

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

<p>I. IDPH License ID Number: <u>0023275</u></p> <p>Facility Name: <u>Sheltered Village</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)338-6803</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>01/01/1977</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Robert Keeler</u> Telephone Number: <u>815-751-2080</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2013</u> to <u>12/31/2013</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>ROBERT F X KEELER</u> (Title) <u>TREASURER</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # () _____</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ROBERT F X KEELER</u> (Title) <u>TREASURER</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<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																												
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # () _____																												

Facility Name & ID Number Sheltered Village

0023275 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	96	Intermediate/DD	96	35,040	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	30,916	365	638	31,919	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,916	365	638	31,919	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.09%

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

814 (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 01/01/1977

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

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: DEC Fiscal Year: DEC

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

Facility Name & ID Number

Sheltered Village

0023275

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	195,162	18,375	6,624	220,161		220,161		220,161		1
2	Food Purchase		221,250		221,250		221,250	(98)	221,152		2
3	Housekeeping	48,571	20,296		68,867		68,867		68,867		3
4	Laundry	37,299	4,792		42,091		42,091		42,091		4
5	Heat and Other Utilities			74,179	74,179		74,179		74,179		5
6	Maintenance	111,698	15,503	13,673	140,874		140,874		140,874		6
7	Other (specify):*										7
8	TOTAL General Services	392,730	280,216	94,476	767,422		767,422	(98)	767,324		8
	B. Health Care and Programs										
9	Medical Director			25,500	25,500		25,500		25,500		9
10	Nursing and Medical Records	1,462,465	103,092	13,648	1,579,205		1,579,205		1,579,205		10
10a	Therapy										10a
11	Activities	134,867	3,491		138,358		138,358		138,358		11
12	Social Services	334,278	1,589	29,234	365,101		365,101		365,101		12
13	CNA Training	9,073			9,073	128	9,201		9,201		13
14	Program Transportation			24,317	24,317	(5,028)	19,289		19,289		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,940,683	108,172	92,699	2,141,554	(4,900)	2,136,654		2,136,654		16
	C. General Administration										
17	Administrative	226,417			226,417		226,417		226,417		17
18	Directors Fees			52,000	52,000		52,000		52,000		18
19	Professional Services			21,409	21,409		21,409		21,409		19
20	Dues, Fees, Subscriptions & Promotions			2,968	2,968		2,968		2,968		20
21	Clerical & General Office Expenses	95,973	13,918	19,913	129,804	(3,355)	126,449		126,449		21
22	Employee Benefits & Payroll Taxes			595,513	595,513		595,513		595,513		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,189	9,189		9,189		9,189		24
25	Other Admin. Staff Transportation			52,704	52,704		52,704		52,704		25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	322,390	13,918	753,696	1,090,004	(3,355)	1,086,649		1,086,649		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,655,803	402,306	940,871	3,998,980	(8,255)	3,990,725	(98)	3,990,627		29

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

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

Facility Name & ID Number

Sheltered Village

#0023275

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			53,652	53,652	5,028	58,680	30,159	88,839			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,615	42,615	3,227	45,842	(918)	44,924			32
33	Real Estate Taxes			67,265	67,265		67,265		67,265			33
34	Rent-Facility & Grounds			238,000	238,000		238,000	(238,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			401,532	401,532	8,255	409,787	(208,759)	201,028			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			256,531	256,531		256,531		256,531			42
43	Other (specify):* Day Training	266,076	17,280	150,964	434,320		434,320	(434,320)				43
44	TOTAL Special Cost Centers	266,076	17,280	407,495	690,851		690,851	(434,320)	256,531			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,921,879	419,586	1,749,898	5,091,363		5,091,363	(643,177)	4,448,186			45

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

Facility Name & ID Number Sheltered Village

0023275

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(918)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	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	(672,320)	34/43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (673,336)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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	30,159	30	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 30,159		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (643,177)		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					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Sheltered Village

ID# 0023275

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheltered Village# 0023275

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(98)	0	0	0	0	0	0	0	0	0	0	(98)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(98)	0	(98)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	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	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(98)	0	(98)	29									

STATE OF ILLINOIS

Facility Name & ID Number Sheltered Village# 0023275

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	30,159	0	0	0	0	0	0	0	0	0	0	30,159	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(918)	0	0	0	0	0	0	0	0	0	0	(918)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	29,241	0	0	0	0	0	0	0	0	0	0	29,241	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	29,143	0	0	0	0	0	0	0	0	0	0	29,143	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
FOREST STEEL COMPANY	100					
ROBERT AND PAMELA BOWMAN OWN 100% OF FOREST STEEL COMPANY						

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name 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.

Facility Name & ID Number

Sheltered Village

0023275

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		**				DIRECTOR FEE	\$ 8,000	18-3	1
2	ROBERT R BOWMAN	PHYSICAL PLANT				35	80.00	WAGE	114,000	17-1	2
3	PAMELA S BOWMAN	VICE PRESIDENT		**				DIRECTOR FEE	8,000	18-3	3
4	EDWARD A ROSENOW	SECRETARY						DIRECTOR FEE	6,000	18-3	4
5	ROBERT FX KEELER	TREASURER						DIRECTOR FEE	6,000	18-3	5
6	ROBB BOWMAN	DIRECTOR						DIRECTOR FEE	12,000	18-3	6
7	AMY MCCUE	DIRECTOR						DIRECTOR FEE	12,000	18-3	7
8	AMY MCCUE	SPEECH THERAPIST				16	40.00	WAGE	18,634	12-1	8
9											9
10											10
11	**ROBERT AND PAMELA BOWMAN OWN 100% OF FOREST STEEL COMPANY WHICH OWNS 100% OF DORR-WOOD, LTD.										11
12											12
13								TOTAL	\$ 184,634		13

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

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

Facility Name & ID Number Sheltered Village

0023275 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	HARRIS BANK		X	WORKING CAPITAL		09/30/13	2,500,000	285,728	09/30/14	4.7500	38,019	6						
7	ROBERT FX KEELER		X	WORKING CAPITAL		10/30/11	150,000	150,000	DEMAND	4.5000	7,250	7						
8	INTEREST ON TRADE PAYABLES										573	8						
9	TOTAL Facility Related					\$	2,650,000	\$ 435,728			\$ 45,842	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related					\$		\$			\$	14						
15	TOTALS (line 9+line14)					\$	2,650,000	\$ 435,728			\$ 45,842	15						

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	<u>54,280</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>60,170</u>			2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>5,890</u>			3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>61,375</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. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$				6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>67,265</u>			7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2008	<u>48,350</u>	8	FOR BHF USE ONLY	
		2009	<u>49,425</u>	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$
		2010	<u>52,026</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
		2011	<u>52,957</u>	11	15	LESS REFUND FROM LINE 6 \$
		2012	<u>60,169</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
ACCRUAL 12/31/13						
60169 @ 1.02 = \$61375						

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.

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

01/01/2013 Ending:

12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,500 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories ONE

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENTIAL CARE</u>	<u>4.9 ACRES</u>	<u>1991</u>	<u>\$ 50,000</u>	1
2					2
3	TOTALS	#VALUE!		\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	96	1991		\$ 950,000	\$	31.5	\$ 30,159	\$ 30,159	\$ 692,396	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	BLACKTOP		1995	8,986		15			8,986	9
10	CONCRETE SIDEWALK & PATIO		2000	3,851	257	15	257		3,509	10
11	90 X 40 BUILDING ADDITION AND REMODEL		2003	629,115	16,131	39	16,131		164,672	11
12	REMODEL SHOWER AREA		2004	27,050	694	39	694		6,734	12
13	BLACKTOP WALKWAY		2006	11,675	778	15	778		5,837	13
14	REPLACE RESIDENT ROOM DOORS		2006	11,614	290	39	290		2,166	14
15	ATTIC FIRE WALLS		2011	9,743	244	39	244		619	15
16	ROOF WORK		2011	18,691	467	39	467		1,032	16
17	WIDEN RESIDENT DOORS		2013	7,580	46	39	46		46	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sheltered Village

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,678,305	\$ 18,907		\$ 49,066	\$ 30,159	\$ 885,997	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 235,130	\$ 32,114	\$ 32,114	\$	5 TO 7	\$ 131,531	71
72	Current Year Purchases	32,076	2,631	2,631		5 TO 7	2,631	72
73	Fully Depreciated Assets	415,342					415,342	73
74								74
75	TOTALS	\$ 682,548	\$ 34,745	\$ 34,745	\$		\$ 549,504	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RES TRANSPORT	2005 CHEV VAN	2006	\$ 23,394	\$	\$	\$		\$ 23,394	76
77	RES TRANSPORT	2009 CHEV IMPALA	2010	30,180	1,775	1,775		5	10,910	77
78	RES TRANSPORT	2012 DODGE VAN	2012	16,264	3,253	3,253		5	4,879	78
79										79
80	TOTALS			\$ 69,838	\$ 5,028	\$ 5,028	\$		\$ 39,183	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)	\$ 2,480,691	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,680	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,839	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,159	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,474,684	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	\$ 104,212	\$ 10,356	\$ 64,000	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 104,212	\$ 10,356	\$ 64,000	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Sheltered Village

0023275

Report Period Beginning:

01/01/2013

Ending: 12/31/2013

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:	1969	96	01/01/91	\$			3
4	Additions							4
5								5
6								6
7	TOTAL		96		\$			7

10. Effective dates of current rental agreement:

Beginning SEPTEMBER 2013

Ending _____

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. 12/31/2014 \$ 238,000

13. 12/31/2015 \$ 264,000

14. 12/31/2016 \$ 264,000

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.

Facility Name & ID Number Sheltered Village # 0023275 Report Period Beginning: 01/01/2013 Ending: 12/31/2013
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. CLASSROOM PORTION:</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>40</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 CNA <u>150</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		128		128
3	Classroom Wages (a)		1,906		1,906
4	Clinical Wages (b)		7,167		7,167
5	In-House Trainer Wages (c)		4,179		4,179
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 13,380	\$	\$ 13,380
10	SUM OF line 9, col. 1 and 2 (e)	\$	13,380		

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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Sheltered Village

0023275

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 76,006	\$	1
2	Cash-Patient Deposits	8,346		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	612,934		3
4	Supply Inventory (priced at <u>COST</u>)	6,966		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,569		6
7	Other Prepaid Expenses	7,539		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 737,360	\$	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	728,305		15
16	Equipment, at Historical Cost	752,387		16
17	Accumulated Depreciation (book methods)	(782,289)		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 TRAINING EQ NET</u>	40,212		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 738,615	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,475,975	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 87,463	\$	26
27	Officer's Accounts Payable	9,896		27
28	Accounts Payable-Patient Deposits	8,346		28
29	Short-Term Notes Payable	435,728		29
30	Accrued Salaries Payable	84,370		30
31	Accrued Taxes Payable (excluding real estate taxes)	61,375		31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,233		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 689,411	\$	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)	\$ 689,411	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 786,564	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,475,975	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 932,118	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 932,118	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(145,554)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (145,554)	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)	\$ 786,564	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,228,044	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,228,044	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	15,190	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)	\$ 15,190	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	918	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 918	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>SEE SCHEDULE</u>	701,656	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 701,656	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,945,808	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	767,422	31
32	Health Care	2,141,554	32
33	General Administration	1,090,004	33
B. Capital Expense			
34	Ownership	401,532	34
C. Ancillary Expense			
35	Special Cost Centers	434,320	35
36	Provider Participation Fee	256,531	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,091,363	40
41	Income before Income Taxes (line 30 minus line 40)**	(145,555)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (145,555)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,360,664	44
45	Private Pay - Net Inpatient Revenue	72,255	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SOCIAL SECURITY AND VA</u>	793,450	47
48	Other-(specify) <u>STATE ILLINOIS TRANSPORTATION</u>	1,675	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,228,044	49

* 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.

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

Facility Name & ID Number Sheltered Village

0023275

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	1,904	2,080	\$ 89,879	\$ 43.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,034	16,097	399,482	24.82	3
4	Licensed Practical Nurses	5,646	5,904	144,722	24.51	4
5	CNAs & Orderlies					5
6	CNA Trainees	950	950	9,073	9.55	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,047	2,180	32,416	14.87	9
10	Activity Assistants	10,182	10,341	102,451	9.91	10
11	Social Service Workers	1,911	2,142	48,061	22.44	11
12	Dietician					12
13	Food Service Supervisor	1,948	2,176	41,244	18.95	13
14	Head Cook	1,672	1,800	25,008	13.89	14
15	Cook Helpers/Assistants	4,235	4,514	55,926	12.39	15
16	Dishwashers	6,908	7,171	72,984	10.18	16
17	Maintenance Workers	6,952	7,585	111,698	14.73	17
18	Housekeepers	4,711	5,013	48,571	9.69	18
19	Laundry	3,105	3,351	37,299	11.13	19
20	Administrator	1,960	2,080	112,417	54.05	20
21	Assistant Administrator	1,400	1,520	114,000	75.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,377	4,001	95,973	23.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,360	10,406	225,714	21.69	28
29	Resident Services Coordinator	1,974	2,270	60,503	26.65	29
30	Habilitation Aides (DD Homes)	64,085	68,084	799,500	11.74	30
31	Medical Records	1,620	1,908	28,882	15.14	31
32	Other Health Care(specify)					32
33	Other(specify) DAY TRAINING	16,851	18,814	266,076	14.14	33
34	TOTAL (lines 1 - 33)	165,832	180,387	\$ 2,921,879 *	\$ 16.20	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	138	\$ 6,624	1 - 3	35
36	Medical Director	101	25,250	10 - 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,469	10 - 3	39
40	Physical Therapy Consultant	30	2,610	10 - 3	40
41	Occupational Therapy Consultant	17	825	10 - 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	390	10 - 3	43
44	Activity Consultant				44
45	Social Service Consultant	48	3,264	12 - 3	45
46	Other(specify) PSYCHIATRIST	48	3,602	12 - 3	46
47	BEHAVIORAL CONSULTANT	988	21,732	12 - 3	47
48	DENTAL CONSULTANT	47	13,939	10 - 3	48
49	TOTAL (lines 35 - 48)	1,523	\$ 80,705		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	64	528	10 - 3	52
53	TOTAL (lines 50 - 52)	64	\$ 528		53

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	\$ 112,417	Workers' Compensation Insurance	\$ 188,408	IDPH License Fee	\$	
ROBERT BOWMAN	PHYSICAL PLANT	100	114,000	Unemployment Compensation Insurance	17,519	Advertising: Employee Recruitment	1,876	
				FICA Taxes	217,494	Health Care Worker Background Check	414	
				Employee Health Insurance		(Indicate # of checks performed 14)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		MCHENRY CO KITCHEN LICENSE	300	
				GROUP HEALTH INSURANCE	217,296	MES/HPSI DUES	175	
				GROUP LIFE INSURANCE	2,700	MISC	203	
				LESS DAY TRAINING FRINGES	(47,904)			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 226,417					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				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		\$ 18,220			\$	Out-of-State Travel	\$
ACCESS I SOURCE	ELEC TIME CLOCK		2,383					
PAYROLL	PAYROLL FEES		806				In-State Travel	2,375
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Seminar Expense	6,814
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 21,409				Entertainment Expense	()
							(agree to Sch. V,	
							line 24, col. 8)	
							TOTAL	\$ 9,189

* Attach copy of IMRF notifications

**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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Sheltered Village

0023275

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. MES/HPSI 175
- (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 YRS
- (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. \$ 256,531
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. \$ 1,675
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0 VEHICLE IN DT ASS
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) 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.

DORR-WOOD LTD D B A SHELTERED VILLAGE SUPPORTING DATA 2013 RECLASSIFICATIONS AND ADJUSTMENTS

RECLASSIFICATIONS

1 LINE		DR	CR
32 - 3	INTEREST EXPENSE	\$ 3,227.00	
21 - 3	GENERAL OFFICE		\$ 3,227.00
	RECLASSIFY INTEREST PAYMENT		
2 30 - 3	DEPRECIATION	\$ 5,028.00	
14 - 3	PROGRAM TRANSPORTATION		\$ 5,028.00
	RECLASSIFY VEHICLE DEPRECIATION		
3 13 - 2	C N A TRAINING	\$ 128.00	
21 - 2	CLERICAL AND GENERAL OFFICE		\$ 128.00
	RECLASSIFY AIDE TRAINING SUPPLIES		

DETAIL OF LINE 29 - VI ADJUSTMENT DETAIL

	LINE	AMOUNT
RELATED PARTY RENT	34	\$ 238,000.00
DAY TRAINING PROGRAM EXPENSE	43	\$ 434,320.00
TOTAL	29	\$ 672,320.00

DETAIL OF LINE 3 - VI ADJUSTMENT

BUILDING DEPRECIATION	30	\$ 30,159.00
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PAGE 23 ITEM 12 BASED ON HOURS WORKED IN POSITION

DORR-WOOD LTD D B A SHELTERED VILLAGE SUPPORTING DATA 2013

PAGE 19 LINE 28	GAIN ON SALE DAY TRAINING ASSET	\$ 1,300.00
	COMMISSARY INCOME NET	\$ 1,371.00
	DAY TRAINING PROGRAM INCOME	\$ 698,985.00
	TOTAL	\$ 701,656.00

DETAIL OF TRAVEL

DATE	NAME	TYPE	LOCATION	AMOUNT
12/20 & 12/21	ROBERT NORRIS	HOTEL	SPRINGFIELD IL	\$ 200.00
01 26 13	BUSINESS MEETING	ROSITAS RESTAURANT	DEKALB IL	\$ 132.00
01 30 13	BUSINESS MEETING	SZECHUAN REST	ST CHARLES IL	\$ 41.00
03 06 13	BUSINESS MEETING	SZECHUAN REST	ST CHARLES IL	\$ 87.00
03 08 13	BUSINESS MEETING	SORRENTO RANCH	SYCAMORE IL	\$ 112.00
03 01 13	BUSINESS MEETING	PORT EDWARD REST.	ALGONQUIN IL	\$ 76.00
03 10 13	BUSINESS MEETING	JAMESON REST	CRYSTAL LAKE IL	\$ 110.00
03 19 13	BUSINESS MEETING	CAPITAL GRILL	CHICAGO IL	\$ 118.00
04 16 13	BUSINESS MEETING	GREAT WALL REST	ROCKFORD IL	\$ 42.00
04 21 13	BUSINESS MEETING	SZECHUAN REST	ST CHARLES IL	\$ 60.00
04 26 13	BUSINESS MEETING	JMK NIPPON REST	ROCKFORD IL	\$ 66.00
04 24 13	BUSINESS MEETING	EL NIAGARA REST	WOODSTOCK IL	\$ 51.00
06 28 13	BUSINESS MEETING	SORRENTO RANCH	SYCAMORE IL	\$ 175.00
06 26 13	ROBERT NORRIS	MOTEL AND MEALS	SPRINGFIELD IL	\$ 176.00
07 15 13	BUSINESS MEETING	RUBY TUESDAY	DEKALB IL	\$ 105.00
08 14 13	BUSINESS MEETING	SORRENTO RANCH	SYCAMORE IL	\$ 137.00
08 29 13	BUSINESS MEETING	BIRCH RIVER GRILL	ARLINGTON HGTS IL	\$ 99.00
09 20 13	BUSINESS MEETING	SZECHUAN REST	ST CHARLES IL	\$ 87.00
10 19 13	BUSINESS MEETING	HINKS REST	SYCAMORE IL	\$ 31.00
10 20 13	BUSINESS MEETING	BLACKBERRY INN	ELBURN IL	\$ 67.00
10 22 13	BUSINESS MEETING	SZECHUAN REST	ST CHARLES IL	\$ 73.00
11 07 13	BUSINESS MEETING	HILLSIDE REST	DEKALB IL	\$ 145.00
12 03 13	BUSINESS MEETING	SORRENTO RANCH	SYCAMORE IL	\$ 185.00
		TOTAL		\$ 2,375.00

DORR-WOOD LTD D B A SHELTERED VILLAGE SUPPORTING DATA 2013

					DETAIL OF SEMINARS	
DATE	DESCRIPTION/SUBJECT	NAME	TITLE	LOCATION	SPONSOR	COST
01 04 13	CPR TRAINING	16 STAFF PERSONS		WOODSTOCK	\$	120.00
01 31 13	IL FOOD SANITARIAN	A STALLMAN	DIETARY MGR	WOODSTOCK	\$	35.00
02 12 13	INA HAA	R NORRIS R BOWMAN	ADMINISTRATOR OWNER	ROCKFORD	\$	200.00
05 09 13	HIPAA & MEDICAL RECORDS LAW	M ARGOL T MILLER	DON LPN	SCHAUMBURG	\$	567.00
05 09 13	NURSING DOCUMENTATION	M ARGOL T MILLER	DON LPN		\$	360.00
07 12 13	CPI RECERTIFICATION FEES	J COLLINS	QIDP		\$	150.00
06 19 13	INTRODUCTION TO PSYCHOLOGY	R CRUZ	COOK	CRYSTAL LAKE IL	\$	279.00
07 15 13	CPI TEACHING MATERIALS				\$	424.00
08 01 13	CURE & MGMNT STRATEGIES FOR NEUROMUSCULAR DISORDERS	R NORRIS, L MARSH R BOWMAN M ARGOL, T MILLER T MILLER	ADMIN, ASST ADMIN OWNER DON, LPE LPN	ARLINGTON HGTS	\$	900.00
09 01 13	EMOTIONAL CONTROL & DIFFICULT PEOP	R NORRIS, L MARSH R BOWMAN	ADMIN, ASST ADMIN OWNER	ROCKFORD	\$	228.00
09 18 13	FALL PREVENTION MANAGEMENT	B HATHCOCK S PEDEN	PHYSICAL REHAB NURSING ASST	ROCKFORD	\$	358.00
09 30 13	STROKE FROM AWARENESS TO ACTION	A MCCUE	SPEECH PATH		\$	180.00
10 28 13	FIRST AID & CPA	11 STAFF PERSONS		WOODSTOCK	\$	360.00
10 15 13	VIRUS AND GERMS	L MARSH	ASST ADMIN	ROCKFORD	\$	228.00
11 08 13	MAGIC OF TEAMWORK ASHA CONVENTION	A MCCUE	SPEECH PATH	CHICAGO IL	\$	445.00
11 12 13	PHARMACOLOGY INFECTIOUS DISEASES	M ARGOL	DON	SYCAMORE IL	\$	190.00
11 25 13	SAFE FOOD HANDLERS	D RASMUSSEN, T BAKER, H PIETRZAK	QIDP	WOODSTOCK	\$	510.00
	FIRST AID & CPR 6 SESSIONS	33 PEOPLE		WOODSTOCK	\$	540.00
12 06 13	ADULT PHYSICAL EXAM BOOT CAMP	M ARGOL B BODE, J SAARI	DON RN, RN	ARLINGTON HGTS	\$	740.00
					TOTAL	\$ 6,814.00