FOR BHF USE

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

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

I. IDPH License ID Number: 0044057

Facility Name: Salem Village Nrsing & Rehab

Address: 1314 Rowell Avenue (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: 8/31/1998

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	50,908	6,125	18,775	75,808	8
9	SNF/PED					9
10	ICF	12,909	896	179	13,984	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,817	7,021	18,954	89,792	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.44%

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 12,872

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	496,219	87,508	29,504	613,231		613,231		613,231			1
2	Food Purchase		553,914		553,914		553,914	(10,491)	543,423			2
3	Housekeeping	437,891	127,106		564,997		564,997		564,997			3
4	Laundry	163,147	133,503		296,650		296,650		296,650			4
5	Heat and Other Utilities			342,978	342,978		342,978		342,978			5
6	Maintenance	175,372	103,285	337,765	616,422		616,422	(66,226)	550,196			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,272,629	1,005,316	710,247	2,988,192		2,988,192	(76,717)	2,911,475			8
	B. Health Care and Programs											
9	Medical Director			61,500	61,500		61,500		61,500			9
10	Nursing and Medical Records	5,886,422	189,274	135,940	6,211,636		6,211,636	10,452	6,222,088			10
10a	Therapy											10a
11	Activities	296,158	22,424		318,582		318,582		318,582			11
12	Social Services	149,811		13,522	163,333		163,333		163,333			12
13	CNA Training			9,066	9,066		9,066		9,066			13
14	Program Transportation			7,946	7,946		7,946		7,946			14
15	Other (specify):*							2,012	2,012			15
16	**TOTAL Health Care and Programs**	6,332,391	211,698	227,974	6,772,063		6,772,063	12,464	6,784,527			16
	C. General Administration											
17	Administrative	215,539		120,000	335,539		335,539	17,380	352,919			17
18	Directors Fees											18
19	Professional Services			648,758	648,758		648,758	(411,540)	237,218			19
20	Dues, Fees, Subscriptions & Promotions			77,837	77,837		77,837	(59,022)	18,815			20
21	Clerical & General Office Expenses	411,444	79,403	865,398	1,356,245		1,356,245	(523,314)	832,931			21
22	Employee Benefits & Payroll Taxes			1,999,366	1,999,366		1,999,366		1,999,366			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,392	9,392		9,392	334	9,726			24
25	Other Admin. Staff Transportation			45,486	45,486		45,486	(3,879)	41,607			25
26	Insurance-Prop.Liab.Malpractice			434,749	434,749		434,749	737	435,486			26
27	Other (specify):*							32,794	32,794			27
28	**TOTAL General Administration**	626,983	79,403	4,200,986	4,907,372		4,907,372	(946,510)	3,960,862			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,232,003	1,296,417	5,139,207	14,667,627		14,667,627	(1,010,763)	13,656,865			29

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

Facility Name & ID Number Salem Village Nrsing & Rehab #0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			399,488	399,488		399,488	394,119	793,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,210	23,210		23,210	695,928	719,138			32
33	Real Estate Taxes			185,857	185,857		185,857	398	186,255			33
34	Rent-Facility & Grounds			1,507,000	1,507,000		1,507,000	(1,470,926)	36,074			34
35	Rent-Equipment & Vehicles			50,937	50,937		50,937	(22,414)	28,523			35
36	Other (specify):*											36
37	TOTAL Ownership			2,166,492	2,166,492		2,166,492	(402,895)	1,763,597			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	198,333	1,265,844	2,272,169	3,736,346		3,736,346	53,107	3,789,453			39
40	Barber and Beauty Shops			860	860		860	(20)	840			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			611,289	611,289		611,289		611,289			42
43	Other (specify):*	187,075		228,000	415,075		415,075	(415,075)	0			43
44	TOTAL Special Cost Centers	385,408	1,265,844	3,112,318	4,763,570		4,763,570	(361,988)	4,401,582			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,617,411	2,562,261	10,418,017	21,597,689		21,597,689	(1,775,645)	19,822,044			45

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,058)	02		4
5	Telephone, TV & Radio in Resident Rooms	(28,109)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	194,668	30		9
10	Interest and Other Investment Income	(9,584)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(433)	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	(92,529)	21		18
19	Entertainment	(9,329)	21		19
20	Contributions	(16,729)	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	(392,486)	21		24
25	Fund Raising, Advertising and Promotional	(42,816)	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	(825,278)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,232,683)		$	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)	(542,962)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (542,962)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,775,645)		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

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Salem Village Nrsing & Rehab

ID# **0044057**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dividend Income	$ (1,833)	21	1
2	Medical Records	(2,271)	10	2
3	Rental Income	(545)	06	3
4	Marketing Salaries	(187,075)	43	4
5	Sequestration Expense	(149,121)	21	5
6	Bank Service Charge	(13,444)	21	6
7	Collection Fees	(1,819)	21	7
8	Late Fees	(64,040)	21	8
9	Building Co - Bank Fees	(429)	21	9
10	Building Co - Amortization	(58,125)	36	10
11	Non- Allowable Auto Lease	(26,196)	35	11
12	Additional R&M	9,887	06	12
13	Capitalized R&M	(52,780)	06	13
14	Non-Care Depreciation	(6,492)	30	14
15	Non-Allowable Legal	(26,678)	19	15
16	Additional R/E Tax (2nd installment of 30-07-23-304-01(	398	33	16
17	Out of State Auto & Travel	(9,666)	25	17
18	Beauty Shop Rent	(20)	40	18
19	Misc. Income	(7,030)	21	19
20	Non-Allowable Fees	(228,000)	43	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**	(825,278)		49

Salem Village Nrsing & Rehab

ID# 0044057

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(10,491)											(10,491)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(71,547)		5,321									(66,226)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(82,038)		5,321									(76,717)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,271)		12,723									10,452	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,012									2,012	15
16	**TOTAL Health Care and Programs**	(2,271)		14,735									12,464	16
	C. General Administration													
17	Administrative			17,380									17,380	17
18	Directors Fees													18
19	Professional Services	(26,678)		(384,862)									(411,540)	19
20	Fees, Subscriptions & Promotions	(59,545)		523									(59,022)	20
21	Clerical & General Office Expenses	(732,060)	429	208,317									(523,314)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			334									334	24
25	Other Admin. Staff Transportation	(9,666)		5,787									(3,879)	25
26	Insurance-Prop.Liab.Malpractice			737									737	26
27	Other (specify):*			32,794									32,794	27
28	**TOTAL General Administration**	(827,949)	429	(118,990)									(946,510)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(912,258)	429	(98,934)									(1,010,763)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	188,176	205,674	269									394,119	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,584)	704,019	1,493									695,928	32
33	Real Estate Taxes	398											398	33
34	Rent-Facility & Grounds		(1,500,000)	29,074									(1,470,926)	34
35	Rent-Equipment & Vehicles	(26,196)		3,782									(22,414)	35
36	Other (specify):*	(58,125)	58,125											36
37	**TOTAL Ownership**	94,669	(532,182)	34,618									(402,895)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					53,107							53,107	39
40	Barber and Beauty Shops	(20)											(20)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(415,075)											(415,075)	43
44	**TOTAL Special Cost Centers**	(415,095)				53,107							(361,988)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,232,683)	(531,753)	(64,316)		53,107							(1,775,645)	45

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,500,000	Salem Village Property, LLC	100.00%	$	$ (1,500,000)	1
2	V	32	Interest	15,170	Salem Village Property, LLC	100.00%	91,250	76,080	2
3	V	32	Mortgage Interest Expense		Salem Village Property, LLC	100.00%	627,939	627,939	3
4	V	21	Bank Service Charge		Salem Village Property, LLC	100.00%	429	429	4
5	V	30	Depreciation		Salem Village Property, LLC	100.00%	205,674	205,674	5
6	V	36	Amortization		Salem Village Property, LLC	100.00%	58,125	58,125	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,515,170			$ 983,417	$ * (531,753)	14

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 5,321	$ 5,321	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	3,782	3,782	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	523	523	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	15,708	15,708	18
19	V	24	SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	334	334	19
20	V	25	TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	5,787	5,787	20
21	V	26	INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	737	737	21
22	V	30	DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	269	269	22
23	V	32	INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,493	1,493	23
24	V	34	OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	29,074	29,074	24
25	V	35	EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	3,782	3,782	25
26	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	189,902	189,902	26
27	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	30,889	30,889	27
28	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	17,380	17,380	28
29	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,581	1,581	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	2,707	2,707	32
33	V	27	EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	324	324	33
34	V								34
35	V	10	NURSING		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	12,723	12,723	35
36	V	15	HEALTH CARE EMPLOYEE BENEFITS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	2,012	2,012	36
37	V								37
38	V	19	BOOKEEPING SERVICES	388,644	HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%		(388,644)	38
39	Total			$ 388,644			$ 324,328	$ * (64,316)	39

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	34	Office Space	$ 7,000	MS HEALTHCARE ACCOUNTING	100.00%	$ 7,000	$	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			$ 7,000			$ 7,000	$ *	39

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	39	THERAPY	$ 2,124,793	TOWN AND COUNTRY REHAB., LLC	100.00%	$ 2,177,900	$ 53,107	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			$ 2,124,793			$ 2,177,900	$ * 53,107	39

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	JOLIET	BUILDING CO.	1
2	DANIEL ROTHNER ACCUMULATION TRUST	5.000%	CORI MANOR	ST. LOUIS MO.	HEALTHCARE ACCOUNTING S	ST. LOUIS MO.	BOOKEEPING/FINANCIAL	2
3	KATHRYN VALES ACCUMULATION TRUST	5.000%	ELMWOOD NURSING & REHABILITATION CENTER, L.L.C.	MARYVILLE	TOWN AND COUNTRY REHAB.,	CHESTERFIELD, MO	THERAPY CO.	3
4	KIMBERLY RICHMAN ACCUMULATION TRUST	5.000%	GRAND MANOR NURSING AND REHAB	ST. LOUIS MO.	MS HEALTHCARE ACCT.	CHICAGO	ACCOUNTING	4
5	MAKHLOUF & LORRAINE SUISSA	45.000%	NORTHVIEW VILLAGE	ST. LOUIS MO.				5
6	MELISSA ROTHNER ACCUMULATION TRUST	5.000%	THE CEDARS OF TOWN AND COUNTRY	CHESTERFIELD, MO				6
7	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	10.000%						7
8	RACHEL ROTHNER ACCUMULATION TRUST	5.000%						8
9	SHOSHANA ARYEH	10.000%						9
10	WILLIAM ROTHNER ACCUMULATION TRUST	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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	13.04	21.73%	Alloc. Sal/Fee	$ 137,380	17-3/17-7	1
2	Lorraine Suissa	Relative	Administrative	N/A	N/A	40	100.00%	Salary	45,860	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 183,240		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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	412,241	7	$ 24,495	$	89,560	$ 5,321	1
2	19	PROFESSIONAL FEES	ILL, CT & MO. PAT. DAYS	412,241	7	17,409		89,560	3,782	2
3	20	DUES, SUBSCRIPTIONS	ILL, CT & MO. PAT. DAYS	412,241	7	2,409		89,560	523	3
4	21	CLERICAL & GENERAL	ILL, CT & MO. PAT. DAYS	412,241	7	72,304		89,560	15,708	4
5	24	SEMINAR	ILL, CT & MO. PAT. DAYS	412,241	7	1,539		89,560	334	5
6	25	TRAVEL	ILL, CT & MO. PAT. DAYS	412,241	7	26,636		89,560	5,787	6
7	26	INSURANCE	ILL, CT & MO. PAT. DAYS	412,241	7	3,391		89,560	737	7
8	30	DEPRECIATION	ILL, CT & MO. PAT. DAYS	412,241	7	1,238		89,560	269	8
9	32	INTEREST	ILL, CT & MO. PAT. DAYS	412,241	7	6,874		89,560	1,493	9
10	34	OFFICE SPACE	ILL, CT & MO. PAT. DAYS	412,241	7	133,828		89,560	29,074	10
11	35	EQUIPMENT RENTAL	ILL, CT & MO. PAT. DAYS	412,241	7	17,411		89,560	3,782	11
12	21	CLERICAL SALARIES	ILL, CT & MO. PAT. DAYS	412,241	7	874,111	874,111	89,560	189,902	12
13	27	EMP. BEN. GEN. & ADMIN.	ILL, CT & MO. PAT. DAYS	412,241	7	142,179		89,560	30,889	13
14	17	ADMIN. SALARY - M. SUISSA	ILL, CT & MO. PAT. DAYS	412,241	7	80,000	80,000	89,560	17,380	14
15	27	EMP. BEN.-M. SUISSA	ILL, CT & MO. PAT. DAYS	412,241	7	7,278		89,560	1,581	15
16										16
17										17
18	21	CLERICAL SALARIES	IL PAT.DAYS	113,793	2	3,440	3,440	89,560	2,707	18
19	27	EMPLOYEE BEN. GEN. & ADM	IL PAT.DAYS	113,793	2	412		89,560	324	19
20										20
21	10	NURSING	IL & MO PAT.DAYS	350,914	6	49,850	49,850	89,560	12,723	21
22	15	HEALTH CARE EMPLOYEE BI	IL & MO PAT.DAYS	350,914	6	7,882		89,560	2,012	22
23										23
24										24
25	TOTALS					$ 1,472,686	$ 1,007,401		$ 324,328	25

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: MS HEALTHCARE ACCOUNTING
Street Address: 3535 WEST GLENLAKE
City / State / Zip Code: CHICAGO, IL 60659
Phone Number: (917) 744-8688
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	34	OFFICE SPACE				$	$		$ 7,000	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					$	$		$ 7,000	25

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: TOWN AND COUNTRY REHAB., LLC
Street Address: 13190 S. OUTER FORTY ROAD
City / State / Zip Code: CHESTERFIELD, MO 63017-5917
Phone Number: (314) 434-3330
Fax Number: (314) 434-9179

	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	39	THERAPY	DIRECT			$	$		$ 2,177,900	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					$	$		$ 2,177,900	25

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	First Midwest Bank		X	Mortgage			$	$ 6,000,000			$ 91,250	1
2	First Midwest Bank		X	Note Payable				14,000,000			627,939	2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit	Interest Only	11/5/13	500,000	500,000	5/31/14	4.1700	23,210	6
7	Select Rehabilitation		X	Note Payable				210,000				7
8												8
9	TOTAL Facility Related						$ 500,000	$ 20,710,000			$ 742,399	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,583)	10
11	Interest Income - Bldg. Co.		X								(15,170)	11
12	Alloc. Health Care Accounting		X								1,492	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (23,261)	14
15	TOTALS (line 9+line14)						$ 500,000	$ 20,710,000			$ 719,138	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.)

** 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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 153,000	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.)		$ 165,694	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,694	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 173,561	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.		$ 186,255	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	112,438	8
	2010	121,960	9
	2011	133,510	10
	2012	150,552	11
	2013	165,694	12

2014 Accrual = $165,694 x 1.04 = $173,561

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nrsing & Rehab 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) 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	$ 164,661.54	$ 164,661.54
2.	30-07-23-304-007-0000	Long Term Care Property	$ 236.38	$ 236.38
3.	30-07-23-304-010-0000	Long Term Care Property	$ 795.92	$ 795.92
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 165,693.84	$ 165,693.84

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nrsing & Rehab 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 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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	204		1998	1976	$ 8,021,280	$ 205,674	35	$ 401,064	$ 195,390	$ 6,550,712	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	108,515		20	5,426	5,426	87,929	9
10	Various			1999	240,599		20	11,864	11,864	183,129	10
11	Various			2000	193,202		20	9,660	9,660	142,779	11
12	Various			2001	97,999		20	4,689	4,689	68,192	12
13	Various			2002	88,413		20	666	666	87,198	13
14	Various			2003	45,533		20	567	567	43,644	14
15	Various			2004	113,428		20	4,000	4,000	106,417	15
16	Various			2005	141,584		20	5,219	5,219	120,045	16
17	Various			2006	207,635		20	12,237	12,237	179,153	17
18	Various			2007	18,325		20	995	995	12,016	18
19	Various			2008	92,767		20	12,916	12,916	82,133	19
20	Various			2009	72,175		20	7,210	7,210	39,744	20
21	Various			2010	276,387		20	31,055	31,055	146,419	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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			392,996			(392,996)		69
70	TOTAL (lines 4 thru 69)		$ 9,717,843	$ 598,670		$ 507,568	$ (91,102)	$ 7,849,511	70

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 9,717,843	$ 598,670		$ 507,568	$ (91,102)	$ 7,849,511	1
2	3Rd Floor Cabinetry	2011	19,793		20	1,979	1,979	7,917	2
3	Dining Room, Bathrooms Trim And Millwork	2011	7,103		20	355	355	1,361	3
4	Dryer Ventilation	2011	6,959		20	696	696	2,552	4
5	Walk Out Patio	2011	3,938		20	263	263	963	5
6	Install Transformed On Roof And Addt'L Outlets	2011	19,750		20	1,975	1,975	7,242	6
7	3Rd Flr Corridor/Resident Rooms Remodel	2011	65,287		20	6,529	6,529	23,395	7
8	5Th Floor Corridor Sink, Various Trimwork	2011	2,834		20	283	283	1,015	8
9	Crashrails	2011	3,240		20	162	162	581	9
10	Accutech Alarm System	2011	5,682		20	812	812	2,976	10
11	Replaced Hot Water Tank	2011	11,864		20	1,186	1,186	4,054	11
12	Install Smoke Detectors	2011	5,125		20	732	732	2,501	12
13	Light Fixtures In Various Areas	2011	4,218		20	422	422	1,406	13
14	Water Softener	2011	3,188		20	319	319	1,063	14
15	Electrical, Plumbing, Heating Remodel	2011	64,005		20	6,401	6,401	21,335	15
16	Crown Moulding, Wallpaper 3Rd Floor	2011	18,004		20	900	900	3,001	16
17	Water Heater	2011	4,161		20	832	832	2,774	17
18	Room Signs	2011	3,470		20	347	347	1,128	18
19	3Rd Floor Handrail, Bumpers	2011	8,172		20	817	817	2,656	19
20	Vent Alarm/Paging System	2011	5,843		20	835	835	2,713	20
21	Smoke Detectors	2011	6,782		20	969	969	3,149	21
22	Handrails And Bumper Guards	2011	3,700		20	185	185	586	22
23	2 Concrete Slabs	2011	8,020		20	802	802	2,540	23
24	Wallpaper, Blinds, Drapes, Lighting - Includes Taxes	2011	22,903		20			22,903	24
25	Install 3 Flood Lights In Parking Lot	2011	3,425		20	343	343	1,056	25
26	Installed 19 Smoke Detectors	2011	4,498		20	643	643	1,981	26
27	Remove And Install New Radiator	2012	7,641		20	764	764	2,292	27
28	Custom Doors On 3Rd And 4Th Floors	2012	8,925		20	893	893	2,603	28
29	Flooring In 4Th Floor Resident Rooms	2012	32,821		20	3,282	3,282	9,573	29
30	Doors	2012	4,645		20	465	465	1,316	30
31	Windows	2012	15,045		20	1,505	1,505	4,012	31
32	Hanging Doors & Header Installation	2012	2,970		20	297	297	792	32
33	Remodel Dishwashing Room	2012	11,945		20	1,195	1,195	3,185	33
34	TOTAL (lines 1 thru 33)		$ 10,113,799	$ 598,670		$ 544,753	$ (53,917)	$ 7,996,130	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 10,113,799	$ 598,670		$ 544,753	$ (53,917)	$ 7,996,130	1
2	Flood Lights On Outside Of Building	2012	2,540		20	508	508	1,228	2
3	Closet Organizers For 51 Resident Rooms	2012	16,737		20	1,674	1,674	4,045	3
4	Shaft Walls	2012	2,935		20	294	294	685	4
5	Room & Common Area Signs	2012	4,314		20	431	431	1,007	5
6	Centrifugal Roof Exhauster	2012	14,203		20	1,420	1,420	3,314	6
7	Concrete Gravel For The Sunken Garden	2012	10,800		20	1,080	1,080	2,430	7
8	Painting Work On 2Nd Floor	2012	5,225		20	523	523	1,176	8
9	Blinds For Resident Rooms On 4Th And 5Th Floors	2012	4,025		20	403	403	906	9
10	Door Materials For Parrish Construction Project	2012	4,829		20	483	483	1,086	10
11	Lighting Fixtures For Corridors	2012	2,853		20	571	571	1,236	11
12	4Th Floor Common Crown Moulding, Wallcoverings, Chair Rail A	2012	12,779		20	1,278	1,278	3,195	12
13	Plastering And Priming Basement Walls	2012	4,999		20	500	500	1,125	13
14	Install Flooring On 5Th Floor Common Areas	2012	34,640		20	3,464	3,464	7,794	14
15	Closet Organizers For Resident Rooms	2012	16,680		20	1,668	1,668	3,475	15
16	Ceiling Tiles	2012	3,037		20	152	152	456	16
17	Custom Handrail & Bumper Guard	2012	3,700		20	370	370	1,110	17
18	Vinyl Wood Plank Flooring For 4Th Floor Common Area	2012	3,055		20	306	306	891	18
19	Tile Flooring For 1St Floor Alzheimer'S Unit	2012	21,780		20	1,452	1,452	4,114	19
20	4Th Floor Common Area Bumper Guards	2012	4,029		20	403	403	1,075	20
21	Resident Room Remodel Supplies	2012	2,815		20	281	281	657	21
22	Closet Doors Supplies	2012	4,840		20	484	484	1,129	22
23	Crown Moulding And Wallcoverings	2012	9,402		20	940	940	2,821	23
24	4Th Floor Common Crown Moulding, Wallcoverings, Chair Rail A	2012	22,129		20	2,213	2,213	5,901	24
25	Work Completed On 1St Floor	2012	4,365		20	437	437	982	25
26	Correction To 2011 Medallion Services Invoices	2012	(20,487)		20	(2,049)	(2,049)	(6,146)	26
27	Bumper Guards On 1St And 3Rd Floors	2012	2,616		20	131	131	338	27
28	Corner Guards & Crash Rails	2012	3,979		20	199	199	514	28
29	New Windows	2012	9,855		20	493	493	1,273	29
30	Flooring 4Th Floor Hallway & Dining Room	2012	40,223		20	2,011	2,011	5,195	30
31	Installation Of Handrail On 1St Floor	2012	5,850		20	293	293	756	31
32	Wallcovering & Crown Molding On 1St Floor	2012	12,816		20	641	641	1,655	32
33	Installed 9 Electric Resistant Heating Units	2012	6,963		20	348	348	870	33
34	TOTAL (lines 1 thru 33)		$ 10,392,325	$ 598,670		$ 568,152	$ (30,518)	$ 8,052,421	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 10,392,325	$ 598,670		$ 568,152	$ (30,518)	$ 8,052,421	1
2	Basement Flooring	2013	22,995		20	4,599	4,599	9,198	2
3	5Th Floor Rooms And Hall - Painting, Door Headers, Electric Wor	2013	30,732		20	3,073	3,073	5,890	3
4	Smoke Detectors	2013	4,043		20	404	404	775	4
5	5Th Floor Remodeling - Painting 17 Rooms, Lights, Switches, Outl	2013	44,113		20	4,411	4,411	8,087	5
6	Crashrails	2013	3,809		20	381	381	698	6
7	Flooring - Hallways, Dining Room And Resident Rooms On The 5T	2013	35,758		20	7,152	7,152	13,111	7
8	Tektone System	2013	4,276		20	855	855	1,497	8
9	Flooring - Breakroom, 2 Bathrooms And 4 Elevatrs	2013	3,100		20	620	620	1,033	9
10	Crash Rails	2013	3,809		20	381	381	635	10
11	3Rd & 4Th Floor Office - Painting, Reistall Outletts, Lights, Etc.	2013	4,935		20	494	494	823	11
12	Nurses Station Remodeling	2013	6,110		20	611	611	1,018	12
13	Water Heater	2013	7,442		20	744	744	1,178	13
14	Crashrails	2013	3,809		20	381	381	603	14
15	3Rd Floor Room Remodeling - Install Closets And Header Blocks	2013	3,379		20	338	338	535	15
16	New Water Heater	2013	6,379		20	638	638	1,010	16
17	Installation Of Closet Shelving Units	2013	3,550		20	355	355	533	17
18	Installation Of Sprinkler Heads	2013	3,334		20	333	333	500	18
19	Installation Of Additional Fire Alarms	2013	7,575		20	758	758	1,136	19
20	Exterior Patio Entrance Door	2013	13,000		20	1,300	1,300	1,842	20
21	Installation Of Closet Shelving Units	2013	3,738		20	374	374	530	21
22	4Th & 5Th Floor Dining Room And Nurses Station - Wall Coverin	2013	16,914		20	1,691	1,691	2,255	22
23	Crash Rails In Hallways	2013	3,097		20	310	310	413	23
24	Fire Dampers	2013	4,900		20	490	490	653	24
25	Security Camera System	2013	5,497		20	550	550	687	25
26	Installation Of 14 Closet Organizers	2013	4,962		20	496	496	620	26
27	Installation Of 16 Closet Organizers	2013	5,448		20	545	545	681	27
28	Ao Smith Water Heater Model #Btr197	2013	6,250		20	625	625	729	28
29	Installation Of 17 Closet Organizers	2013	5,501		20	550	550	642	29
30	Light Fixtures	2013	11,643		20	1,164	1,164	1,261	30
31	Convection Pellet Heater	2013	3,950		20	790	790	856	31
32	600 Crashrails And 200 Retainers	2013	3,959		20	396	396	429	32
33	Closet Organizers	2013	23,645		20	2,364	2,364	2,956	33
34	TOTAL (lines 1 thru 33)		$ 10,703,976	$ 598,670		$ 606,325	$ 7,655	$ 8,115,236	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 10,703,976	$ 598,670		$ 606,325	$ 7,655	$ 8,115,236	1
2	Cylinder With Code Compliant Cylinder	2013	46,495		20	4,650	4,650	5,424	2
3	12 Lighting Unfinished Crown Molding	2013	2,614		20	261	261	348	3
4	12 Lighting Unfinished Crown Molding	2013	2,614		20	261	261	327	4
5	Closet Organizers	2013	16,627		20	1,663	1,663	2,910	5
6	Correction To 2012 Roof Exhauster Paid Twice	2013	(7,101)		20	(710)	(710)	(1,420)	6
7	Elevator Repairs	2013	5,100		20	255	255	298	7
8	Sprinkler Head In Pit Of 2 Elevator Shafts	2013	6,450		20	323	323	457	8
9	Heating / Cooling Units For Resident Rooms	2013	22,187		20	1,109	1,109	1,202	9
10	New Doors And Security Pads	2014	8,349		20	835	835	835	10
11	Crashrail C400 Aluminum Retainer	2014	4,135		20	414	414	414	11
12	Door Alarms And Reactivation Of Magnetic Locks	2014	8,887		20	741	741	741	12
13	Kitchen Water Heater	2014	9,949		20	912	912	912	13
14	Crashrail And Aluminum Retainer	2014	4,135		20	345	345	345	14
15	Ejector Pump	2014	4,137		20	207	207	207	15
16	Basement Flooring For Sunken Garden	2014	10,115		20	421	421	421	16
17	Shower Room Doors	2014	14,976		20	374	374	374	17
18	Dementia Unit Doors, Oxygen Storage, Rooftop	2014	7,357		20	245	245	245	18
19	Flooring And Carpet In 6Th Floor Hallways And Elevator Floors	2014	30,407		20	507	507	507	19
20	Elevator Repair	2014	3,081		20	154	154	154	20
21	Sprinkler System Repair	2014	15,247		20	762	762	762	21
22	Replace Retaining Wall	2014	9,000		20	450	450	450	22
23	Crackfilling Parking Lot	2014	3,937		20	197	197	197	23
24	Asphalt Repairs	2014	2,750		20	138	138	138	24
25	Repair A/C	2014	3,150		20	157	157	157	25
26	Replace Heater	2014	3,384		20	169	169	169	26
27	Hvac/Boiler	2014	4,014		20	201	201	201	27
28	Hvac/Boiler	2014	3,226		20	161	161	161	28
29	Painting	2014	4,991		20	250	250	250	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,954,188	$ 598,670		$ 621,776	$ 23,106	$ 8,132,420	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	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
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)		$	$		$	$	$	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$	$		$	$	$	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
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$	$		$	$	$	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
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 988,732	$ 269	$ 136,152	$ 135,883	10	$ 681,603	71
72	Current Year Purchases	259,660		30,758	30,758	10	30,758	72
73	Fully Depreciated Assets	1,472,141				10	1,471,625	73
74								74
75	TOTALS	$ 2,720,533	$ 269	$ 166,910	$ 166,641		$ 2,183,985	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		2011 LEXUS LS 460	2011	$ 30,000	$	$ 4,921	$ 4,921	5	$ 20,773	76
77										77
78										78
79										79
80	TOTALS			$ 30,000	$	$ 4,921	$ 4,921		$ 20,773	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)	$ 14,112,721	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 598,939	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 793,607	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 194,668	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,337,178	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	$ 38,952	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 39,141	$ 6,492	$ 38,952	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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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				29,074			5
6	Allocated from MS Healthcare Accounting				7,000			6
7	TOTAL				$ 36,074 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 24,329 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	GMAC Mountaineer	$	$ 4,194	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,194	21

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

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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? [X] YES [ ] 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	$	$ 8,820	$	$ 8,820
2	Books and Supplies		246		246
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	$	$ 9,066	$	$ 9,066
10	SUM OF line 9, col. 1 and 2 (e)	$ 9,066			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$		$ 818,870	$		$ 818,870	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			348,074			348,074	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			957,848			957,848	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				580,035		580,035	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			198,333		147,377	685,809		1,031,519	13
14	TOTAL			$ 198,333		$ 2,272,169	$ 1,265,844		$ 3,736,346	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.

STATE OF ILLINOIS

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 470,606	$ 7,767,742	1
2	Cash-Patient Deposits	21,308	21,308	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,673,871	7,673,871	3
4	Supply Inventory (priced at)	51,242	51,242	4
5	Short-Term Investments			5
6	Prepaid Insurance	40,057	40,057	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,135,080	2,748,263	8
9	Other(specify):	3,234	3,234	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,395,398	$ 18,305,717	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	2,876,001	2,876,001	15
16	Equipment, at Historical Cost	2,205,117	3,021,117	16
17	Accumulated Depreciation (book methods)	(3,231,895)	(7,407,235)	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):	247,414	412,102	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,096,637	$ 7,331,265	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,492,035	$ 25,636,982	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,275,700	$ 2,127,137	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,548	4,548	28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	705,546	705,546	30
31	Accrued Taxes Payable (excluding real estate taxes)	49,894	49,894	31
32	Accrued Real Estate Taxes(Sch.IX-B)	173,561	173,561	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,500	8,500	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,001,457	1,041,457	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,719,206	$ 4,610,643	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	210,000	14,210,000	39
40	Mortgage Payable		6,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 210,000	$ 20,210,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,929,206	$ 24,820,643	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,562,829	$ 816,339	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,492,035	$ 25,636,982	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 849,497	1
2	Restatements (describe):		2
3	**Late Journal Entry**	490,727	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,340,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,554,755	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	(332,150)	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)**	$ 1,222,605	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)**	$ 2,562,829	24 *

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 26,079,499	1
2	Discounts and Allowances for all Levels	(9,551,527)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,527,972	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,860,706	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,860,706	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	20	13
14	Non-Patient Meals	10,058	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	545	16
17	Sale of Drugs	569,169	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	99,221	19
20	Radiology and X-Ray	40,638	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 719,651	23
	D. Non-Operating Revenue		
24	Contributions	7,808	24
25	Interest and Other Investment Income***	9,584	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,392	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	26,723	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,723	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 23,152,444	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,988,192	31
32	Health Care	6,772,063	32
33	General Administration	4,907,372	33
	B. Capital Expense		
34	Ownership	2,166,492	34
	C. Ancillary Expense		
35	Special Cost Centers	4,152,281	35
36	Provider Participation Fee	611,289	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,597,689	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,554,755	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,554,755	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,569,784	44
45	Private Pay - Net Inpatient Revenue	1,344,804	45
46	Medicare - Net Inpatient Revenue	3,299,815	46
47	Other-(specify) Hospice	114,879	47
48	Other-(specify) Insurance	198,690	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,527,972	49

* **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.**

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,938	2,128	$ 82,961	$ 38.99	1
2	Assistant Director of Nursing	3,907	4,340	166,575	38.38	2
3	Registered Nurses	47,485	52,295	1,522,082	29.11	3
4	Licensed Practical Nurses	50,273	57,317	1,508,466	26.32	4
5	CNAs & Orderlies	172,647	197,650	2,521,386	12.76	5
6	CNA Trainees					6
7	Licensed Therapist	7,593	7,593	198,333	26.12	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	28,678	29,935	296,158	9.89	10
11	Social Service Workers	9,369	10,466	149,811	14.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,739	42,614	496,219	11.64	15
16	Dishwashers					16
17	Maintenance Workers	11,634	12,676	175,372	13.83	17
18	Housekeepers	34,983	38,274	437,891	11.44	18
19	Laundry	16,016	17,438	163,147	9.36	19
20	Administrator	1,859	2,128	169,679	79.74	20
21	Assistant Administrator					21
22	Other Administrative	2,381	2,387	45,860	19.21	22
23	Office Manager					23
24	Clerical	19,828	22,548	411,444	18.25	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	2,774	4,194	62,419	14.88	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental S	5,817	6,333	209,608	33.10	33
34	TOTAL (lines 1 - 33)	455,921	510,316	$ 8,617,411 *	$ 16.89	34

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

** See instructions.

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	628	$ 29,504	01-03	35
36	Medical Director	Monthly	61,500	09-03	36
37	Medical Records Consultant	Monthly	4,704	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	901	36,059	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	211	13,522	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,740	$ 145,289		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	4,134	95,177	10-03	52
53	TOTAL (lines 50 - 52)	4,134	$ 95,177		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kelly Covarrubias	Administrator	0	$ 169,679
Lorraine Suissa	Administrative	0	45,860
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 215,539

B. Administrative - Other

Description	Amount
Management Fees - Mark Suissa	$ 120,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 125,202
Healthcare Accounting Svcs.	Bookkeeping/Accounting	388,644
FR&R	Accounting	40,000
Personnel Planners	Unemployment Tax Cons.	4,284
American Data	Computer Services	5,208
E-Health Data Solutions	Computer Services	7,425
National Datacare	Computer Services	5,248
Paychex	Payroll Processing	22,652
Achieve Accreditation	Joint Commision Consult	27,230
Employers Services Consult	Workers Comp Consult.	2,400
See Supplemental Schedule		20,465
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 648,758

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 427,704
Unemployment Compensation Insurance	156,490
FICA Taxes	643,197
Employee Health Insurance	636,111
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	6,289
Disability/Life /Dental Insurance	21,512
Employee Benefit Plan	108,063
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,999,366

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	1,700
Health Care Worker Background Check	
(Indicate # of checks performed 364)	5,636
Patient Background Checks 300	3,000
Dues & Subscriptions	2,483
License & Fees	5,473
Allocated from Healthcare Accounting	523
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,815

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,392
Allocated from Healthcare Accounting	334
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,726

* Attach copy of IMRF notifications

**See instructions.

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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													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,714** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **611,289**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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? **Yes**
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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.