FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0044057

Facility Name: Salem Village Nursing

Address: 1314 Rowell Ave (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-5451 **Fax #** (815) 727-9413

HFS ID Number:

Date of Initial License for Current Owners: 08/31/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	230	Skilled (SNF)	230	83,950	1
2		Skilled Pediatric (SNF/PED)			2
3	36	Intermediate (ICF)	36	13,140	3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,190	5
6		ICF/DD 16 or Less			6
7	272	TOTALS	272	99,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			20,448	20,448	8
9	SNF/PED					9
10	ICF	34,628	9,343	445	44,416	10
11	ICF/DD					11
12	SC	8,711	2,829	166	11,706	12
13	DD 16 OR LESS					13
14	TOTALS	43,339	12,172	21,059	76,570	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.13%

D. How many bed-hold days during this year were paid by the Department?
None (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 8/31/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 230 and days of care provided 15,166

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	488,041	148,781	29,187	666,009		666,009		666,009			1
2	Food Purchase		523,355		523,355		523,355	(7,171)	516,184			2
3	Housekeeping	420,765	94,407		515,172		515,172		515,172			3
4	Laundry	175,624	92,649		268,273		268,273		268,273			4
5	Heat and Other Utilities			435,878	435,878		435,878	(20,228)	415,650			5
6	Maintenance	107,684	128,681	185,987	422,352		422,352	37,871	460,223			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,192,114	987,873	651,052	2,831,039		2,831,039	10,472	2,841,511			8
	B. Health Care and Programs											
9	Medical Director			74,000	74,000		74,000		74,000			9
10	Nursing and Medical Records	4,359,360	395,775	19,832	4,774,967		4,774,967	(9,219)	4,765,749			10
10a	Therapy	141,102	340	24,125	165,567		165,567		165,567			10a
11	Activities	182,378	11,447		193,825		193,825		193,825			11
12	Social Services	136,567		9,772	146,339		146,339		146,339			12
13	CNA Training											13
14	Program Transportation			20,002	20,002		20,002		20,002			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,819,407	407,562	147,731	5,374,700		5,374,700	(9,219)	5,365,482			16
	C. General Administration											
17	Administrative	156,614		81,600	238,214		238,214	20,517	258,731			17
18	Directors Fees											18
19	Professional Services			808,123	808,123		808,123	(443,729)	364,394			19
20	Dues, Fees, Subscriptions & Promotions			176,761	176,761		176,761	(130,897)	45,864			20
21	Clerical & General Office Expenses	374,512	57,145	241,817	673,474		673,474	78,583	752,057			21
22	Employee Benefits & Payroll Taxes			1,529,021	1,529,021		1,529,021	(9,246)	1,519,775			22
23	Inservice Training & Education											23
24	Travel and Seminar			805	805		805	187	992			24
25	Other Admin. Staff Transportation			27,416	27,416		27,416	3,751	31,167			25
26	Insurance-Prop.Liab.Malpractice			674,147	674,147		674,147	438	674,585			26
27	Other (specify):*							35,249	35,249			27
28	**TOTAL General Administration**	531,126	57,145	3,539,690	4,127,961		4,127,961	(445,147)	3,682,814			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,542,647	1,452,580	4,338,473	12,333,700		12,333,700	(443,894)	11,889,806			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing #0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			236,773	236,773		236,773	415,502	652,275			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,419	15,419		15,419	378,254	393,673			32
33	Real Estate Taxes			131,767	131,767		131,767		131,767			33
34	Rent-Facility & Grounds			1,080,500	1,080,500		1,080,500	(1,059,511)	20,989			34
35	Rent-Equipment & Vehicles			50,642	50,642		50,642	(12,139)	38,503			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,515,101	1,515,101		1,515,101	(277,894)	1,237,207			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,053,503	1,716,478	2,769,981		2,769,981		2,769,981			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,340	1,340		1,340		1,340			41
42	Provider Participation Fee			419,010	419,010		419,010		419,010			42
43	Other (specify):*	111,058		266,400	377,458		377,458	(377,458)	(0)			43
44	**TOTAL Special Cost Centers**	111,058	1,053,503	2,403,228	3,567,789		3,567,789	(377,458)	3,190,331			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,653,705	2,506,083	8,256,802	17,416,590		17,416,590	(1,099,246)	16,317,344			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,764)	02		4
5	Telephone, TV & Radio in Resident Rooms	(20,228)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	215,420	30		9
10	Interest and Other Investment Income	(1,972)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(832)	02		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	(10,307)	21		19
20	Contributions	(41,479)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,224)	21		24
25	Fund Raising, Advertising and Promotional	(83,237)	20		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	(463,812)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (476,435)		$	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 Amount	2 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)	(622,811)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (622,811)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,099,246)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					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

SEE ACCOUNTANTS' COMPILATION REPORT

Salem Village Nursing

ID# 0044057

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (111,058)	43	1
2	Bank Charge	(10,640)	21	2
3	Collection Fees	(6,614)	21	3
4	Late Fees	(1,668)	21	4
5	Taxes	(19,284)	21	5
6	COPE Dues	(6,859)	20	6
7	Medical Records	(471)	10	7
8	Vendor Income	(1,575)	02	8
9	Rental Income	(140)	06	9
10	Gain on Disposal	(4,940)	21	10
11	Miscellaneous Income - Medical Supply Refund	(8,747)	10	11
12	Miscellaneous Income - COBRA Reimbursement	(9,246)	22	12
13	Miscellaneous Income - Garnishment Fees	(1,268)	21	13
14	Misc. Income	(8,650)	21	14
15	Additional R&M	35,167	06	15
16	Building Company - Replacement Taxes	(202)	21	16
17	Non-Allowable Auto Lease	(14,244)	35	17
18	Non-Allowable Legal Fees	(20,480)	19	18
19	Non-Allowable Fees	(266,400)	43	19
20	Noncare Depreciation	(6,492)	30	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**	(463,812)		49

Salem Village Nursing

ID# 0044057

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Salem Village Nursing **#** 0044057 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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													1
2	Food Purchase	(7,171)											(7,171)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(20,228)											(20,228)	5
6	Maintenance	35,027		2,844									37,871	6
7	Other (specify):*													7
8	**TOTAL General Services**	7,628		2,844									10,472	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,219)											(9,219)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(9,219)											(9,219)	16
	C. General Administration													
17	Administrative			20,517									20,517	17
18	Directors Fees													18
19	Professional Services	(20,480)		(423,249)									(443,729)	19
20	Fees, Subscriptions & Promotions	(131,575)		678									(130,897)	20
21	Clerical & General Office Expenses	(128,797)	202	207,178									78,583	21
22	Employee Benefits & Payroll Taxes	(9,246)											(9,246)	22
23	Inservice Training & Education													23
24	Travel and Seminar			187									187	24
25	Other Admin. Staff Transportation			3,751									3,751	25
26	Insurance-Prop.Liab.Malpractice			438									438	26
27	Other (specify):*			35,249									35,249	27
28	**TOTAL General Administration**	(290,098)	202	(155,251)									(445,147)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(291,689)	202	(152,407)									(443,894)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	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)	
30	Depreciation	208,928	205,674	900									415,502	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,972)	380,152	74									378,254	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,080,500)	20,989									(1,059,511)	34
35	Rent-Equipment & Vehicles	(14,244)		2,105									(12,139)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	192,712	(494,674)	24,068									(277,894)	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													42
43	Other (specify):*	(377,458)											(377,458)	43
44	**TOTAL Special Cost Centers**	(377,458)											(377,458)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(476,435)	(494,472)	(128,339)									(1,099,246)	45

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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. [X] 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	Rental Income	$ 1,080,500	Salem Village Property, LLC	100.00%	$	$ (1,080,500)	1
2	V	33	Rental Income - RE Tax	131,767	Salem Village Property, LLC	100.00%		(131,767)	2
3	V	30	Depreciation		Salem Village Property, LLC	100.00%	205,674	205,674	3
4	V	32	Mortgage Interest Expense		Salem Village Property, LLC	100.00%	380,152	380,152	4
5	V	21	Replacement Taxes		Salem Village Property, LLC	100.00%	202	202	5
6	V	33	Real Estate Tax Expense		Salem Village Property, LLC	100.00%	131,767	131,767	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,212,267			$ 717,795	$ * (494,472)	14

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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. [X] 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)	
15	V	6	REPAIRS & MAINTENANCE	$	HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	$ 2,844	$ 2,844	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	7,123	7,123	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	678	678	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	12,815	12,815	18
19	V	24	SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	187	187	19
20	V	25	TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	3,751	3,751	20
21	V	26	INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	438	438	21
22	V	30	DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	900	900	22
23	V	32	INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	74	74	23
24	V	34	OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	20,989	20,989	24
25	V	35	EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	2,105	2,105	25
26	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	151,825	151,825	26
27	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	29,228	29,228	27
28	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	20,517	20,517	28
29	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,992	1,992	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	42,538	42,538	32
33	V	27	EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,029	4,029	33
34	V								34
35	V	19	BOOKEEPING SERVICES	430,372				(430,372)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 430,372			$ 302,033	$ * (128,339)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	ADAM VALES ACCUMULATION TRUST	5.000%	ADVANCED NURSING AND REHABILITATION CENTER, LLC	NEW HAVEN, CT	SALEM VILLAGE PROPERTIES,		BUILDING CO.	1
2	DANIEL ROTHNER ACCUMULATION	5.000%	CORI MANOR	ST. LOUIS MO.	HEALTHCARE ACCOUNTING S	ST. LOUIS MO.	BOOKEEPING/FINANCIA	2
3	KATHRYN VALES ACCUMULATION	5.000%	ELMWOOD NURSING & REHABILITATION CENTER, L.L.C.	MARYVILLE				3
4	KIMBERLY RICHMAN ACCUMULATION	5.000%	GRAND MANOR NURSING AND REHAB	ST. LOUIS MO.				4
5	MAKHLOUF & LORRAINE SUISSA	45.000%	NORTHVIEW VILLAGE	ST. LOUIS MO.				5
6	MELISSA ROTHNER ACCUMULATION	5.000%						6
7	NATHAN & SHIRLEY ROTHNER	10.000%						7
8	RACHEL ROTHNER ACCUMULATION	5.000%						8
9	SHOSHANA ARYEH	10.000%						9
10	WILLIAM ROTHNER ACCUMULATION	5.000%						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 Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Suissa	Owner	Administrative	45.00	See Attached	15.39	25.65%	Alloc. Sal/Fee	$ 102,116	17-3/17-7	1
2	Lorraine Suissa	Relative	Administrative	0.00	N/A	10	100.00%	Salary	35,534	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										10
11	the IL. Dept of HFS										11
12											12
13								TOTAL	$ 137,650		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 Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X] NO [ ]

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

Name of Related Organization: HEALTHCARE ACCOUNTING SERVICES, LI
Street Address: 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code: BRENTWOOD, MO. 63144
Phone Number: (314) 963-7570
Fax Number: (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	ILL, CT & MO. PAT. DAYS	298,569	6	$ 11,091	$	76,570	$ 2,844	1
2	19	PROFESSIONAL FEES	ILL, CT & MO. PAT. DAYS	298,569	6	27,775		76,570	7,123	2
3	20	DUES, SUBSCRIPTIONS	ILL, CT & MO. PAT. DAYS	298,569	6	2,642		76,570	678	3
4	21	CLERICAL & GENERAL	ILL, CT & MO. PAT. DAYS	298,569	6	49,968		76,570	12,815	4
5	24	SEMINAR	ILL, CT & MO. PAT. DAYS	298,569	6	729		76,570	187	5
6	25	TRAVEL	ILL, CT & MO. PAT. DAYS	298,569	6	14,625		76,570	3,751	6
7	26	INSURANCE	ILL, CT & MO. PAT. DAYS	298,569	6	1,710		76,570	438	7
8	30	DEPRECIATION	ILL, CT & MO. PAT. DAYS	298,569	6	3,510		76,570	900	8
9	32	INTEREST	ILL, CT & MO. PAT. DAYS	298,569	6	288		76,570	74	9
10	34	OFFICE SPACE	ILL, CT & MO. PAT. DAYS	298,569	6	81,844		76,570	20,989	10
11	35	EQUIPMENT RENTAL	ILL, CT & MO. PAT. DAYS	298,569	6	8,209		76,570	2,105	11
12	21	CLERICAL SALARIES	ILL, CT & MO. PAT. DAYS	298,569	6	592,012	592,012	76,570	151,825	12
13	27	EMP. BEN. GEN. & ADMIN.	ILL, CT & MO. PAT. DAYS	298,569	6	113,968		76,570	29,228	13
14	17	ADMIN. SALARY - M. SUISSA	ILL, CT & MO. PAT. DAYS	298,569	6	80,000	80,000	76,570	20,517	14
15	27	EMP. BEN.-M. SUISSA	ILL, CT & MO. PAT. DAYS	298,569	6	7,767		76,570	1,992	15
16										16
17										17
18	21	CLERICAL SALARIES	IL PAT.DAYS	103,768	2	57,648	57,648	76,570	42,538	18
19	27	EMPLOYEE BEN. GEN. & ADM	IL PAT.DAYS	103,768	2	5,461		76,570	4,029	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,059,247	$ 729,660		$ 302,033	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Chase Bank		X	Mortgage			$	$ 5,328,460			$ 380,152	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Chase Bank		X	Line of Credit				380,000			15,419	6
7	Alloc. -Health Care Accounting										74	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 5,708,460			$ 395,644	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,972)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,972)	14
15	TOTALS (line 9+line14)						$	$ 5,708,460			$ 393,672	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 117,891	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.)		$ 121,960	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,069	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 127,874	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.		$ 131,943	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	107,669	8
	2007	107,254	9
	2008	108,442	10
	2009	112,438	11
	2010	121,960	12

2011 Accrual = $121,960 x 1.05 = $127,874

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-23-304-011-0000	Long Term Care Property	$ 121,784.78	$ 121,784.78
2.	30-07-23-304-007-0000	Long Term Care Property	$ 174.84	$ 174.84
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,959.62	$ 121,959.62

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 NO

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

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 127,847 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 408,000	1
2					2
3	TOTALS			$ 408,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	230			1976	$ 8,021,280	$ 205,674	35	$ 401,064	$ 195,390	$ 5,347,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	108,515		20	5,426	5,426	71,652	9
10	Various			1999	240,599		20	11,864	11,864	147,535	10
11	Various			2000	193,202		20	9,660	9,660	113,799	11
12	Various			2001	97,999		20	4,900	4,900	54,125	12
13	Various			2002	88,413		20	7,894	7,894	81,454	13
14	Various			2003	45,533		20	2,805	2,805	38,752	14
15	Various			2004	113,428		20	9,210	9,210	86,579	15
16	Various			2005	141,584		20	11,854	11,854	103,688	16
17	Various			2006	222,982		20	22,673	22,673	140,701	17
18	Various			2007	18,325		20	1,916	1,916	8,421	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 Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			230,281			(230,281)		69
70	TOTAL (lines 4 thru 69)		$ 9,291,860	$ 435,955		$ 489,266	$ 53,311	$ 6,194,228	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,291,860	$ 435,955		$ 489,266	$ 53,311	$ 6,194,228	1
2	Condensor	2008	4,842		20	484	484	1,816	2
3	Windows	2008	2,925		20	293	293	999	3
4	Sprinkler Syst	2008	87,975		20	12,568	12,568	41,893	4
5	Sprinkler Repair	2008	2,625		20	131	131	405	5
6	Reduction In Cost Of Sprinkler System	2009	(5,600)		20	(800)	(800)	(2,400)	6
7	Dock Door	2009	5,148		20	515	515	1,459	7
8	Flooring	2009	9,476		20	632	632	1,685	8
9	Shower Remodeling	2009	32,000		20	3,200	3,200	8,533	9
10	Flooring	2009	28,657		20	1,910	1,910	5,095	10
11	Bathroom Remodeling - Showers And Hallways	2009	5,956		20	298	298	769	11
12	Modifications To Fire Pump	2009	8,659		20	1,237	1,237	3,196	12
13	Evaporator Coil	2009	2,680		20	268	268	670	13
14	Fire Pump	2009	7,300		20	1,043	1,043	2,607	14
15	Kitchen Floor Drain	2009	6,417		20	642	642	1,604	15
16	Flooring	2009	5,985		20	399	399	998	16
17	Switches And Valve	2009	5,163		20	738	738	1,782	17
18	Water Cooler Condesor	2009	7,150		20	715	715	1,728	18
19	Water Heater	2009	3,971		20	331	331	772	19
20	Water Heater	2009	4,069		20	339	339	791	20
21	Tile Flooring	2009	2,700		20	180	180	375	21
22	A/C Repair	2009	3,458		20	173	173	447	22
23	5 A/C Units	2010	3,081		20	154	154	308	23
24	Zoneline Heating/Cooling Units	2010	10,784		20	1,541	1,541	3,081	24
25	10 Zoneline Heating/Cooling Units	2010	6,790		20	970	970	1,940	25
26	90 Heating/Cooling Units (Parial Pmt 1)	2010	35,820		20	5,117	5,117	10,234	26
27	90 Heating/Cooling Units (Parial Pmt 2)	2010	8,010		20	1,144	1,144	2,289	27
28	3 Zoneline Heating/Cooling Units	2010	4,820		20	689	689	1,377	28
29	6 Heating/Cooling Units	2010	3,384		20	484	484	967	29
30	Heat/Ac Circuits, Upgrading Circuits For Coffee Maker, Coffee M	2010	4,435		20	887	887	1,626	30
31	Replace 10 Showers	2010	25,060		20	2,506	2,506	4,594	31
32	Kitchen Doors	2010	5,593		20	559	559	1,025	32
33	Tile Flooring	2010	6,855		20	457	457	838	33
34	TOTAL (lines 1 thru 33)		$ 9,638,048	$ 435,955		$ 529,068	$ 93,113	$ 6,297,731	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,638,048	$ 435,955		$ 529,068	$ 93,113	$ 6,297,731	1
2	Parking Lot	2010	72,675		20	7,268	7,268	12,718	2
3	Heat/Ac Circuits, Coffee Maker Receipt	2010	3,775		20	755	755	1,321	3
4	Sunken Garden	2010	12,000		20	1,200	1,200	2,100	4
5	Repair & Paint Drywall In 29 Rooms	2010	11,600		20	1,160	1,160	1,933	5
6	509' Privacy Curtain	2010	5,082		20	1,016	1,016	1,609	6
7	Repair/Overhaul Of Radiator	2010	5,371		20	448	448	709	7
8	Drywall Exposed Beams	2010	4,760		20	476	476	714	8
9	Install 4 Sprinkler Heads	2010	2,675		20	382	382	573	9
10	Install Fire Alarm Devices	2010	14,080		20	2,011	2,011	3,017	10
11	Installation Of New Floor In Dining Room	2010	20,661		20	1,377	1,377	1,837	11
12	275" Privacy Curtain	2010	2,744		20	549	549	732	12
13	Cafeteria Opening #1	2010	5,617		20	562	562	702	13
14	Cafeteria Opening #2	2010	4,934		20	493	493	617	14
15	Replaced Exhaust Fan	2010	4,837		20	322	322	403	15
16	Carpet Conference Room, Hall, Offices	2010	4,675		20	668	668	835	16
17	Door Security (Keypad, Locks, Etc.)	2010	4,900		20	700	700	933	17
18	Drywall Repair And Painting.	2010	5,800		20	580	580	870	18
19	3Rd Floor Cabinetry	2011	19,793		20	1,979	1,979	1,979	19
20	Dining Room, Bathrooms Trim And Millwork	2011	7,103		20	296	296	296	20
21	Dryer Ventilation	2011	6,959		20	464	464	464	21
22	Walk Out Patio	2011	3,938		20	175	175	175	22
23	Install Transformer On Roof And Addt'L Outlets	2011	19,750		20	1,317	1,317	1,317	23
24	Existing Cove Base And Vct Removal, Custom Vct And 4" Cover	2011	65,287		20	3,808	3,808	3,808	24
25	5Th Floor Corridor Sink, Various Trimwork	2011	2,834		20	165	165	165	25
26	Crashrails	2011	3,240		20	95	95	95	26
27	Accutech Alarm System	2011	5,682		20	541	541	541	27
28	Replaced Hot Water Tank	2011	11,864		20	494	494	494	28
29	Install Smoke Detectors	2011	5,125		20	305	305	305	29
30	Light Fixtures In Various Areas	2011	4,218		20	141	141	141	30
31	Water Softener	2011	3,188		20	106	106	106	31
32	Electrical, Plumbing, Heating Remodel	2011	150,000		20	5,000	5,000	5,000	32
33	Crown Moulding, Wallpaper 3Rd Floor	2011	35,175		20	586	586	586	33
34	TOTAL (lines 1 thru 33)		$ 10,168,389	$ 435,955		$ 564,508	$ 128,553	$ 6,344,827	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,168,389	$ 435,955		$ 564,508	$ 128,553	$ 6,344,827	1
2	Water Heater	2011	4,161		20	277	277	277	2
3	3 Amana 9500 Air Conditioner	2011	2,204		20	79	79	79	3
4	Room Signs	2011	3,470		20	87	87	87	4
5	3Rd Floor Handrail, Bumpers	2011	8,172		20	204	204	204	5
6	Vent Alarm/Paging System	2011	5,843		20	209	209	209	6
7	Smoke Detectors	2011	6,782		20	242	242	242	7
8	Handrails And Bumper Guards	2011	3,700		20	31	31	31	8
9	2 Concrete Slabs	2011	8,020		20	134	134	134	9
10	Wallpaper, Blinds, Drapes, Lighting - Includes Taxes	2011	38,421		20	6,403	6,403	6,403	10
11	Install 3 Flood Lights In Parking Lot	2011	3,425		20	29	29	29	11
12	Installed 19 Smoke Detectors	2011	4,498		20	54	54	54	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	TOTAL (lines 1 thru 33)		$ 10,257,085	$ 435,955		$ 572,256	$ 136,301	$ 6,352,575	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,257,085	$ 435,955		$ 572,256	$ 136,301	$ 6,352,575	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,257,085	$ 435,955		$ 572,256	$ 136,301	$ 6,352,575	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 636,723	$ 559	$ 68,755	$ 68,196	10	$ 452,215	71
72	Current Year Purchases	114,701	341	7,387	7,046	10	7,387	72
73	Fully Depreciated Assets	1,329,168		74	74	10	513,168	73
74								74
75	TOTALS	$ 2,080,591	$ 900	$ 76,216	$ 75,316		$ 972,770	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		2009 LEXUS LS 460	2009	$	$	$ 2,678	$ 2,678		$	76
77		2011 LEXUS LS 460	2011	30,000		1,125	1,125	5	1,125	77
78										78
79										79
80	TOTALS			$ 30,000	$	$ 3,803	$ 3,803		$ 1,125	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)	$ 12,775,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 436,855	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 652,275	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 215,420	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,326,470	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	2011 Lexus LS 460 - 2011	$ 39,141	$ 6,492	$ 19,476	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 39,141	$ 6,492	$ 19,476	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 Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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	Allocated from Healthcare Accounting Services				20,989			5
6								6
7	TOTAL				$ 20,989 **			7

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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 34,614 Description: See Attached Schedule
(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	Facility	2008 Auto	$ 500.00	$ 1,890	17
18	Facility	AMAC Mountaineer	500.00	2,000	18
19					19
20					20
21	TOTAL		$ 1,000.00	$ 3,890	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing STATE OF ILLINOIS # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 669,612	$		$ 669,612	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			136,911			136,911	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			785,081			785,081	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				1,006,495		1,006,495	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					124,874	47,008		171,882	13
14	TOTAL			$		$ 1,716,478	$ 1,053,503		$ 2,769,981	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 17,517	$ 19,653	1
2	Cash-Patient Deposits	86,930	86,930	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,079,493	5,079,493	3
4	Supply Inventory (priced at)	78,669	78,669	4
5	Short-Term Investments			5
6	Prepaid Insurance	76,647	76,647	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	761,098	761,098	8
9	Other(specify): See Attached Schedule	11,775	11,775	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,112,129	$ 6,114,265	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		408,000	13
14	Buildings, at Historical Cost		8,021,280	14
15	Leasehold Improvements, at Historical Cost	2,006,224	2,006,224	15
16	Equipment, at Historical Cost	1,493,354	2,309,354	16
17	Accumulated Depreciation (book methods)	(2,163,362)	(5,721,680)	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): See Attached Schedule	3,738	4,036	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,339,954	$ 7,027,214	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,452,083	$ 13,141,479	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,879,418	$ 5,879,418	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	85,159	85,159	28
29	Short-Term Notes Payable	380,000	380,000	29
30	Accrued Salaries Payable	398,768	398,768	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,992	28,992	31
32	Accrued Real Estate Taxes(Sch.IX-B)	127,874	127,874	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	12,000	12,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	250,905	(3,177,445)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,163,116	$ 3,734,766	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,328,460	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,328,460	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,163,116	$ 9,063,226	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 288,967	$ 4,078,253	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,452,083	$ 13,141,479	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 565,112	1
2	Restatements (describe):		2
3	**Rounding**	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 565,110	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,201,266	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	(2,477,409)	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)**	$ (276,143)	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)**	$ 288,967	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,782,953	1
2	Discounts and Allowances for all Levels	(4,012,966)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,769,987	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,690,114	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,690,114	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	140	16
17	Sale of Drugs	904,699	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	103,494	19
20	Radiology and X-Ray	57,140	20
21	Other Medical Services	47,862	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,113,335	23
	D. Non-Operating Revenue		
24	Contributions	2,787	24
25	Interest and Other Investment Income***	1,972	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,759	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	39,661	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,661	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,617,856	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,831,039	31
32	Health Care	5,374,700	32
33	General Administration	4,127,961	33
	B. Capital Expense		
34	Ownership	1,515,101	34
	C. Ancillary Expense		
35	Special Cost Centers	3,148,779	35
36	Provider Participation Fee	419,010	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,416,590	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,201,266	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,201,266	43

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

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,250	2,417	$ 86,524	$ 35.80	1
2	Assistant Director of Nursing	2,248	2,457	88,433	35.99	2
3	Registered Nurses	45,245	49,828	1,296,994	26.03	3
4	Licensed Practical Nurses	39,008	41,830	970,161	23.19	4
5	CNAs & Orderlies	137,819	150,803	1,860,866	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,901	12,057	141,102	11.70	8
9	Activity Director	3,688	4,251	62,366	14.67	9
10	Activity Assistants	11,468	11,790	120,012	10.18	10
11	Social Service Workers	8,259	9,019	136,567	15.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	41,170	44,671	488,041	10.93	15
16	Dishwashers					16
17	Maintenance Workers	9,174	9,996	107,684	10.77	17
18	Housekeepers	40,499	45,362	420,765	9.28	18
19	Laundry	17,795	19,894	175,624	8.83	19
20	Administrator	1,832	2,053	121,080	58.98	20
21	Assistant Administrator					21
22	Other Administrative	528	714	35,534	49.77	22
23	Office Manager					23
24	Clerical	17,130	18,520	374,512	20.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,728	4,173	56,382	13.51	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,923	4,447	111,058	24.97	33
34	TOTAL (lines 1 - 33)	396,665	434,282	$ 6,653,705 *	$ 15.32	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 29,187	01-03	35
36	Medical Director	Monthly	74,000	09-03	36
37	Medical Records Consultant	Monthly	4,600	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,232	10-03	39
40	Physical Therapy Consultant	Monthly	2,472	10a-03	40
41	Occupational Therapy Consultant	Monthly	2,395	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	58	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	9,772	12-03	45
46	Other(specify)				46
47	Therapy Consultant	Monthly	19,200	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 156,916		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kelly Covarrubias	Administrator	0.00%	$ 121,080
Lorraine Suissa	Administrative	0.00%	35,534
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 156,614

B. Administrative - Other

Description	Amount
Management Fees - Mark Suissa	$ 81,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 81,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Accounting	$ 11,000
Healthcare Accounting Svcs.	Bookkeeping/Accounting	430,372
Honkamp, Krueger & Co	Accounting	2,398
Personnel Planners	Unemployment Tax Consult.	3,242
See Attached	Legal	282,964
Healthcare Horizons	Medical Claims Audit	5,825
Legat Architects	Architect Services	16,588
American Data	Computer Services	5,837
Best Servers, LLC	Computer Services	18,571
E-Health Data Solutions	Computer Services	4,680
National Data Corp	Computer Services	3,415
See Supplemetal Schedule		23,231
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 808,124

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 259,897
Unemployment Compensation Insurance	123,476
FICA Taxes	509,008
Employee Health Insurance	557,522
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	11,207
Life Insurance	2,028
Other Employee Benefits	56,636
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,519,775

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,207
Health Care Worker Background Check	
(Indicate # of checks performed 157.7)	8,671
Patient Background Checks 300	3,000
Dues and Subscriptions	22,688
Licenses and Fees	4,620
Allocated from Health Care Actg.	678
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,865

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	805
Allocated from Health Care Actg.	187
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 992

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCTC $24,964**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **N/A**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,842** Line **10**

(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. **N/A**

(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. $ **419,010**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **N/A** 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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
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?
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.