

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

<p>I. IDPH License ID Number: <u>0021766</u></p> <p>Facility Name: <u>Meadows</u></p> <p>Address: <u>3250 South Plum Grove Road</u> <u>Rolling Meadows</u> <u>60008</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 397-0055</u> Fax # <u>(847) 397-0477</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/1975</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Robin Witt</u> Telephone Number: <u>(847) 397-0055</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>01/01/2014</u> to <u>12/31/2014</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>Robin Witt</u> (Title) <u>Administrator</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (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>Robin Witt</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Robin Witt</u> (Title) <u>Administrator</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

STATE OF ILLINOIS

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	99	Intermediate/DD	99	36,135	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	30,779	1,401		32,180
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	30,779	1,401		32,180

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.05%

D. How many bed-hold days during this year were paid by the Department? 167 (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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/1975

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAU MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

STATE OF ILLINOIS

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014
 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	196,410	20,713	4,745	221,868		221,868		221,868		1
2	Food Purchase		198,128		198,128		198,128		198,128		2
3	Housekeeping	89,743	32,292		122,035		122,035		122,035		3
4	Laundry	92,693	26,236		118,929		118,929		118,929		4
5	Heat and Other Utilities			126,712	126,712		126,712		126,712		5
6	Maintenance	152,536	10,911	57,345	220,792		220,792		220,792		6
7	Other (specify):*										7
8	TOTAL General Services	531,382	288,280	188,802	1,008,464		1,008,464		1,008,464		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800	(13,440)	3,360		3,360		9
10	Nursing and Medical Records	1,261,421	100,329	7,556	1,369,306		1,369,306		1,369,306		10
10a	Therapy	10,587		8,388	18,975	4,001	22,976		22,976		10a
11	Activities	58,261	5,696		63,957	496	64,453		64,453		11
12	Social Services	104,485		17,193	121,678	(4,497)	117,181		117,181		12
13	CNA Training										13
14	Program Transportation			32	32		32		32		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,434,754	106,025	49,969	1,590,748	(13,440)	1,577,308		1,577,308		16
	C. General Administration										
17	Administrative	60,000			60,000		60,000		60,000		17
18	Directors Fees										18
19	Professional Services			34,983	34,983	(1,830)	33,153		33,153		19
20	Dues, Fees, Subscriptions & Promotions			10,837	10,837	(5)	10,832		10,832		20
21	Clerical & General Office Expenses	242,255	21,272	(37,755)	225,772	250	226,022	50,328	276,350		21
22	Employee Benefits & Payroll Taxes			328,778	328,778	1,830	330,608	(1,561)	329,047		22
23	Inservice Training & Education										23
24	Travel and Seminar			407	407	(245)	162		162		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			15,081	15,081		15,081	23,876	38,957		26
27	Other (specify):*										27
28	TOTAL General Administration	302,255	21,272	352,331	675,858		675,858	72,643	748,501		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,268,391	415,577	591,102	3,275,070	(13,440)	3,261,630	72,643	3,334,273		29

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

Facility Name & ID Number Meadows Sheltered Care, Inc. #0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			16,820	16,820		16,820	48,169	64,989			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							152,458	152,458			32
33	Real Estate Taxes							270,743	270,743			33
34	Rent-Facility & Grounds			729,600	729,600		729,600	(729,600)				34
35	Rent-Equipment & Vehicles			8,798	8,798		8,798		8,798			35
36	Other (specify):*											36
37	TOTAL Ownership			755,218	755,218		755,218	(258,230)	496,988			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			11,621	11,621	13,440	25,061		25,061			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			249,215	249,215		249,215		249,215			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			260,836	260,836	13,440	274,276		274,276			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,268,391	415,577	1,607,156	4,291,124		4,291,124	(185,587)	4,105,537			45

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals		2.2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(2,007)	30.3		9
10 Interest and Other Investment Income		32.3		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees		13		27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	37,405			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 35,398		\$	30

BHF USE ONLY						
48		49		50		52

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

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(220,985)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (220,985)		36
(sum of SUBTOTALS (A) and (B))			
37 TOTAL ADJUSTMENTS	\$ (185,587)		37

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

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

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39 Physician Care	x		13,440	9.3	39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$ 13,440		47

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Facility Rent	\$ 729,600	Byrn T. Witt & Barbara S. Witt	100.00%	\$	\$ (729,600)	1
2	V							2
3	V	30 Depreciation		Byrn T. Witt & Barbara S. Witt	100.00%	51,951	51,951	3
4	V	32 Interest		Byrn T. Witt & Barbara S. Witt	100.00%	152,458	152,458	4
5	V	17						5
6	V	33 Real Estate Taxes		Byrn T. Witt & Barbara S. Witt	100.00%	270,743	270,743	6
7	V							7
8	V	26 Property Insurance		Byrn T. Witt & Barbara S. Witt	100.00%	33,463	33,463	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 729600			\$ 508,615	\$ * (220,985)	14

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robin Witt	Administrator	Administration			40	100%	Salary	\$ 60,000	17.1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,000		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.

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2	HUD		X	Debt Refinance / Bldg Constructio	Varies	2006	2,700,000	2,526,876	2046	0.0600	152,458	2
3					-							3
4					-						Interest Income	4
5					-							5
	Working Capital											
6					-							6
7					-							7
8					-							8
9	TOTAL Facility Related						\$ 2,700,000	\$ 2,526,876			\$ 152,458	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,700,000	\$ 2,526,876			\$ 152,458	15

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc.# 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.		Important, please see the next worksheet, "RE Tax". The real estate tax statement and bill must accompany the cost report.	\$	<u>221,997</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>246,370</u>	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>24,373</u>	3																			
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>246,370</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>270,743</u>	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2009	<u>260,921</u>	8	<table border="1"> <thead> <tr> <th colspan="3">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2013</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </tbody> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2013	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2013	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2010	<u>204,804</u>	9																					
	2011	<u>210,832</u>	10																					
	2012	<u>221,997</u>	11																					
	2013	<u>246,370</u>	12																					
<u>Accrual based on current year assessment.</u>																								

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
 RE: 2013 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 2013 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2013.

Please complete the Real Estate Tax Statement below and include it in the 2014 cost report along with a copy of your 2013 real estate tax bill.

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meadows Sheltered Care, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0021766

CONTACT PERSON REGARDING THIS REPORT Robin Witt

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02-35-100-016-0000</u>	<u>3250 South Plum Grove Road</u>	\$ <u>246,370.00</u>	\$ <u>246,370.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>246,370.00</u>	\$ <u>246,370.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>52,300</u>	<u>1986</u>	<u>\$ 25,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	52,300		\$ 25,000	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	98		1986	1975	\$ 1,500,000	\$	30	\$		\$ 1,500,000	4
5			1996	1996	1,478,674		39	37,915	37,915	701,583	5
6	1		1996	1996	15,000		39	385	385	7,012	6
7											7
8											8
	Improvement Type**										
9	Remodeling		1976		3,548		10			3,548	9
10			1977		21,344		10			21,344	10
11			1979		169		10			169	11
12			1980		9,111		10			9,111	12
13			1981		3,203		10			3,203	13
14			1983		7,355		10			7,355	14
15			1984		11,356		10			11,356	15
16	Garage		1985		3,165		10			3,165	16
17	Remodeling		1986		2,386		10			2,386	17
18	Water Heater & Fire Alarm System		1987		3,199		15			3,199	18
19	Roof		1988		40,520		20			40,520	19
20	Heat Pump		1988		1,900		15			1,900	20
21	Carpeting		1988		10,119		5			10,119	21
22	Carpeting		1989		4,185		5			4,185	22
23	Roof		1990		3,527		20			3,527	23
24	Kitchen		1990		2,319		10			2,319	24
25	Heater Repairs		1991		840		7			840	25
26	Improvements		1993		737	4	10		(4)	737	26
27	Water Heater		1995		3,000		7			3,000	27
28	Air Conditioners		1995		5,627		5			5,627	28
29	Unit Heaters		1995		737		5			737	29
30	Exterior Doors		1995		628	16	39	16		314	30
31	Garage Door		1996		385		10			385	31
32	Parking Lot Repair		1996		6,655		20	333	333	6,162	32
33	Driveway		1996		22,572		20	1,129	1,129	20,891	33
34	Walk-in Freezer & Cooler		1996		12,333		10			12,333	34
35	Air Conditioning Units		1996		3,554		5			3,554	35
36	Draperies		1997		16,239		39	416	416	7,282	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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2014

Ending: 12/31/2014

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 Fencing	1997	\$ 8,090	\$ 207	39	\$ 207	\$	\$ 3,624	37
38 Windows & Doors	1997	2,128		39	55	55	963	38
39 New Building Addition	1998	7,500		39	192	192	3,264	39
40 Time Clock System	1999	8,785		5			8,785	40
41 Air Conditioning Units	1999	7,589		5			7,589	41
42 Time Clock System	2001	1,452		5			1,452	42
43 Telephone Equipment	2001	1,850		5			1,850	43
44 Air Conditioning Units	2001	4,568		39	117	117	1,586	44
45 Window Screens	2001	1,400		39	36	36	487	45
46 Draperies	2001	4,118		39	106	106	1,470	46
47 Magnetic Door Holders	2002	1,350		7			1,350	47
48 6 Air Conditioner Units	2002	4,671		39	120	120	1,329	48
49 12 Resident Room Closet Doors	2002	2,346		39	60	60	675	49
50 Nurse Call System	2002	38,000		5			38,000	50
51 Magnetic Door Holders	2002	3,696		5			3,696	51
52 Signage	2003	1,698		7			1,698	52
53 Flooring	2002	1,731		10	105	105	1,731	53
54 Draperies	2003	1,052		7			1,052	54
55 Windows	2003	710		39	18	18	180	55
56 HVAC Units	2003	3,813		5			3,813	56
57 Carpeting	2003	10,994		10	1,099	1,099	10,990	57
58 Parking Lot	2004	26,879		15	1,792	1,792	17,920	58
59 HVAC Units	2004	5,825		5			5,825	59
60 Signage	2004	318		5			318	60
61 Security System	2004	18,600		5			18,600	61
62 HVAC Units	2005	484		5			484	62
63 Nurse call system	2005	6,231		5			6,231	63
64 Electrical cabling	2005	1,450		5			1,450	64
65 HVAC Units	2005	281		5			281	65
66 Air conditioning units	2006	1,656		7			1,656	66
67 Security System	2006	3,590		7			3,590	67
68 Draperies	2006	1,610		7			1,610	68
69 Toilets	2006	1,295		39	33	33	297	69
70 TOTAL (lines 4 thru 69)		\$ 3,380,147	\$ 227		\$ 44,134	\$ 43,907	\$ 2,551,709	70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning:

01/01/2014

Ending: 12/31/2014

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,380,147	\$ 227		\$ 44,134	\$ 43,907	\$ 2,551,709	1
2	Interior doors	2006	2,200		39	56	56	495	2
3	Double egress doors	2006	5,908		39	151	151	1,319	3
4	Bathroom vanities	2006	1,104		39	28	28	241	4
5	Payroll time clock	2006	6,440		7			6,440	5
6	Telephone system	2006	669		7			669	6
7	Air conditioning units	2007	555	31	7	42	11	555	7
8	Generator & electrical panel	2008	2,500	112	7	357	245	2,232	8
9	Handrails	2008	1,864	48	39	48		320	9
10	HVAC Units	2008	1,096		7	157	157	1,087	10
11	Replacement Doors	2008	2,859		39	73	73	493	11
12	Fire Alarm System	2008	17,084		39	438	438	2,707	12
13	HVAC Units	2008	791		7	113	113	683	13
14	HVAC Units	2009	4,209		7	601	601	3,327	14
15	Fire door hinges	2009	1,338		7	191	191	1,125	15
16	Fire alarm system	2009	6,108		39	157	157	824	16
17	Wall guards	2009	1,553		7	222	222	1,141	17
18	Driveway repair	2010	4,604		15	307	307	1,280	18
19	Heat/AC units in rooms	2010	4,453		7	636	636	3,126	19
20	Kitchen roof exhaust vent	2010	1,430		7	204	204	970	20
21	Resident and interior doors - 12	2011	4,343		39	111	111	380	21
22	Wheelchair guards, kitchen disposal, vanities, toilets, 2 HVAC	2011	5,977		7	854	854	2,777	22
23	HVAC Units	2012	2,549		7	364	364	805	23
24	Cooling compressor	2012	2,627		7	375	375	933	24
25	Toilets, bath cabinets, sinks	2012	3,452		7	493	493	1,170	25
26	Communication sys, hot water booster, generator	2012	4,349		7	621	621	1,751	26
27	Replacement Water Heater	2013	4,310		7	616	616	1,055	27
28	New flooring main hallways	2014	80,327		39	1,721	1,721	1,721	28
29	Door alarm replacement panel	2014	4,969		5	509	509	509	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,559,815	\$ 418		\$ 53,579	\$ 53,161	\$ 2,591,844	34

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

Facility Name & ID Number Meadows Sheltered Care, Inc. # 0021766 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	\$ 63,429	\$ 911	\$ 911	\$	Various	\$ 59,833	71
72	Current Year Purchases	4,868	2,556	2,556		Various	2,556	72
73	Fully Depreciated Assets	150,334					150,334	73
74								74
75	TOTALS	\$ 218,631	\$ 3,467	\$ 3,467	\$		\$ 212,723	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Mini Van	Dodge, 2014	2014	\$ 39,713	\$ 11,160	\$ 7,943	\$ (3,217)	5	\$ 7,943	76
77										77
78										78
79										79
80	TOTALS			\$ 39,713	\$ 11,160	\$ 7,943	\$ (3,217)		\$ 7,943	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,843,159	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,045	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,989	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 49,944	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,812,510	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

	Fiscal Year Ending	Annual Rent
12.	<u>2015</u>	\$ _____
13.	<u>2016</u>	\$ _____
14.	<u>2017</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: \$ 8,798 Description: Copier: \$8,150; Mailing Machine: \$648
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766 Report Period Beginning:

01/01/2014 Ending: 12/31/2014

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		153	8,388		153	8,388	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits		134	13,440		134	13,440	5
6	Dental Care	39.3	visits		116	11,621		116	11,621	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care</u>	39.2								12
13	Other (specify): <u>Medical Supplies</u>	39.2								13
14	TOTAL			\$	403	\$ 33,449	\$	403	\$ 33,449	14

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

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 505,098	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	432,881	3
4	Supply Inventory (priced at FIFO)	6,693	4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	33,073	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 977,745	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	15,923	15
16	Equipment, at Historical Cost	324,722	16
17	Accumulated Depreciation (book methods)	(258,266)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 82,379	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,060,124	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 51,101	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable		30
31	Accrued Taxes Payable (excluding real estate taxes)	121,600	31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
	Other Current Liabilities(specify):		
36	A/P Other	386,862	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 559,563	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)	\$ 559,563	46
47	TOTAL EQUITY(page 18, line 24)	\$ 500,561	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,060,124	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 495,118	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(92,852)	4
5	Rounding		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 402,266	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	149,195	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	(50,900)	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)	\$ 98,295	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)	\$ 500,561	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,440,319	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,440,319	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,440,319	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,008,464	31
32	Health Care	1,590,748	32
33	General Administration	675,858	33
B. Capital Expense			
34	Ownership	755,218	34
C. Ancillary Expense			
35	Special Cost Centers	11,621	35
36	Provider Participation Fee	249,215	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,291,124	40
41	Income before Income Taxes (line 30 minus line 40)**	149,195	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 149,195	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,164,119	44
45	Private Pay - Net Inpatient Revenue	276,200	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Rounding		47
48	Other-(specify) Rounding		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,440,319	49

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

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

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

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

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	2,087	2,228	\$ 55,303	\$ 24.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,468	3,495	108,268	30.98	3
4	Licensed Practical Nurses	10,914	11,205	293,698	26.21	4
5	CNAs & Orderlies	52,314	54,306	727,752	13.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	645	645	10,587	16.41	8
9	Activity Director					9
10	Activity Assistants	4,117	4,481	58,261	13.00	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,924	14,939	196,410	13.15	15
16	Dishwashers					16
17	Maintenance Workers	8,783	9,254	152,536	16.48	17
18	Housekeepers	7,370	7,788	89,743	11.52	18
19	Laundry	7,488	7,876	92,693	11.77	19
20	Administrator	1,872	1,872	60,000	32.05	20
21	Assistant Administrator					21
22	Other Administrative	1,366	1,366	74,000	54.17	22
23	Office Manager					23
24	Clerical	6,206	6,886	157,547	22.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,989	5,179	104,485	20.17	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	2,644	2,809	76,400	27.20	33
34	TOTAL (lines 1 - 33)	128,187	134,329	\$ 2,257,683 *	\$ 16.81	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	183	\$ 4,745	1.3	35
36	Medical Director	34	3,360	9.3	36
37	Medical Records Consultant	26	1,275	10.3	37
38	Nurse Consultant	46	2,300	10.3	38
39	Pharmacist Consultant	40	3,981	10.3	39
40	Physical Therapy Consultant	57	4,001	10a.3	40
41	Occupational Therapy Consultant			10a.3	41
42	Respiratory Therapy Consultant			10a.3	42
43	Speech Therapy Consultant			10a.3	43
44	Activity Consultant	8	496	11.3	44
45	Social Service Consultant	1	50	12.3	45
46	Other(specify) <u>Psychologist</u>	40	4,358	12.3	46
47				12.3	47
48	<u>Psychiatrist</u>	28	8,288	12.3	48
49	TOTAL (lines 35 - 48)	461	\$ 32,853		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 10.3	50
51	Licensed Practical Nurses		10.3	51
52	Certified Nurse Assistants/Aides		10.3	52
53	TOTAL (lines 50 - 52)		\$	53

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												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Meadows Sheltered Care, Inc.

0021766

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IARF Membership Dues 5,916
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,423 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 249,215
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ Zero
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.