centers**	444,257	17,180	479,133	940,570		940,570	(674,850)	265,720			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,263,222	525,010	1,793,213	5,581,445		5,581,445	(818,867)	4,762,578			45

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(47)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,646)	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	(100)	20		20
21	Owner or Key-Man Insurance	(1,383)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(845,850)	43/34		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (849,026)		$	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)	30,159	30	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 30,159		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (818,867)		37

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

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

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

Sheltered Village

ID# 0023275

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 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	(1,646)	0	0	0	0	0	0	0	0	0	0	(1,646)	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**	(1,646)	0	0	0	0	0	0	0	0	0	0	(1,646)	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	(100)	0	0	0	0	0	0	0	0	0	0	(100)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(1,383)	0	0	0	0	0	0	0	0	0	0	(1,383)	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**	(1,483)	0	0	0	0	0	0	0	0	0	0	(1,483)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,129)	0	0	0	0	0	0	0	0	0	0	(3,129)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheltered Village # 0023275 **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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	30,159	0	0	0	0	0	0	0	0	0	0	30,159	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47)	0	0	0	0	0	0	0	0	0	0	(47)	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**	30,112	0	0	0	0	0	0	0	0	0	0	30,112	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)**	26,983	0	0	0	0	0	0	0	0	0	0	26,983	45

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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					
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 ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 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	Pamela Boman	100						1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Pamela Bowman	President		**		4	10.00	Directors Fees	$ 9,000	18-3	1
2											2
3	Robert F.X. Keeler	Treasurer					12.00	Wage	12,000	17-1	3
4											4
5	Amy McCue	Secretary									5
6	Amy McCue	Speech Therapist					20.00	Wage	30,410	12-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 51,410		13

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

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BMO Harris N A		x	Working Capital		9/20/2018	2,000,000	681,946	9/30/19	6.2500	29,527	6
7												7
8												8
9	TOTAL Facility Related						$ 2,000,000	$ 681,946			$ 29,527	9
	B. Non-Facility Related*											
10	TCF EquipFinanced		x	DT Program Bus	$1,363.00		70,394	67,357	10/14/23	8.0000	1,304	10
11												11
12									In DT expense			12
13												13
14	TOTAL Non-Facility Related				$1,363.00		$ 70,394	$ 67,357			$ 1,304	14
15	TOTALS (line 9+line14)						$ 2,070,394	$ 749,303			$ 30,831	15

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

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

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 69,000	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.)		$ 60,082	2
3. Under or (over) accrual (line 2 minus line 1).		$ (8,918)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 63,085	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.		$ 54,167	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	64,639	8
	2014	62,194	9
	2015	62,806	10
	2016	60,029	11
	2017	63,085	12

Accrual 12/31/2018 60082 @ 1.05% =630086- Round to 63085

	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheltered Village COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 0023275

CONTACT PERSON REGARDING THIS REPORT Robert Norris

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

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

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-06-326-001	600 Borden st	$ 60,082.00	$ 60,082.00
2.		Woodstock	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 60,082.00	$ 60,082.00

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 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 Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,500 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	4.9 Acres	1981	$ 50,000	1
2					2
3	TOTALS	#VALUE!		$ 50,000	3

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 843,191	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Blacktop			1998	8,986		15			8,986	9
10	Concrete Sedewalk and Patio			2000	3,851		15			3,851	10
11	90X40 Addition and Remodel			2003	629,115	16,131	39	16,131		245,328	11
12	Remodel Shower Area			2004	27,050	693	39	693		10,202	12
13	Blacktop Walkway			2006	11,675	779	15	779		9,729	13
14	Replace Resident Beds			2006	11,614	290	39	290		3,617	14
15	Attic Fire Walls			2011	9,743	244	39	244		1,837	15
16	Roof Work			2011	18,691	467	39	467		3,368	16
17	Widen Resident Doors			2013	7,580	189	39	189		994	17
18	Roof Work			2014	13,100	907	15	907		4,935	18
19	New Front Door			2016	9,250	232	39	232		662	19
20	Front Door			2018	2,251	75	15	75		75	20
21	Seal Coating			2018	2,642	88	15	88		88	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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)		$ 1,705,548	$ 20,095		$ 50,254	$ 30,159	$ 1,136,863	70

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 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	$ 186,309	$ 17,867	$ 17,867	$	7-May	$ 154,378	71
72	Current Year Purchases	27,820	2,104	2,104		7-May	2,104	72
73	Fully Depreciated Assets	541,994					541,994	73
74								74
75	TOTALS	$ 756,123	$ 19,971	$ 19,971	$		$ 698,476	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	Res Trans	2009 Chevy Impla	2010	$ 30,180	$ 6,275	$ 6,275	$	5	$ 24,285	76
77	Res Trans	2012 Dodge Caravan	2018	16,264	1,875	1,875		5	15,529	77
78	Res Trans	2014 Chevy 350 Van	2015	29,403	5,881	5,881		5	20,588	78
79	Res Trans	2014 Caravan Wheelchair Van	2017	21,252	4,250	4,250		5	4,782	79
80	TOTALS			$ 97,099	$ 18,281	$ 18,281	$		$ 65,184	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)	$ 2,608,770	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,347	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,506	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 30,159	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,900,523	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	$ 284,775	$ 11,584	$ 109,391	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 284,775	$ 11,584	$ 109,391	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 171,000	Not Stated		3
4	Additions							4
5								5
6								6
7	TOTAL		96		$ 171,000 **			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.	12/31/2019	$ 18,000
13.	12/31/2020	$ open
14.	12/31/2021	$ open

8. List separately any amortization of lease expense included on page 4, line 34. N/A
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.

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 110

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)		4,594		4,594
4	Clinical Wages	(b)		11,167		11,167
5	In-House Trainer Wages	(c)		8,357		8,357
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$ 24,374	$	$ 24,374
10	SUM OF line 9, col. 1 and 2	(e)	$ 24,374			

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ 0	14

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

STATE OF ILLINOIS

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 183,035	$	1
2	Cash-Patient Deposits	71,940		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	728,980		3
4	Supply Inventory (priced at)	5,122		4
5	Short-Term Investments			5
6	Prepaid Insurance	86,731		6
7	Other Prepaid Expenses	130,371		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,206,179	$	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	755,548		15
16	Equipment, at Historical Cost	853,221		16
17	Accumulated Depreciation (book methods)	(1,057,326)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Day Training Assets	175,384		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 726,827	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,933,006	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 123,885	$	26
27	Officer's Accounts Payable	11,221		27
28	Accounts Payable-Patient Deposits	71,940		28
29	Short-Term Notes Payable	681,946		29
30	Accrued Salaries Payable	146,200		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,085		32
33	Accrued Interest Payable	2,985		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)**	$ 1,101,262	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	67,357		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)**	$ 67,357	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,168,619	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 764,387	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,933,006	$	48

***(See instructions.)**

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 810,325	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 810,325	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(45,939)	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)**	$ (45,939)	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)**	$ 764,386	24 *

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

Facility Name & ID Number Sheltered Village # 0023275 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,614,071	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,614,071	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	19,626	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)**	$ 19,626	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	47	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 47	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training	901,120	28
28a	Commissary Net	638	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 901,758	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,535,502	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	852,908	31
32	Health Care	2,437,783	32
33	General Administration	1,054,424	33
	B. Capital Expense		
34	Ownership	295,760	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	265,720	36
	D. Other Expenses (specify):		
37	Day training program	674,850	37
38			38
39	Rounding	(4)	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,581,441	40
41	**Income before Income Taxes (line 30 minus line 40)****	(45,939)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (45,939)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,740,847	44
45	Private Pay - Net Inpatient Revenue	21,264	45
46	Medicare - Net Inpatient Revenue	849,997	46
47	Other-(specify) social security	1,963	47
48	Other-(specify) Transit Medical		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,614,071	49

* This must agree with page 4, line 45, column 4. Line 43 (45939)

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Linfe Ins 1383 50% Meals & Ent

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. Taxable Income (39449

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,020	2,200	$ 86,265	$ 39.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,405	15,196	444,889	29.28	3
4	Licensed Practical Nurses	10,156	10,513	283,639	26.98	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,502	1,502	12,951	8.62	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,182	2,366	44,332	18.74	9
10	Activity Assistants	13,820	14,325	148,343	10.36	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,201	2,440	51,346	21.04	13
14	Head Cook	2,020	2,235	27,163	12.15	14
15	Cook Helpers/Assistants	4,870	5,169	65,310	12.63	15
16	Dishwashers	4,567	4,653	46,302	9.95	16
17	Maintenance Workers	6,062	6,879	109,252	15.88	17
18	Housekeepers	7,037	7,634	86,745	11.36	18
19	Laundry	3,721	4,015	69,640	17.34	19
20	Administrator	1,960	2,080	115,665	55.61	20
21	Assistant Administrator					21
22	Other Administrative	300	300	12,000	40.00	22
23	Office Manager					23
24	Clerical	3,809	4,438	108,440	24.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,065	9,277	196,523	21.18	28
29	Resident Services Coordinator	1,964	2,080	61,671	29.65	29
30	Habilitation Aides (DD Homes)	52,778	56,799	817,495	14.39	30
31	Medical Records	1,799	2,011	30,994	15.41	31
32	Other Health Care(specify)					32
33	Other(specify)	25,263	27,832	444,257	15.96	33
34	TOTAL (lines 1 - 33)	170,501	183,944	$ 3,263,222 *	$ 17.74	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 11,400	1-3	35
36	Medical Director	96	33,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	2,959	10-3	39
40	Physical Therapy Consultant	20	1,523	10-3	40
41	Occupational Therapy Consultant	15	1,038	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	420	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	65	3,264	12-3	45
46	Other(specify)				46
47		70	15,255	10-3	47
48					48
49	TOTAL (lines 35 - 48)	525	$ 68,859		49

C. CONTRACT NURSES

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

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Norris	Administrator	0	$ 115,665
Robert Keeler	Accountant	0	12,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,665

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
Jay Montgomery	Business Consultant	$ 20,000
Pro Data	Payroll Fees	7,417
Siepert &Co LLP	Compiled Reports	2,859
Sitzberger &Co	401K Audit	7,250
Regas Frezados		
& Dallas LLP	Legal Guardianship	714
Filler & Assoc	Legal Guardianship	2,132
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 40,372

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 120,380
Unemployment Compensation Insurance	15,109
FICA Taxes	243,834
Employee Health Insurance	283,806
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Term LifeIns	18,429
Administrative Life Insurance	1,383
Day Training Fringes	(93,085)
TOTAL (agree to Schedule V, line 22, col.8)	$ 589,856

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30,924
Health Care Worker Background Check	
(Indicate # of checks performed)	874
Patient Background Checks	16
Contribution	100
Less: Public Relations Expense	100
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,014

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,088
Seminar Expense	10,215
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,303

* Attach copy of IMRF notifications

**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. **No**

(3) Did the nursing home make political contributions or payments to a politica
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 fo
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 Departmen
during this cost report period. $ **265,720**
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? **Y-Aide Trai** 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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **1,963**
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 othe
times when not in use?
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. $ **Vehicle in 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

Date	transaction type	num	name	memo/ description	account	split	amount	balance
01 05 18	check	51767	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	253.96	253.96
02 06 18	check	51859	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	328.42	582.38
02 22 18	check	51966	Lauren Schlendorf		1045 travel/meeting expense	101 Cash in bank - general	49.67	632.05
03 05 18	check	51991	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	205.41	837.46
03 20 18	check	52053	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	244.56	1082.02
04 12 18	check	52117	Lauren Schlendorf		1045 travel/meeting expense	101 Cash in bank - general	63.43	1145.45
04 19 18	check	52168	Lauren Schlendorf		1045 travel/meeting expense	101 Cash in bank - general	0.00	1145.45
04 23 18	check	52172	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	246.57	1392.02
04 30 18	check	52180	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	181.97	1573.99
05 02 18	check	52210	Lauren Schlendorf		1045 travel/meeting expense	101 Cash in bank - general	49.67	1623.66
05 21 18	check	52278	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	366.90	1990.56
06 11 18	check	52350	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	330.06	2320.62
06 27 18	check	52423	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	171.45	2492.07
06 28 18	check	52451	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	146.33	2638.4
07 12 18	check	52476	Lauren Schlendorf		1045 travel/meeting expense	101 Cash in bank - general	53.99	2692.39
07 24 18	check	52546	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	66.68	2759.07
08 03 18	check	52582	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	51.83	2810.9
08 16 18	expense	2813	BMO credit card		1045 travel/meeting expense	101 Cash in bank - general	80.42	2891.32
08 30 18	check	52688	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	283.04	3174.36
09 10 18	check	52730	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	127.88	3302.24
09 21 18	check	52796	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	190.53	3492.77
10 04 18	check	52821	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	168.05	3660.82
10 19 18	check	52901	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	0.00	3660.82
10 19 18	check	52901	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	271.96	3932.78
10 31 18	check	52940	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	143.14	4075.92
11 12 18	check	52959	Cheri Forsberg		1045 travel/meeting expense	101 Cash in bank - general	176.31	4252.23
11 21 18	check	53029	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	219.03	4471.26
12 07 18	check	53066	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	233.17	4704.43
12 21 18	check	53147	Robert Norris		1045 travel/meeting expense	101 Cash in bank - general	384.00	5088.43
Total for traveling expense							**5088.43**	
TOTAL							**5088.43**	

Date	Name or Description	Sponsor	Number of Staff	Cost
01 16 18	Fall Prevention Challenges	PESI	1	199
02 01 18	ATEC Amb. Svcs. CPR/FirstAid	In House	7	550
02 14 18	ATEC Amb. Svcs. CPR/FirstAid	In House	6	1070
03 02 18	Food Services Manager Certification	Safe Food Handling	1	195
03 19 18	ATEC Amb. Svcs. CPR/FirstAid	In House	4	90
03 20 18	ATEC Amb. Svcs. CPR/FirstAid	In House	7	220
04 03 18	ATEC Amb. Svcs. CPR/FirstAid	In House	6	90
04 10 18	ATEC Amb. Svcs. CPR/FirstAid	In House	8	430
04 10 18	ATEC Amb. Svcs. CPR/FirstAid	In House	6	320
04 12 18	Abnormal Psychology	MCC	1	424
06 01 18	ATEC Amb. Svcs. CPR/FirstAid	In House	9	530
07 10 18	ATEC Amb. Svcs. CPR/FirstAid	In House	6	180
07 12 18	ATEC Amb. Svcs. CPR/FirstAid	In House	6	180
08 16 18	Safe Food Handling	Safe Food Handling	3	585
08 16 18	Humanities of the Arts	MCC	1	443
09 07 18	ATEC Amb. Svcs. CPR/FirstAid	In House	7	350
09 17 18	Crisis Prevention	Elgin Illinois	1	485
09 19 18	SLP Education	on line	1	145
09 20 18	Sexual Harassment	Cynthia Cobb	120	1500
10 04 18	ATEC Amb. Svcs. CPR/FirstAid	In House	4	90
10 04 18	Home study course	on line	2	155
10 09 18	ATEC Amb. Svcs. CPR/FirstAid	In House	5	440
10 18 18	ATEC Amb. Svcs. CPR/FirstAid	In House	6	210
11 15 18	Chad Woolford RN	Seminar	1	233
12 18 18	Challenging Behaviors in Dementia	PESI	2	300
12 26 18	ATEC Amb. Svcs. Choking	In House	all staff	800
TOTAL				**10214**

LINE	Reclassifications	Debit	Credit
30-3	Depreciation	18281	
14-3	Program Transportation		18281
	Reclassify Vehicle Depreciation		
13-2	CNA Training	256	
	Clerical and general office		256
	Reclassify AID Training Supplies		

Adjustments Line 29

	Line	
Day Training Program	43	674850
Facility Rent	34	171000
	TOTAL	**845850**