

		FOR OHF USE				

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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 Facility ID Number: <u>0023275</u></p> <p>Facility Name: <u>Sheltered Village-Woodstock</u></p> <p>Address: <u>600 Borden Street</u> <u>Woodstock</u> <u>60098</u> Number City Zip Code</p> <p>County: <u>McHenry</u></p> <p>Telephone Number: <u>(815) 338-6440</u> Fax # <u>(815) 338-0124</u></p> <p>IDPA ID Number: <u>36-289441001</u></p> <p>Date of Initial License for Current Owners: <u>01/01/77</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Robert F.X. Keeler</u> Telephone Number: <u>(815) 895-3303</u></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>01/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Robert R. Bowman</u> (Title) <u>President</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>Compilation Report Attached</u> (Print Name and Title) <u>Robert F.X. Keeler, Partner</u> (Firm Name & Address) <u>204 South Main Street, Sycamore, IL 60178-1824</u> (Telephone) <u>(815) 895-3303</u> Fax # <u>(815) 895-6857</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Robert R. Bowman</u> (Title) <u>President</u>	Paid Preparer	(Signed) <u>Compilation Report Attached</u> (Print Name and Title) <u>Robert F.X. Keeler, Partner</u> (Firm Name & Address) <u>204 South Main Street, Sycamore, IL 60178-1824</u> (Telephone) <u>(815) 895-3303</u> Fax # <u>(815) 895-6857</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village-Woodstock

0023275 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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	94	Intermediate/DD	94	34,404	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	94	TOTALS	94	34,404	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	31,360	1,202		32,562	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,360	1,202		32,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.65%

D. How many bed-hold days during this year were paid by Public Aid?

966 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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

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 1/1/77

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ 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: December 31 Fiscal Year: December 31

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

STATE OF ILLINOIS

Facility Name & ID Number Sheltered Village-Woodstock # 0023275 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	112,531	14,108	7,032	133,671		133,671		133,671		1
2	Food Purchase		138,602		138,602		138,602	(244)	138,358		2
3	Housekeeping	70,491	14,361		84,852		84,852		84,852		3
4	Laundry	6,594	5,047		11,641		11,641		11,641		4
5	Heat and Other Utilities			56,637	56,637		56,637		56,637		5
6	Maintenance	31,644	26,863		58,507		58,507		58,507		6
7	Other (specify):*										7
8	TOTAL General Services	221,260	198,981	63,669	483,910		483,910	(244)	483,666		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	894,948	26,391	18,218	939,557		939,557		939,557		10
10a	Therapy										10a
11	Activities	116,962	3,102		120,064		120,064		120,064		11
12	Social Services	242,448	913	18,253	261,614		261,614		261,614		12
13	Nurse Aide Training	10,520			10,520	3,877	14,397		14,397		13
14	Program Transportation			14,181	14,181	(10,805)	3,376		3,376		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,264,878	30,406	62,652	1,357,936	(6,928)	1,351,008		1,351,008		16
	C. General Administration										
17	Administrative	237,280			237,280		237,280		237,280		17
18	Directors Fees			22,000	22,000		22,000		22,000		18
19	Professional Services			18,399	18,399		18,399		18,399		19
20	Dues, Fees, Subscriptions & Promotions			4,113	4,113		4,113		4,113		20
21	Clerical & General Office Expenses	54,383	7,166	11,236	72,785		72,785		72,785		21
22	Employee Benefits & Payroll Taxes			380,482	380,482		380,482		380,482		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,316	11,316	(3,877)	7,439	(1,362)	6,077		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,380	29,380		29,380		29,380		26
27	Other (specify):*										27
28	TOTAL General Administration	291,663	7,166	476,926	775,755	(3,877)	771,878	(1,362)	770,516		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,777,801	236,553	603,247	2,617,601	(10,805)	2,606,796	(1,606)	2,605,190		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheltered Village-Woodstock

#0023275

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			12,909	12,909	10,805	23,714	30,159	53,873			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			30,673	30,673		30,673		30,673			33
34	Rent-Facility & Grounds			182,000	182,000		182,000	(182,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			225,582	225,582	10,805	236,387	(151,841)	84,546			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			196,390	196,390		196,390		196,390			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			196,390	196,390		196,390		196,390			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,777,801	236,553	1,025,219	3,039,573		3,039,573	(153,447)	2,886,126			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village-Woodstock

0023275

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

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	OHF 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	(57,060)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(244)	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	(1,362)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Rent Related Party	(182,000)	34		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (240,666)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	87,219		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 87,219		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (153,447)		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						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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0023275
 Report Period Beginning: 01/01/2000
 Ending: 12/31/2000

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
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67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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%	None		None		

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

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

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

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

Facility Name & ID Number Sheltered Village-Woodstock # 0023275 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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	Robert R Bowman	President		**	0			Director Fee	\$ 5,500	18-3	1
2	Robert R. Bowman	Physcial Plant Sup				32	80.00	Wage	156,000	17-1	2
3	Pamela S. Bowman	Vice President		**	0			Director Fee	5,500	18-3	3
4	Edward A. Rosenow	Secretary			0			Director Fee	5,500	18-3	4
5	Fobert F.X. keeler	Treasurer			0			Director Fee	5,500	18-3	5
6											6
7											7
8											8
9	** Robert & Pamela Bowman own 100% of Forest Steel Company which										9
10	owns 100% of Dorr Wood LTD.										10
11											11
12											12
13								TOTAL	\$ 178,000		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village-Woodstock # 0023275 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Miller Roskamp		X	Purchase Land & Building	\$10,000.00	1/1/91	\$ 985,000	\$ 561,719	3/1/07	10.0000	\$ 57,060	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related				\$10,000.00		\$ 985,000	\$ 561,719			\$ 57,060	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$ 985,000	\$ 561,719			\$ 57,060	15						

* 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-Woodstock# 0023275 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	<u>31,538</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>30,646</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(892)</u>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>31,565</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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 used previously to calculate a payment rate. 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 19 _____ 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.	\$	<u>30,673</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<u>25,558</u>	8
	1996	<u>28,301</u>	9
	1997	<u>29,287</u>	10
	1998	<u>30,036</u>	11
	1999	<u>30,646</u>	12
Accrual at 12/31/00 30,646 @103% = 31,565			
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village-Woodstock# 0023275 Report Period Beginning:01/01/2000 Ending:12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,300 B. General Construction Type: Exterior Brick Frame Wood with Sprinkler Number of Stories 1C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>1991</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village-Woodstock

0023275

Report Period Beginning:

01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	94		1991	1969	\$ 950,000	\$	31.5	\$ 30,159	\$ 30,159	\$ 300,332	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements per audit, Prior cost reports			1979	2,110		13			2,110	9
10	Blacktop			1995	8,986	599	15	599		3,046	10
11	Concrete Sidewalk and Pad			2000	3,851	171	15	171		171	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	TOTAL (lines 4 thru 35)				\$ 964,947	\$ 770		\$ 30,929	\$ 30,159	\$ 305,659	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 ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 79,279	\$ 11,949	\$ 11,949	\$	5-7 years	\$ 41,310	37
38	Current Year Purchases	7,297	190	190		5-7 years	190	38
39	Fully Depreciated Assets	240,632				5-7 years	240,632	39
40								40
41	TOTALS	\$ 327,208	\$ 12,139	\$ 12,139	\$		\$ 282,132	41

D. Vehicle Depreciation (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	
42	Resident Transport	Van Chev 99	1998	\$ 29,027	\$ 5,805	\$ 5,805	\$	5	\$ 12,336	42
43	Resident Transport	Sedan Olds 99	1999	25,249	5,000	5,000		5	7,525	43
44										44
45										45
46	TOTALS			\$ 54,276	\$ 10,805	\$ 10,805	\$		\$ 19,861	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,396,431	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 23,714	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 53,873	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 30,159	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 607,652	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Trust 13-1435

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1969</u>	<u>94</u>	<u>1/1/91</u>	\$ <u>182,000</u>	<u>Year to Year</u>	<u>Not Stated</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		94		\$ 182,000			7

10. Effective dates of current rental agreement:

Beginning 1/1/00
Ending 12/31/00

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

Fiscal Year Ending Annual Rent

12. 12/31/2001 \$ 192,000
13. 12/31/2002 \$ Not Stated
14. 12/31/2003 \$ Not Stated

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>43.5</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>97.5</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 3,877	\$	\$ 3,877
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		10,520		10,520
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 14,397	\$	\$ 14,397
10	SUM OF line 9, col. 1 and 2 (e)	\$	14,397		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	None

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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village-Woodstock

0023275

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000

(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	\$ 1,339,726	1
2	Cash-Patient Deposits	2,588	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	475,572	3
4	Supply Inventory (priced at Cost)	3,290	4
5	Short-Term Investments		5
6	Prepaid Insurance	23,923	6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,845,099	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	12,837	15
16	Equipment, at Historical Cost	381,484	16
17	Accumulated Depreciation (book methods)	(305,209)	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)	\$ 89,112	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,934,211	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 55,218	26
27	Officer's Accounts Payable	3,733	27
28	Accounts Payable-Patient Deposits	2,588	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	36,055	30
31	Accrued Taxes Payable (excluding real estate taxes)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,565	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes	6,876	35
Other Current Liabilities(specify):			
36	Accrued Profit Sharing	80,000	36
37	Accrued Payroll Tax	1,026	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 217,061	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 217,061	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,717,150	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,934,211	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,555,494	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,555,494	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	450,118	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	(288,462)	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)	\$ 161,656	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)	\$ 1,717,150	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village-Woodstock

0023275

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,428,755	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,428,755	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	Nurses Aide 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***	65,766	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 65,766	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Commissary Net of Expense	2,046	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,046	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,496,567	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	483,910	31
32	Health Care	1,357,936	32
33	General Administration	775,755	33
B. Capital Expense			
34	Ownership	225,582	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	196,390	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,039,573	40
41	Income before Income Taxes (line 30 minus line 40)**	456,994	41
42	Income Taxes	6,876	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 450,118	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheltered Village-Woodstock

0023275

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

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	1,848	\$ 54,758	\$ 26.33	1
2	Assistant Director of Nursing				2
3	Registered Nurses	12,357	278,225	21.24	3
4	Licensed Practical Nurses	2,421	50,507	20.79	4
5	Nurse Aides & Orderlies				5
6	Nurse Aide Trainees	1,170	10,520	8.99	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,890	32,846	15.54	9
10	Activity Assistants	10,317	89,694	8.50	10
11	Social Service Workers	1,179	13,352	10.95	11
12	Dietician				12
13	Food Service Supervisor	2,058	29,460	13.33	13
14	Head Cook				14
15	Cook Helpers/Assistants	6,342	74,172	10.71	15
16	Dishwashers	2,268	14,139	5.10	16
17	Maintenance Workers	1,887	31,370	15.51	17
18	Housekeepers	7,242	73,959	9.74	18
19	Laundry	741	6,594	8.90	19
20	Administrator	1,880	81,280	39.08	20
21	Assistant Administrator				21
22	Other Administrative	1,880	156,000	75.00	22
23	Office Manager				23
24	Clerical	3,798	53,622	12.95	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	10,745	185,102	15.87	28
29	Resident Services Coordinator	1,813	43,787	21.12	29
30	Habilitation Aides (DD Homes)	43,575	498,324	10.79	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	115,411	\$ 1,777,711 *	\$ 14.43	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	147	\$ 7,032	1-3	35
36	Medical Director	60	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,633	10-3	39
40	Physical Therapy Consultant	35	1,772	10-3	40
41	Occupational Therapy Consultant	69	3,596	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	19	750	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	42	1,045	12-3	45
46	Other(specify) Psychiatrist	48	3,900	10-3	46
47	Behavior Consultant	764	17,208	12-3	47
48	Dental Consultant & Misc	125	4,982	10-3	48
49	TOTAL (lines 35 - 48)	1,333	\$ 53,918		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses			51	
52	Nurse Aides	198	1,585	10-3	52
53	TOTAL (lines 50 - 52)	198	\$ 1,585		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Ildiko Magyar	Administrator	0	\$ 81,280	Workers' Compensation Insurance	\$ 21,809	IDPH License Fee	\$	
Robert R. Bowman	Physical Plant	100%	156,000	Unemployment Compensation Insurance	9,260	Advertising: Employee Recruitment	3,157	
				FICA Taxes	130,482	Health Care Worker Background Check	216	
				Employee Health Insurance	112,447	(Indicate # of checks performed <u>18</u>)		
				Employee Meals		McHenry County Health Department	255	
				Illinois Municipal Retirement Fund (IMRF)*		American College Health Care Admin	255	
				Profit Sharing Plan	80,000	Money	30	
				401 K Match	25,347	MES/HPSI (Buyers Club)	175	
				Plan Fees - Transamerica	1,137	Other	25	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 237,280			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 380,482	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,113	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Siepert & Co. LLP, CPA's	CPA		\$ 14,240			\$	Out-of-State Travel	\$
ADP	Payroll Service		4,159					
							In-State Travel	4,763
							Unsubstantiated Expense	(1,362)
							Seminar Expense	6,553
							Reclass Aide Training	(3,877)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 18,399	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,077

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
1	SEE IMPROVEMENTS PAGE 12	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheltered Village-Woodstock# 0023275Report Period Beginning: 01/01/2000Ending: 12/31/2000**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 196,390
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? None Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 465
- c. What percent of all travel expense relates to transportation of nurses and patients? _____
- 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? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes - Personal use credited to vehicle expense
- 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? None
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. Adjustment Detail

Line		Reference	
10	Interest Income		
	Limited to Interest Expense	32	(57,060)
13	Sales Tax - Per Return Filed	2	(244)
19	Entertainment - Unsubstantiated Expense	24	(1,362)
29	Rent - Related Party	34	(182,000)
35	Other		
	Mortgage Interest	32	57,060
	Building Depreciation	30	30,159
	Total Line 35		<u>87,219</u>
	Total Adjustments		<u>(153,447)</u>
	Summary		
	Sales Tax	2	(244)
	Travel & Seminar	24	(1,362)
	Depreciation	30	30,159
	Interest	32	0
	Rent Facility & Grounds	34	<u>(182,000)</u>
	Total		<u>(153,447)</u>

Schedule V. Cost Center Expense Reclassification

Line	Operating Expense	
30	Depreciation	10,805
14	Program Transportation	(10,805)
	Reclassify Vehicle Depreciation	
13	Nurse Aide Training	3,877
24	Travel & Seminar	(3,877)
	Reclassify Community College Cost for Aide Training	

Date	Course	Attendee	Job Title	Location	Cost
1/20/2000	Introduction to Psychology	J. Hansen	Hab Tech	McHenry Community College	\$ 132
2/2/2000	IL Nursing Home Admin	I. Magyar	Administrator	INHAA	85
	Assoc. Conference	C. Bundshuh	Dir. Soc Ser	INHAA	85
2/15/2000	Hab Tech Class	5 Hab Techs		McHenry Community College	1,428
3/9/2000	DDNA Conference	C. Couris	DON	DDNA	259
3/9/2000	DDNA Conference	E. Filler	Nurse	DDNA	260
3/23/2000	The Healthy Heart	B. Sandberg	Nurse	Med 2000	72
4/5/2000	Living with Grief	I. Magyar	Administrator	OCC	40
5/10/2000	Food Service Sanitation	S. Walden	PM Cook	Corporate Training	150
6/9/2000	CPR Class	6 Hab Techs		Woodstock Fire Department	60
7/6/2000	Introduction to English	T. Baumbach	Cook	McHenry Community College	138
8/25/2000	Legal Aspects of Long Term Care				
	Advocating for your client	W. Renz	QMRP	University Madison	89
8/25/2000	Surviving Difficult People	R. Bowman	Owner	Another Answer	139
8/25/2000	Surviving Difficult People	I. Magyar	Administrator	Another Answer	139
10/5/2000	CPR Refresher Course	C. Couris	DON	Woodstock Fire Department	12
10/5/2000	CPR Refresher Course	6 Nurses		Woodstock Fire Department	72
10/11/2000	Hab Tech Class	8 Hab Techs		McHenry Community College	2,449
10/11/2000	Food Service Sanitation	G. Schaefer	AM Cook	Corporate Training Center	50
11/1/2000	Surviving Difficult People Part 2	R. Bowman	Owner	Another Answer	99
11/1/2000	Surviving Difficult People Part 2	I. Magyar	Administrator	Another Answer	99
10/31/2000	Health Care Compliance & Fraud	R. Bowman	Owner	IL CPA Foundation	265
10/31/2000	Health Care Compliance & Fraud	I. Magyar	Administrator	IL CPA Foundation	165
11/14/2000	Review Course for the IL Licensure				
	Examination for Nursing Home				
	Administrators	D. DeRose	QMRP	IHCA	138
12/15/2000	Human Relations in Business	L. Marsh	Bookkeeper	McHenry Community College	138
	Void O/S check from 99				(120)
7/12/2000	Public Health				35
8/31/2000	Crisis Prevention				75
					\$ 6,553

Date	Source	Business Meeting	Board & Admin Meeting	Reimburse Expense	NO Detail	Location
1/17/2000	First Card	\$ 97	\$ 98	\$		Sycamore, IL
2/17/2000	Citi Bank Visa	96	122			Sycamore, IL
3/15/2000	Citi Bank Visa	121				DeKalb, IL
3/15/2000	Citi Bank Visa	128				Rockford, IL
3/15/2000	First Card		119			Sycamore, IL
4/13/2000	Ildiko Magyar			21		
4/19/2000	Citi Bank Visa	110	117			Sycamore, IL
5/15/2000	Citi Bank Visa	74	282		475	
6/7/2000	Ildiko Magyar			101		
7/12/2000	Ildiko Magyar			66		
7/15/2000	Citi Bank Visa		142			Sycamore, IL
8/10/2000	Ildiko Magyar			6		
8/15/2000	Citi Bank Visa	40	189			Sycamore, IL
9/15/2000	Citi Bank Visa	122	125			Sycamore, IL
9/15/2000	Citi Bank Visa	118				Sycamore, IL
10/12/2000	Ildiko Magyar			156		
11/10/2000	Ildiko Magyar			80		
11/15/2000	Citi Bank Visa				887	
12/12/2000	Ildiko Magyar			95		
12/15/2000	Citi Bank Visa	221	238			Sycamore, IL
A/P	Ildiko Magyar			317		
	Column Totals	<u>1,127</u>	<u>\$ 1,432</u>	<u>\$ 842</u>	<u>\$ 1,362</u>	
	Total	<u>\$4,763</u>				

Schedule XX

Line 12 Aide Training Wages were Allocated