

		FOR BHF USE				

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2020
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)
 FOR LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2020)

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

<p>I. IDPH License ID Number: <u>0021766</u></p> <p>Facility Name: <u>Meadows</u></p> <p>Address: <u>3250 S Plum Grove Rd</u> <u>Rolling Meadows</u> <u>60008</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 397-0055</u> Fax # <u>(847) 397-0477</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/1975</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jessica Krugler</u> Telephone Number: <u>(847) 397-0055</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;">(Type or Print Name) <u>Jessica Krugler</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">(Title) <u>Administrator</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;">(Print Name and Title) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">(Firm Name & Address) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">(Telephone) () _____ Fax # () _____</td> <td style="border: none;"></td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Jessica Krugler</u>		(Title) <u>Administrator</u>		Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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(Telephone) () _____ Fax # () _____																																							

STATE OF ILLINOIS

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	32,971	366		33,337
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	32,971	366		33,337

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.00%

D. How many bed reserve days during this year were paid by the Department? 274 (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 08/1975

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020
 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
1	Dietary	134,557	16,052	5,268	155,877		155,877	155,877			1
2	Food Purchase		235,222		235,222		235,222	235,222			2
3	Housekeeping	28,915	22,597	53,443	104,955		104,955	104,955			3
4	Laundry	18,052	22,573		40,625		40,625	40,625			4
5	Heat and Other Utilities			110,427	110,427		110,427	110,427			5
6	Maintenance	133,827	5,611	50,129	189,567		189,567	189,567			6
7	Other (specify):*										7
8	TOTAL General Services	315,351	302,055	219,267	836,673		836,673	836,673			8
	B. Health Care and Programs										
9	Medical Director					646	646	646			9
10	Nursing and Medical Records	1,653,612	182,608	235,979	2,072,199	(16,800)	2,055,399	2,055,399			10
10a	Therapy	1,749			1,749	775	2,524	2,524			10a
11	Activities	62,974	655		63,629	65	63,694	63,694			11
12	Social Services	130,423	6,050	9,262	145,735	(840)	144,895	144,895			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,848,758	189,313	245,241	2,283,312	(16,154)	2,267,158	2,267,158			16
	C. General Administration										
17	Administrative	69,248			69,248		69,248	69,248			17
18	Directors Fees										18
19	Professional Services			51,732	51,732	14,063	65,795	65,795			19
20	Dues, Fees, Subscriptions & Promotions			11,213	11,213	(1,719)	9,494	9,494			20
21	Clerical & General Office Expenses	241,648	13,788	63,282	318,718	(12,313)	306,405	(12,658)	293,747		21
22	Employee Benefits & Payroll Taxes			448,346	448,346		448,346	(3,970)	444,376		22
23	Inservice Training & Education										23
24	Travel and Seminar			1	1	(1)					24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			382,443	382,443		382,443	(22,333)	360,110		26
27	Other (specify):*										27
28	TOTAL General Administration	310,896	13,788	957,017	1,281,701	30	1,281,731	(38,961)	1,242,770		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,475,005	505,156	1,421,525	4,401,686	(16,124)	4,385,562	(38,961)	4,346,601		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 Meadows Sheltered Care, Inc. #0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			19,169	19,169		19,169	45,761	64,930			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5	5		5	131,049	131,054			32
33	Real Estate Taxes							253,996	253,996			33
34	Rent-Facility & Grounds			595,685	595,685		595,685	(595,685)				34
35	Rent-Equipment & Vehicles			9,257	9,257	(30)	9,227		9,227			35
36	Other (specify):*											36
37	TOTAL Ownership			624,116	624,116	(30)	624,086	(164,879)	459,207			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			3,070	3,070	16,154	19,224		19,224			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			305,133	305,133		305,133		305,133			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			308,203	308,203	16,154	324,357		324,357			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,475,005	505,156	2,353,844	5,334,005		5,334,005	(203,840)	5,130,165			45

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		2.2		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	3,752	30.3		9
10 Interest and Other Investment Income	(5)	32.3		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees		13		27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	(79,900)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,153)		\$	30

BHF USE ONLY						
48		49		50		52

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

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(127,687)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (127,687)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (203,840)		37

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

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

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39 Physician Care	x		16,154	9.3	39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$ 16,154		47

STATE OF ILLINOIS

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

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

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

1 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	34 Facility Rent	\$ 595,685	Byrn T. Witt & Barbara S. Witt	100.00%	\$	\$ (595,685)	1
2	V							2
3	V	30 Depreciation		Byrn T. Witt & Barbara S. Witt	100.00%	43,784	43,784	3
4	V	32 Interest		Byrn T. Witt & Barbara S. Witt	100.00%	131,054	131,054	4
5	V	17						5
6	V	33 Real Estate Taxes		Byrn T. Witt & Barbara S. Witt	100.00%	253,996	253,996	6
7	V							7
8	V	26 Property Insurance		Byrn T. Witt & Barbara S. Witt	100.00%	39,164	39,164	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 595,685			\$ 467,998	\$ * (127,687)	14

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robin Witt	Administrator	Administration			40	100%	Salary	\$ 50,591	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	\$ 50,591		13

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
A. Directly Facility Related												
Long-Term												
1							\$	\$			\$	1
2	HUD		X	Debt Refinance / Bldg Constructio	Varies	2006	2,700,000	2,338,105	2046	0.0600	131,054	2
3					-							3
4					-							4
5					-							5
Working Capital												
6					-							6
7					-						-	7
8					-							8
9	TOTAL Facility Related						\$ 2,700,000	\$ 2,338,105			\$ 131,054	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,700,000	\$ 2,338,105			\$ 131,054	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.)

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meadows Sheltered Care, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0021766

CONTACT PERSON REGARDING THIS REPORT Jessica Krugler

TELEPHONE (847) 397-0055 FAX #: (847) 397-0477

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-35-100-016-0000</u>	<u>_____</u>	\$ <u>273,731.00</u>	\$ <u>273,731.00</u>
2. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
3. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
4. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
5. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
6. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
7. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
8. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
9. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
10. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
	TOTALS	\$ <u>273,731.00</u>	\$ <u>273,731.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation*. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
			Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	98		1986	1975	\$ 1,500,000	\$	30	\$		\$ 1,500,000	4
5			1996	1996	1,478,674		39	37,915	37,915	929,073	5
6	1		1996	1996	15,000		39	385	385	9,322	6
7											7
8											8
	Improvement Type**										
9	Remodeling		1976		3,548		10			3,548	9
10			1977		21,344		10			21,344	10
11			1979		169		10			169	11
12			1980		9,111		10			9,111	12
13			1981		3,203		10			3,203	13
14			1983		7,355		10			7,355	14
15			1984		11,356		10			11,356	15
16	Garage		1985		3,165		10			3,165	16
17	Remodeling		1986		2,386		10			2,386	17
18	Water Heater & Fire Alarm System		1987		3,199		15			3,199	18
19	Roof		1988		40,520		20			40,520	19
20	Heat Pump		1988		1,900		15			1,900	20
21	Roof		1990		3,527		20			3,527	21
22	Kitchen		1990		2,319		10			2,319	22
23	Heater Repairs		1991		840		7			840	23
24	Improvements		1993		737	4	10		(4)	737	24
25	Water Heater		1995		3,000		7			3,000	25
26	Exterior Doors		1995		628	16	39	16		410	26
27	Garage Door		1996		385		10			385	27
28	Parking Lot Repair		1996		6,655		20			6,655	28
29	Driveway		1996		22,572		20			22,572	29
30	Walk-in Freezer & Cooler		1996		12,333		10			12,333	30
31	Draperies		1997		16,239		39	416	416	9,778	31
32	Fencing		1997		8,090	207	39	207		4,866	32
33	Windows & Doors		1997		2,128		39	55	55	1,293	33
34	New Building Addition		1998		7,500		39	192	192	4,416	34
35	Telephone Equipment		2001		1,850		5			1,850	35
36	Air Conditioning Units		2001		4,568		39	117	117	2,288	36

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

See Page 12A, Line 70 for total

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

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Page 12A

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2020

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Window Screens	2001	\$ 1,400	\$	39	\$ 36	\$ 36	\$ 703	37
38 Draperies	2001	4,118		39	106	106	2,106	38
39 Magnetic Door Holders	2002	1,350		7			1,350	39
40 6 Air Conditioner Units	2002	4,671		39	120	120	2,049	40
41 12 Resident Room Closet Doors	2002	2,346		39	60	60	1,035	41
42 Nurse Call System	2002	38,000		5			38,000	42
43 Magnetic Door Holders	2002	3,696		5			3,696	43
44 Signage	2003	1,698		7			1,698	44
45 Flooring	2002	1,731		10			1,731	45
46 Draperies	2003	1,052		7			1,052	46
47 Windows	2003	710		39	18	18	288	47
48 HVAC Units	2003	3,813		5			3,813	48
49 Carpeting	2003	10,994		10			10,994	49
50 Parking Lot	2004	26,879		15			26,879	50
51 HVAC Units	2004	5,825		5			5,825	51
52 Security System	2004	18,600		5			18,600	52
53 HVAC Units	2005	484		5			484	53
54 Nurse call system	2005	6,231		5			6,231	54
55 Electrical cabling	2005	1,450		5			1,450	55
56 HVAC Units	2005	281		5			281	56
57 Security System	2006	3,590		7			3,590	57
58 Double egress doors	2006	5,908		39	151	151	2,225	58
59 Generator & electrical panel	2008	2,500		7			2,500	59
60 Replacement Doors	2008	2,859		39	73	73	931	60
61 Fire Alarm System	2008	17,084		39	438	438	5,335	61
62 HVAC Units	2009	4,209		7			4,209	62
63 Fire alarm system	2009	6,108		39	157	157	1,766	63
64 Driveway repair	2010	4,604		15	307	307	3,122	64
65 Heat/AC units in rooms	2010	4,453		7			4,453	65
66 Resident and interior doors - 12	2011	4,343		39	111	111	1,046	66
67 Wheelchair guards, kitchen disposal, vanities, toilets, 2 HVAC	2011	2,876		7			2,876	67
68 HVAC Units	2012	2,549		7			2,549	68
69 Cooling compressor	2012	2,627		7			2,627	69
70 TOTAL (lines 4 thru 69)		\$ 3,393,340	\$ 227		\$ 40,880	\$ 40,653	\$ 2,788,414	70

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2020

Ending: 12/31/2020

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	
1	Totals from Page 12A, Carried Forward		\$ 3,393,340	\$ 227		\$ 40,880	\$ 40,653	\$ 2,788,414	1
2	Toilets, bath cabinets, sinks	2012	3,452		7			3,452	2
3	Replacement Water Heater	2013	4,310		7	175	175	4,310	3
4	New flooring main hallways	2014	80,327		39	2,060	2,060	14,081	4
5	Door alarm replacement panel	2014	3,549		5			3,549	5
6	Exterior Door & Locking system	2015	3,765		39	97	97	581	6
7	Activity Flooring	2015	3,488		39	89	89	534	7
8	Sprinkler System	2015	20,274		39	520	520	2,784	8
9	5 ton condenser unit & HVAC unit	2015	6,478		39	166	166	916	9
10	Staff lounge flooring	2016	2,586		5	517	517	2,068	10
11	Exterior fencing	2016	5,500		15	367	367	1,528	11
12	New driveway by dumpster	2016	3,830		15	255	255	1,062	12
13	100 amp electrical panel	2017	9,000		7	1,286	1,286	4,823	13
14	Resident room flooring all rooms 1 - 49	2017	63,720	1,634	39	1,634		5,171	14
15	Direct Supply Flooring all rooms 1 - 49	2017	27,513		39	705	705	2,173	15
16	Electrical cabling entire building	2017	3,483		7	498	498	1,701	16
17	Plank Flooring all rooms 1 - 49	2018	10,634		39	273	273	818	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,645,249	\$ 1,861		\$ 49,522	\$ 47,661	\$ 2,837,965	34

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	\$ 123,768	\$ 736	\$ 736	\$	Various	\$ 124,631	71
72	Current Year Purchases	13,868	12,922	12,922		Various	12,922	72
73	Fully Depreciated Assets	76,653					76,653	73
74								74
75	TOTALS	\$ 214,289	\$ 13,658	\$ 13,658	\$		\$ 214,206	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Mini Van	Dodge, 2014	2014	\$ 39,713	\$ 1,875	\$	\$ (1,875)	5	\$ 39,713	76
77	Lift for Dodge		2017	8,749		1,750	1,750	5	6,127	77
78										78
79										79
80	TOTALS			\$ 48,462	\$ 1,875	\$ 1,750	\$ (125)		\$ 45,840	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,933,000	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,394	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,930	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 47,536	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,098,011	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2021</u>	\$ _____
13.	<u>/2022</u>	\$ _____
14.	<u>/2023</u>	\$ _____

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: \$ 9,227 Description: Copier: \$7,671; Mailing Machine: \$1,556
 (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.

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

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

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

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.

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766 Report Period Beginning:

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits		200	16,154		200	16,154	5
6	Dental Care	39.3	visits		31	3,070		31	3,070	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2								13
14	TOTAL			\$	231	\$ 19,224	\$	231	\$ 19,224	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

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Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning: 01/01/2020

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (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	\$ 1,491,659	\$	1
2	Cash-Patient Deposits	14,032		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	98,136		3
4	Supply Inventory (priced at FIFO)	6,693		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,838		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	26,981		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,665,339	\$	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	103,355		15
16	Equipment, at Historical Cost	368,791		16
17	Accumulated Depreciation (book methods)	(359,730)		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)	\$ 112,416	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,777,755	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 422,521	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(5,220)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	A/P Other			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 417,301	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	450,000		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)	\$ 450,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 867,301	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 910,454	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,777,755	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 767,059	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(135,004)	4
5	Rounding	1	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 632,056	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	278,398	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)	\$ 278,398	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)	\$ 910,454	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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	\$ 5,612,352	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,612,352	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	51	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 51	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,612,403	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	836,673	31
32	Health Care	2,283,312	32
33	General Administration	1,281,701	33
B. Capital Expense			
34	Ownership	624,116	34
C. Ancillary Expense			
35	Special Cost Centers	3,070	35
36	Provider Participation Fee	305,133	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,334,005	40
41	Income before Income Taxes (line 30 minus line 40)**	278,398	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 278,398	43

		3	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,516,151	44
45	Private Pay - Net Inpatient Revenue	96,202	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Rounding	(1)	47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,612,352	49

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

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

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	1,718	1,901	\$ 64,236	\$ 33.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,597	2,668	86,834	32.55	3
4	Licensed Practical Nurses	9,854	10,303	383,346	37.21	4
5	CNAs & Orderlies	47,918	50,353	1,016,195	20.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	127	127	1,749	13.77	8
9	Activity Director					9
10	Activity Assistants	3,821	4,172	62,974	15.09	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,652	8,010	134,557	16.80	15
16	Dishwashers					16
17	Maintenance Workers	7,046	7,488	133,827	17.87	17
18	Housekeepers	2,008	2,062	28,915	14.02	18
19	Laundry	1,577	1,858	18,052	9.72	19
20	Administrator	1,214	1,371	69,248	50.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,109	4,692	219,732	46.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,160	2,382	67,545	28.36	28
29	Resident Services Coordinator	1,744	2,160	62,878	29.11	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	2,806	2,992	103,001	34.43	33
34	TOTAL (lines 1 - 33)	96,351	102,539	\$ 2,453,089 *	\$ 23.92	34

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	203	\$ 5,268	1.3	35
36	Medical Director	8	646	9.3	36
37	Medical Records Consultant			10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	32	3,183	10.3	39
40	Physical Therapy Consultant	8	541	10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant			10a.3	42
43	Speech Therapy Consultant	3	234	10a.3	43
44	Activity Consultant	1	65	11.3	44
45	Social Service Consultant			12.3	45
46	Other(specify) <u>Psychologist</u>	29	2,573	12.3	46
47					47
48	<u>Psychiatrist</u>	20	5,850	12.3	48
49	TOTAL (lines 35 - 48)	303	\$ 18,360		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	140	\$ 7,944	10.3	50
51	Licensed Practical Nurses	1,237	69,646	10.3	51
52	Certified Nurse Assistants/Aides	4,535	134,652	10.3	52
53	TOTAL (lines 50 - 52)	5,912	\$ 212,242		53

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

** See instructions.

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning: 01/01/2020

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IARF Membership Dues 8,436
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,438 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 305,133
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ Zero
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.