



Facility Name & ID Number SHELTERED VILLAGE

# 0023275 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 96

	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	<u>96</u>	Intermediate (ICF)	<u>96</u>	<u>35,040</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>96</u>	TOTALS	<u>96</u>	<u>35,040</u>	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	<u>30,909</u>	<u>506</u>		<u>31,415</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>30,909</u>	<u>506</u>		<u>31,415</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.65%

D. How many bed-hold days during this year were paid by the Department? \_\_\_\_\_ (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

ACCURAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number SHELTERED VILLAGE # 0023275 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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
	<b>A. General Services</b>										
1	Dietary	154,893	15,825	7,950	178,668		178,668		178,668		1
2	Food Purchase		174,087		174,087		174,087	(280)	173,807		2
3	Housekeeping	117,256	19,061		136,317		136,317		136,317		3
4	Laundry	35,550	4,460		40,010		40,010		40,010		4
5	Heat and Other Utilities			73,456	73,456		73,456		73,456		5
6	Maintenance	51,165	16,288	6,591	74,044		74,044		74,044		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	358,864	229,721	87,997	676,582		676,582	(280)	676,302		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,232,476	45,834	20,196	1,298,506	(38,704)	1,259,802		1,259,802		10
10a	Therapy										10a
11	Activities	206,635	2,519	435	209,589		209,589		209,589		11
12	Social Services	248,051	1,058	23,783	272,892		272,892		272,892		12
13	CNA Training					38,979	38,979		38,979		13
14	Program Transportation			21,962	21,962	(8,615)	13,347		13,347		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,687,162	49,411	84,376	1,820,949	(8,340)	1,812,609		1,812,609		16
	<b>C. General Administration</b>										
17	Administrative	253,496			253,496		253,496		253,496		17
18	Directors Fees			72,000	72,000		72,000		72,000		18
19	Professional Services			26,229	26,229		26,229		26,229		19
20	Dues, Fees, Subscriptions & Promotions			7,373	7,373		7,373	(2,327)	5,046		20
21	Clerical & General Office Expenses	115,353	11,664	12,340	139,357	(275)	139,082		139,082		21
22	Employee Benefits & Payroll Taxes			517,973	517,973		517,973		517,973		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,230	5,230		5,230		5,230		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			89,869	89,869		89,869		89,869		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	368,849	11,664	731,014	1,111,527	(275)	1,111,252	(2,327)	1,108,925		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,414,875	290,796	903,387	3,609,058	(8,615)	3,600,443	(2,607)	3,597,836		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

#0023275

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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	
	<b>D. Ownership</b>											
30	Depreciation			34,851	34,851	8,615	43,466	30,159	73,625			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,504	3,504		3,504	(3,504)				32
33	Real Estate Taxes			44,467	44,467		44,467		44,467			33
34	Rent-Facility & Grounds			228,000	228,000		228,000	(228,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			310,822	310,822	8,615	319,437	(201,345)	118,092			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			240,654	240,654		240,654		240,654			42
43	Other (specify):*	200,176	18,688	79,992	298,856		298,856	(298,856)				43
44	<b>TOTAL Special Cost Centers</b>	200,176	18,688	320,646	539,510		539,510	(298,856)	240,654			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,615,051	309,484	1,534,855	4,459,390		4,459,390	(502,808)	3,956,582			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# 0023275

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	(7,861)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(280)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(529,183)	SCH		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (537,324)</b>		<b>\$</b>	<b>30</b>

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	34,516	SCH	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 34,516</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (502,808)</b>		<b>37</b>

\*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		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

SHELTERED VILLAGE

ID# 0023275

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SHELTERED VILLAGE

# 0023275

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(280)	0	0	0	0	0	0	0	0	0	0	(280)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(280)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(280)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(280)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(280)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number SHELTERED VILLAGE

# 0023275

Report Period Beginning:

01/01/2006 Ending:

Summary B

12/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,861)	0	0	0	0	0	0	0	0	0	0	(7,861)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(7,861)</b>	<b>0</b>	<b>(7,861)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(8,141)</b>	<b>0</b>	<b>(8,141)</b>	<b>45</b>									

**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%					

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHELTERED VILLAGE # 0023275 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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	\$ 12,000	18-3	1
2	ROBERT R BOWMAN	PHYSICAL PLANT SUPERVISOR			0	35	80.00	WAGE	156,000	17-1	2
3	PAMELA S BOWMAN	VICE PRESIDENT		**	0			DIRECTOR FEE	12,000	18-3	3
4	EDWARD A ROSENOW	SECRETARY			0			DIRECTOR FEE	12,000	18-3	4
5	ROBERT F X KEELER	TREASURER			0			DIRECTOR FEE	12,000	18-3	5
6	AMY MC CUE	DIRECTOR			0			DIRECTOR FEE	12,000	18-3	6
7	ROBB BOWMAN	DIRECTOR			0			DIRECTOR FEE	12,000	18-3	7
8											8
9	ROBERT & PAMELA BOWMAN OWN 100% OF FOREST STEEL COMPANY WHICH OWNS 100%										9
10	OF DORR WOOD LTD										10
11											11
12											12
13								TOTAL	\$ 228,000		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

# 0023275 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HARRIS BANK		X	BUILDING	\$10,000.00	01/03/02	\$ 504,400	\$		PRIME	\$ 3,081	1								
2				LOAN FEE 01/03/02							1,276	2								
3				5 YR AMORTIZATION								3								
4												4								
5												5								
<b>Working Capital</b>																				
6	HARRIS BANK		X	OPERATING LINE OF CREDIT			400,000	323,000	02/28/07	PRIME	3,504	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$10,000.00		\$ 904,400	\$ 323,000			\$ 7,861	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 904,400	\$ 323,000			\$ 7,861	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SHELTERED VILLAGE COUNTY MC HENRY

FACILITY IDPH LICENSE NUMBER 0023275

CONTACT PERSON REGARDING THIS REPORT ROBERT KEELER

TELEPHONE (815) 787-7657 FAX #: (815)787-6797

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>13-06-326-001</u>	<u>600 BORDENT STREET</u>	\$ <u>42,437.00</u>	\$ <u>42,437.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>42,437.00</u>	\$ <u>42,437.00</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number SHELTERED VILLAGE

# 0023275 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 22,800 B. General Construction Type: Exterior BRICK Frame WOOD 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).

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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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENTIAL CARE</u>	<u>4.99 ACRES</u>	<u>1991</u>	<u>\$ 50,000</u>	1
2					2
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 50,000</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHELTERED VILLAGE

# 0023275

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96		1991		\$ 950,000	\$	31.5	\$ 30,159	\$ 30,159	\$ 481,283	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		BLACKTOP		1995	8,986	599	15	599		6,641	9
10		CONCRETE SIDEWALK & PATIO		2000	3,851	257	15	257		1,712	10
11											11
12		90 X 40 BUILDING ADDITION & REMODEL									12
13		NURSING STATION AND TREATMENT AREA		2003	629,115	16,131	39	16,131		51,754	13
14											14
15		REMODEL SHOWER AREA		2004	27,050	694	39	694		1,878	15
16											16
17		BLACKTOP WALKWAY		2006	11,675	389	15	389		389	17
18											18
19		REPLACE RESIDENT ROOM DOORS		2006	11,614	133	39	133		133	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHELTERED VILLAGE

# 0023275

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,642,291	\$ 18,203		\$ 48,362	\$ 30,159	\$ 543,790	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
71	Purchased in Prior Years	\$ 112,452	\$ 15,116	\$ 15,116	\$	5 TO 7	\$ 66,646	71
72	Current Year Purchases	20,022	1,532	1,532		5 TO 7	1,532	72
73	Fully Depreciated Assets	308,667					308,667	73
74								74
75	TOTALS	\$ 441,141	\$ 16,648	\$ 16,648	\$		\$ 376,845	75

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	
76	RESIDENT TRANS	2002 BUICK SEDAN	2002	\$ 33,805	\$ 1,775	\$ 1,775	\$	5	\$ 14,460	76
77	RESIDENT TRANS	2004 CHEV VAN	2005	22,501	4,500	4,500		5	6,750	77
78	RESIDENT TRANS	2005 CHEV VAN	2006	23,394	2,340	2,340		5	2,340	78
79										79
80	TOTALS			\$ 79,700	\$ 8,615	\$ 8,615	\$		\$ 23,550	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,213,132	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,466	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,625	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,159	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 944,185	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	DAY TRAINING ASSETS	\$ 72,496	\$ 7,840	\$ 11,440	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 72,496	\$ 7,840	\$ 11,440	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHELTERED VILLAGE

# 0023275

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: TRUST 134-1435 (CONTROLLED BY ROBERT BOWMAN)

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:	<u>1969</u>	<u>96</u>	<u>01/01/91</u>	\$ <u>228,000</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>96</b>		\$ <b>228,000</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 01/01/06

Ending 01/01/07

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/2007</u>	\$ <u>228,000</u>
13.	<u>12/31/2008</u>	\$ <u>NOT STATED</u>
14.	<u>12/31/2009</u>	\$ <u>NOT STATED</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: \$ \_\_\_\_\_ 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	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>82</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>105</u></p>
--	--	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		275		275
3	Classroom Wages (a)	10,705	14,530		25,235
4	Clinical Wages (b)		13,469		13,469
5	In-House Trainer Wages (c)		13,216		13,216
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 10,705	\$ 41,490	\$	\$ 52,195
10	SUM OF line 9, col. 1 and 2 (e)	\$ 52,195			

**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	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>25</b>

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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	<b>TOTAL</b>			\$		\$	\$		\$	<b>NONE</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHELTERED VILLAGE# 0023275Report Period Beginning: 01/01/2006

Ending:

12/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 473,781	\$	1
2	Cash-Patient Deposits	4,433		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	963,402		3
4	Supply Inventory (priced at )	4,505		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,652		6
7	Other Prepaid Expenses	420		7
8	Accounts Receivable (owners or related parties)	957		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,465,150	\$	10
	<b>B. Long-Term Assets</b>			
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	692,291		15
16	Equipment, at Historical Cost	520,841		16
17	Accumulated Depreciation (book methods)	(462,901)		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): <u>DAY TRAIN EQ NET</u>	61,056		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 811,287	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,276,437	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 174,779	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,433		28
29	Short-Term Notes Payable	323,000		29
30	Accrued Salaries Payable	107,800		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,645		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,130		32
33	Accrued Interest Payable	1,115		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 656,902	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 656,902	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,619,535	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,276,437	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,699,232	1
2	Restatements (describe):	(1)	2
3	<b>ROUNDING</b>		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,699,231	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(12,796)	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	(66,900)	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)	\$ (79,696)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,619,535	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHELTERED VILLAGE# 0023275Report Period Beginning: 01/01/2006Ending: 12/31/2006**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,960,532	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,960,532	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	30,578	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 30,578	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,235	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,235	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>COMMISSARY NET OF EXPENSE</b>	3,328	28
28a	<b>DAY TRAINING PROGRAM</b>	442,521	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 445,849	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,445,194	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	676,582	31
32	Health Care	1,820,949	32
33	General Administration	1,111,527	33
<b>B. Capital Expense</b>			
34	Ownership	310,822	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	240,654	36
<b>D. Other Expenses (specify):</b>			
37	<b>DAY TRAINING PROGRAM</b>	298,856	37
38	<b>GAIN ON FIXED ASSETS</b>	(1,400)	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,457,990	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(12,796)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (12,796)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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

# 0023275

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

**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	1,896	2,120	\$ 82,343	\$ 38.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,537	15,453	404,693	26.19	3
4	Licensed Practical Nurses	2,544	2,660	64,360	24.20	4
5	CNAs & Orderlies					5
6	CNA Trainees	3,970	3,970	38,704	9.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,897	2,117	45,286	21.39	9
10	Activity Assistants	14,197	15,197	146,772	9.66	10
11	Social Service Workers	3,357	3,773	40,734	10.80	11
12	Dietician					12
13	Food Service Supervisor	1,957	2,137	39,305	18.39	13
14	Head Cook	1,745	1,937	20,147	10.40	14
15	Cook Helpers/Assistants	3,852	4,300	54,672	12.71	15
16	Dishwashers	3,426	3,498	31,335	8.96	16
17	Maintenance Workers	5,186	5,548	115,756	20.86	17
18	Housekeepers	4,860	5,096	51,750	10.16	18
19	Laundry	2,735	2,887	35,649	12.35	19
20	Administrator	1,960	2,080	97,496	46.87	20
21	Assistant Administrator					21
22	Other Administrative	1,820	1,820	156,000	85.71	22
23	Office Manager					23
24	Clerical	4,130	4,514	102,614	22.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,602	11,433	189,437	16.57	28
29	Resident Services Coordinator	1,814	2,086	58,600	28.09	29
30	Habilitation Aides (DD Homes)	51,768	54,180	639,226	11.80	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>DAY TRAINING</u>	13,401	14,364	200,172	13.94	33
34	TOTAL (lines 1 - 33)	151,654	161,170	\$ 2,615,051 *	\$ 16.23	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	191	\$ 7,950	1-3	35
36	Medical Director	96	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	814	10-3	39
40	Physical Therapy Consultant	18	1,041	10-3	40
41	Occupational Therapy Consultant	30	1,785	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	584	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	48	2,820	12-3	45
46	Other(specify) <u>PSYCHIATRIST</u>	48	3,600	10-3	46
47	<u>BEHAVIOR CONSULTANT</u>	1,040	20,615	12-3	47
48	<u>DENTAL CONSULTANT</u>	46	4,759	10-3	48
49	TOTAL (lines 35 - 48)	1,628	\$ 61,968		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 325	10-3	50
51	Licensed Practical Nurses	8	149	10-3	51
52	Certified Nurse Assistants/Aides	226	1,334	10-3	52
53	TOTAL (lines 50 - 52)	250	\$ 1,808		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **SHELTERED VILLAGE**

# **0023275**

Report Period Beginning: **01/01/2006**

Ending: **12/31/2006**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ROBERT NORRIS	ADMINISTRATOR	0	\$ 97,496	Workers' Compensation Insurance	\$ 77,523	IDPH License Fee	\$	
ROBERT BOWMAN	PHYSICAL PLANT	100%	156,000	Unemployment Compensation Insurance	18,322	Advertising: Employee Recruitment	5,009	
				FICA Taxes	195,486	Health Care Worker Background Check	2,224	
				Employee Health Insurance	191,475	(Indicate # of checks performed <u>139</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		<b>DUES &amp; SUBSCRIPTIONS</b>	140	
				401K MATCHING	35,167			
TOTAL (agree to Schedule V, line 17, col. 1)				RE-CLASS DAY TRAINING				
(List each licensed administrator separately.)			\$ 253,496	FRINGES	(35,953)			
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount			Non-allowable advertising	(2,327)	
			\$			Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 482,020	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,046	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
ADP	PAYROLL		7,674					
SIEPERT & CO LLP	CPA'S		18,450				In-State Travel	3,499
J.K FILLAR JR PC	LEGAL		105					
							Seminar Expense	1,731
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 5,230
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 26,229					

\* 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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number SHELTERED VILLAGE

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5 to 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 during this cost report period. \$ 240,654  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? 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. \$ 976
- 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 EXP
- g. Does the facility transport residents to and from day training? SEE NOTE**  
**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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

**DORR WOOD LTD  
dba SHELTERED VILLAGE  
2006 COST REPORT**

**RECLASSIFICATIONS**

	<b>1 RECLASS VEHICLE DEPRECIATION</b>		
<b>30-3</b>	DEPRECIATION	\$ 8,615.00	
<b>14-3</b>	PROGRAM TRANSPORTATION		\$ 8,615.00
	<b>2 RECLASS AIDE TRAINING SUPPLIES</b>		
<b>13-2</b>	CNA TRAINING	275.00	
	CLERICAL & GENERAL OFFICE		275.00
	<b>3 RECLASS WAGES FOR CAN TRAINING</b>		
<b>13-1</b>	CNA TRAINING	38,704.00	
	NURSING & MEDICAL REORDS		38,704.00

**SUMMARY**

<u>LINE</u>	<u>AMOUNT</u>
10	(38,704.00)
13	38,979.00
14	(8,615.00)
21	(275.00)
30	8,615.00
<b>NET</b>	<b><u>0</u></b>

**2006 ADJUSTMENTS**

	<b>AMOUNT</b>	<b>REF.</b>
LINE 29		
NON- ALLOWABLE ADVERTISING	\$ 2,327.00	20
RENT RELATED PARTIES	228,000.00	34
DAY TRAINING PROGRAM EXPENSE	<u>298,856.00</u>	44
<b>TOTAL</b>	<b><u>\$ 529,183.00</u></b>	
LINE 35		
MORTGAGE INTEREST	\$ 4,357.00	32
BUILDING DEPRECIATION	<u>30,159.00</u>	30
<b>TOTAL</b>	<b><u>\$ 34,516.00</u></b>	

**DORR WOOD LTD**  
**dba SHELTERED VILLAGE**  
**2006 DETAIL OF SEMINARS**

<b>DATE</b>	<b>DESCRIPTION</b>	<b>AMOUNT</b>
March-06	INSTITUTE FOR NATURAL RESOURCES SEMINAR FEE ROBT BOWMAN & ROBT NORRIS ADHD AUTISM & DYSLEXSIA	\$ 451.00
May-06	INSTITUTE FOR NATURAL RESOURCES SEMINAR - MEMORY, AGING & SLEEP C COURSES RN D OLSZEWSRE RN C BUNASCHUH SOCIAL SERVICE	220.00
July-06	MC HENRY COUNTY COLLEGE DIETARY REVIEW COURSE	90.00
	IL DEPT PUBLIC HEALTH 2 FOOD SERVICE SANITATION CERTIFICATE S LOMZ AND G SCHAEFEN	70.00
August-06	MC HENERY COUNTY COLLEGE P SCHNEIDEN PSYCH 101	204.00
September-06	NIODNA NO IL DD NURSE ASSOC CONFERENCE, UTICS, IL C COURSE RN D OLSZEWSRI RN C BUNDSCHUH SOCIAL SERVICE T MILLER	400.00
October-06	INSTITUTE FOR NATURAL RESOURCES ROBT BOWMAN & ROBERT NORRIS THE AGING BRAIN	296.00
<b>TOTAL</b>		<b><u>\$ 1,731.00</u></b>

**DORR WOOD LTD  
DETAIL OF TRAVEL  
2006**

<u>DATE</u>	<u>DESCRIPTION</u>	<u>AMOUNT</u>
12/20/2005	BUSINESS MEETING JOHN EVENS RESTRAUNT CRYSTAL LAKE IL	\$ 100.45
1/18/2006	ROBERT NORRIS - REIMBURSEMENT EXPENSE	97.89
1/20/2006	BUSINESS MEETING ROSITS, DEKALB, IL	103.86
1/15/2006	ROBERT NORRIS -TIP TOP RESTURANT, WOODSTOCK, IL	62.12
2/20/2006	BUSINESS MEETING JOHN EVENS RESTRAUNT CRYSTAL LAKE IL	85.51
3/2/2006	BUSINESS MEETING JOHN EVENS RESTRAUNT CRYSTAL LAKE IL	140.12
3/5/2006	BUSINESS MEETING - SORRENTO'S RANCH - SYCAMORE, IL	120.12
3/16/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	64.40
3/23/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	63.35
4/6/2006	BUSINESS MEETING JOHN EVENS RESTRAUNT CRYSTAL LAKE IL	97.38
5/15/2006	BUSINESS MEETING RECEIPT LOST	750.00
5/25/2006	BUSINESS MEETING BENNIGANS RESTURANT, ST. CHARLES, IL	25.58
1/2/2006	BUSINESS MEETING - SORRENTO'S RANCH - SYCAMORE, IL	104.94
5/18/2006	BUSINESS MEETING JOHN EVENS RESTRAUNT CRYSTAL LAKE IL	87.86
5/30/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	56.45
6/3/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	38.90
7/6/2006	BUSINESS MEETING - SORRENTO'S RANCH - SYCAMORE, IL	112.81
7/13/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	66.80
7/28/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	81.25
8/8/2006	BUSINESS MEETING JOHN EVENS RESTRAUNT CRYSTAL LAKE IL	68.18
8/31/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	53.15
9/28/2006	BUSINESS MEETING ROSITS, DEKALB, IL	96.09
9/28/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	80.60
10/28/2006	BUSINESS MEETING ROSITS, DEKALB, IL	70.71
10/19/2006	BUSINESS MEETING COLEMAN & CO. RESTURANT, WOODSTOCK, IL	71.75
10/25/2006	BUSINESS MEETING EL NIAGEN RESTURANT, WOODSTOCK, IL	42.95
11/2/2006	BUSINESS MEETING - TGI FRIDAY, WOODSTOCK, IL	74.63
10/19/2006	ROBERT NORRIS - EXPENSE 3 DAY TRIP SPRING FIELD	305.41
11/1/2006	ROBERT NORRIS - MILAGE AND EXPENSES	375.45
	<b>TOTAL</b>	<b><u>\$ 3,498.71</u></b>