FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0051920

Facility Name: Saline Care Center

Address: 120 S Land St Bx 468 (Number) Harrisburg (City) 62946 (Zip Code)

County: Saline

Telephone Number: (618) 252-7405 **Fax #** (618) 253-3418

HFS ID Number:

Date of Initial License for Current Owners: 5/15/1985

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: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/2014 to 12/31/2014 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) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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 Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

	1 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	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	142	TOTALS	142	51,830	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	28,213	5,225	4,287	37,725	8
9	SNF/PED					9
10	ICF	9,876	431		10,307	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,089	5,656	4,287	48,032	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.67%

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 5/15/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/15/1985 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 4,259

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 Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	293,788	13,683	11,402	318,873		318,873		318,873			1
2	Food Purchase		280,111		280,111		280,111	(6,650)	273,461			2
3	Housekeeping	215,895	25,083		240,978		240,978		240,978			3
4	Laundry	79,803	18,942		98,745		98,745	138	98,883			4
5	Heat and Other Utilities			127,529	127,529		127,529	3,369	130,898			5
6	Maintenance	57,341	19,926	32,066	109,333		109,333	1,130	110,463			6
7	Other (specify):* Waste Removal			9,862	9,862		9,862		9,862			7
8	TOTAL General Services	646,827	357,745	180,859	1,185,431		1,185,431	(2,013)	1,183,418			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,618,125	91,595	1,350	1,711,070		1,711,070		1,711,070			10
10a	Therapy			303,360	303,360		303,360		303,360			10a
11	Activities	59,895			59,895		59,895		59,895			11
12	Social Services	86,603	7,286	11,703	105,592		105,592		105,592			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,764,623	98,881	320,013	2,183,517		2,183,517		2,183,517			16
	C. General Administration											
17	Administrative	115,327		556,182	671,509		671,509	(329,240)	342,269			17
18	Directors Fees											18
19	Professional Services			52,543	52,543		52,543	2,226	54,769			19
20	Dues, Fees, Subscriptions & Promotions			25,472	25,472		25,472	(5)	25,467			20
21	Clerical & General Office Expenses	113,044	29,935	14,464	157,443		157,443	91,355	248,798			21
22	Employee Benefits & Payroll Taxes			408,258	408,258		408,258		408,258			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,088	1,088		1,088	753	1,841			24
25	Other Admin. Staff Transportation			11,574	11,574		11,574	40,500	52,074			25
26	Insurance-Prop.Liab.Malpractice			97,963	97,963		97,963	3,615	101,578			26
27	Other (specify):* RDK/SI Benefits Alloc							23,701	23,701			27
28	TOTAL General Administration	228,371	29,935	1,167,544	1,425,850		1,425,850	(167,095)	1,258,755			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,639,821	486,561	1,668,416	4,794,798		4,794,798	(169,108)	4,625,690			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 Saline Care Center #0051920 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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			76,388	76,388		76,388	75,920	152,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,692	28,692		28,692	(493)	28,199			32
33	Real Estate Taxes			52,513	52,513		52,513	395	52,908			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,197	9,197		9,197		9,197			35
36	Other (specify):*											36
37	**TOTAL Ownership**			166,790	166,790		166,790	75,822	242,612			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		129,243		129,243		129,243		129,243			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			363,435	363,435		363,435		363,435			42
43	Other (specify):* Non-allowable Costs			92,802	92,802		92,802	(92,802)				43
44	**TOTAL Special Cost Centers**		129,243	456,237	585,480		585,480	(92,802)	492,678			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,639,821	615,804	2,291,443	5,547,068		5,547,068	(186,088)	5,360,980			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 Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

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

	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				4
5	Telephone, TV & Radio in Resident Rooms	(5,834)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	70,463	30		9
10	Interest and Other Investment Income	(493)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(817)	43		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	(857)	20		17
18	Fines and Penalties	210	43		18
19	Entertainment	(137)	43		19
20	Contributions	(1,175)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,784)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,808)	43		24
25	Fund Raising, Advertising and Promotional	(3,901)	43		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 See Page 5A	(13,078)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,211)		$	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)	(152,877)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (152,877)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (186,088)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Saline Care Center

ID# 0051920

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Funeral Expense	$ (1,135)	43	1
2	Birthday Expense	(4,940)	43	2
3	Gifts	(265)	43	3
4	Miscellaneous income offset	(88)	21	4
5	Vending Machine income offset	(6,650)	2	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,078)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Saline Care Center # 0051920 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,650)	0	0	0	0	0	0	0	0	0	0	(6,650)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	138	0	0	0	0	0	0	0	0	0	138	4
5	Heat and Other Utilities	0	3,369	0	0	0	0	0	0	0	0	0	3,369	5
6	Maintenance	0	1,130	0	0	0	0	0	0	0	0	0	1,130	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,650)	4,637	0	0	0	0	0	0	0	0	0	(2,013)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(253,324)	(75,916)	0	0	0	0	0	0	0	0	(329,240)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,784)	2,260	2,750	0	0	0	0	0	0	0	0	2,226	19
20	Fees, Subscriptions & Promotions	(857)	750	102	0	0	0	0	0	0	0	0	(5)	20
21	Clerical & General Office Expenses	(88)	28,047	63,396	0	0	0	0	0	0	0	0	91,355	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	753	0	0	0	0	0	0	0	0	753	24
25	Other Admin. Staff Transportation	0	39,346	1,154	0	0	0	0	0	0	0	0	40,500	25
26	Insurance-Prop.Liab.Malpractice	0	3,457	158	0	0	0	0	0	0	0	0	3,615	26
27	Other (specify):*	0	10,579	13,122	0	0	0	0	0	0	0	0	23,701	27
28	**TOTAL General Administration**	(3,729)	(168,885)	5,519	0	0	0	0	0	0	0	0	(167,095)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,379)	(164,248)	5,519	0	0	0	0	0	0	0	0	(169,108)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Saline Care Center **#** 0051920 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	70,463	5,457	0	0	0	0	0	0	0	0	0	75,920	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(493)	0	0	0	0	0	0	0	0	0	0	(493)	32
33	Real Estate Taxes	0	395	0	0	0	0	0	0	0	0	0	395	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	69,970	5,852	0	0	0	0	0	0	0	0	0	75,822	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(92,802)	0	0	0	0	0	0	0	0	0	0	(92,802)	43
44	**TOTAL Special Cost Centers**	(92,802)	0	0	0	0	0	0	0	0	0	0	(92,802)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,211)	(158,396)	5,519	0	0	0	0	0	0	0	0	(186,088)	45

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dr. Larry Jones	50	Carrier Mills Nursing & Rehab	Carrier Mills	RDK Management, Inc.	Harrisburg	Management Co.
Dr. Roger Herrin	50	Stonebridge Senior Living Center, LLC	Benton	SI Management Svc, LLC	Harrisburg	Management Co.
		Pinckneyville Nursing & Rehab	Pinckneyville			
		DuQuoin Nursing & Rehab	DuQuoin			

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	4	Laundry	$	RDK Management, Inc.	100.00%	$ 138	$ 138	1
2	V	5	Utilities		RDK Management, Inc.	100.00%	3,369	3,369	2
3	V	6	Repairs and Maint.		RDK Management, Inc.	100.00%	1,130	1,130	3
4	V	17	Administrative	411,582	RDK Management, Inc.	100.00%	158,258	(253,324)	4
5	V	19	Professional Fees		RDK Management, Inc.	100.00%	2,260	2,260	5
6	V	20	Fees, Subscriptions		RDK Management, Inc.	100.00%	750	750	6
7	V	21	Clerical And General		RDK Management, Inc.	100.00%	28,047	28,047	7
8	V	25	Admin. Staff Trans.		RDK Management, Inc.	100.00%	39,346	39,346	8
9	V	26	Insurance-Prop./Liab./Malprac.		RDK Management, Inc.	100.00%	3,457	3,457	9
10	V	27	Gen. Admin. Emp. Ben.		RDK Management, Inc.	100.00%	10,579	10,579	10
11	V	30	Depreciation		RDK Management, Inc.	100.00%	5,457	5,457	11
12	V	33	Real Estate Tax		RDK Management, Inc.	100.00%	395	395	12
13	V								13
14	Total			$ 411,582			$ 253,186	$ * (158,396)	14

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	17	Administrative	$ 144,600	SI Management Services, LLC	100.00%	$ 68,684	$ (75,916)	15
16	V	19	Professional Fees		SI Management Services, LLC	100.00%	2,750	2,750	16
17	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	102	102	17
18	V	21	Clerical And General		SI Management Services, LLC	100.00%	63,396	63,396	18
19	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	753	753	19
20	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	1,154	1,154	20
21	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	158	158	21
22	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	13,122	13,122	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			$ 144,600			$ 150,119	$ * 5,519	39

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

	1	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	Dr. Roger Herrin	Stockholder	Administrative	50.00	See Att Sch 7A	10.18	25.45	Alloc. Salary	$ 139,924	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 139,924		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 Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: RDK Management, Inc.
Street Address: 607 South Commercial
City / State / Zip Code: Harrisburg, Illinois
Phone Number: ((618) 252-7707
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	4	Laundry	Census	118,000	5	339		48,032	$ 138	1
2	5	Utilities	Census	118,000	5	8,278		48,032	3,369	2
3	6	Repairs and Maint.	Census	118,000	5	2,777		48,032	1,130	3
4	17	Administrative	Census	118,000	5	388,792	388,792	48,032	158,258	4
5	19	Professional Fees	Census	118,000	5	5,552		48,032	2,260	5
6	20	Fees, Subscriptions	Census	118,000	5	1,842		48,032	750	6
7	21	Clerical And General	Census	118,000	5	68,903	44,301	48,032	28,047	7
8	25	Admin. Staff Trans.	Census	118,000	5	96,661		48,032	39,346	8
9	26	Insurance-Prop./Liab./Malprac.	Census	118,000	5	8,492		48,032	3,457	9
10	27	Gen. Admin. Emp. Ben.	Census	118,000	5	25,990		48,032	10,579	10
11	30	Depreciation	Census	118,000	5	13,405		48,032	5,457	11
12	33	Real Estate Tax	Census	118,000	5	970		48,032	395	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					$ 622,001	$ 433,093		$ 253,186	25

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: SI Management Services, LLC
Street Address: 607 South Commercial
City / State / Zip Code: Harrisburg, Illinois
Phone Number: (618) 252-7707
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	17	Administrative	Census	118,000	5	168,736	168,736	48,032	$ 68,684	1
2	19	Professional Fees	Census	118,000	5	6,755		48,032	2,750	2
3	20	Fees, Subscriptions	Census	118,000	5	250		48,032	102	3
4	21	Clerical And General	Census	118,000	5	155,745	154,984	48,032	63,396	4
5	24	Travel and Seminar	Census	118,000	5	1,851		48,032	753	5
6	25	Admin. Staff Trans.	Census	118,000	5	2,835		48,032	1,154	6
7	26	Insurance-Prop./Liab./Malprac.	Census	118,000	5	388		48,032	158	7
8	27	Gen. Admin. Emp. Ben.	Census	118,000	5	32,236		48,032	13,122	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					$ 368,796	$ 323,720		$ 150,119	25

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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
	Working Capital											
6	Farmer's State Bank		X	Line of Credit	Interest Only		1,150,000	1,049,604			28,692	6
7												7
8												8
9	TOTAL Facility Related						$ 1,150,000	$ 1,049,604			$ 28,692	9
	B. Non-Facility Related*											
10												10
11								Offset Interest Income			(493)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (493)	14
15	TOTALS (line 9+line14)						$ 1,150,000	$ 1,049,604			$ 28,199	15

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

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

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

Facility Name & ID Number Saline Care Center # 0051920 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 51,718	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.)	2013	$ 51,601	2
3. Under or (over) accrual (line 2 minus line 1).		$ (117)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,630	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.	**Allocated From RDK**	395	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ 395	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 52,908	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	46,126	8
	2010	48,657	9
	2011	49,823	10
	2012	50,704	11
	2013	51,601	12

2014 Accrual = $51,601 x 1.02 = $52,630

	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 Saline Care Center COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0051920

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #:

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.	06-1-098-06	Long Term Care Property	$ 19,944.66	$ 19,944.66
2.	06-1-098-01	Long Term Care Property	$ 31,655.64	$ 31,655.64
3.	06-2-275-02	Home Office Allocation	$ 969.58	$ 395.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,569.88	$ 51,995.30

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? X YES _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,506 B. General Construction Type: Exterior Brick Frame Masonry Brick Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (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).

N/A

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: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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	514,920	1985	$ 50,000	1
2	Home Office Allocation			8,406	2
3	TOTALS	514,920		$ 58,406	3

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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	124		1985	1969	$ 1,230,310	$	30	$ 41,010	$ 41,010	$ 1,214,921	4
5	18		1992	1992	700,233		30	23,341	23,341	517,641	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	131,167		20			131,167	9
10	Various			1986	80,813		20			80,813	10
11	Various			1987	7,050		20			7,050	11
12	Various			1988	15,938		20			15,938	12
13	Various			1992	10,381		20			10,381	13
14	Various			1994	1,859		20			1,859	14
15	Various			1997	14,650		20	733	733	13,186	15
16	Various			1998	4,557		20	228	228	3,874	16
17	Various			2000	72,282		20	3,614	3,614	54,211	17
18	Various			2001	7,245		20	362	362	5,071	18
19	Various			2004	4,333		20	217	217	2,384	19
20	Various			2006	1,523		20	76	76	685	20
21	Various			2009	16,374		20	819	819	4,913	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 Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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	Wallpaper	2011	$ 12,591	$	20	$ 630	$ 630	$ 2,519	37
38	Tile	2011	8,438		20	422	422	1,688	38
39	Window Sheers	2011	2,338		20	117	117	468	39
40	Valances	2011	8,361		20	418	418	1,672	40
41	Remodeling-Lights, Flooring, Windows	2011	15,015		20	751	751	3,003	41
42	Remodeling-Painting, Flooring, Wallcovering,	2011	27,547		20	1,377	1,377	5,509	42
43	Install New Exit/Emergency Lighting, Wiring In Family Room & F	2011	2,604		20	130	130	521	43
44	Architectural Fees	2011	2,752		20	138	138	551	44
45	Painting & Hanging Of Wallcovering	2011	3,001		20	150	150	600	45
46	Electrical -Family Room-Outlets & Circuits For Lighting & Wired	2011	3,065		20	153	153	613	46
47	New Panel Feeds To Family Room, Exit Lighting In Halls, Lighting	2011	3,145		20	157	157	629	47
48	Painting & Hanging Of Wallcovering	2011	3,196		20	160	160	639	48
49	Architectural Documents	2011	3,398		20	170	170	680	49
50	Painting & Vinyl Hanging	2011	4,253		20	213	213	851	50
51	Remove Old And Install New Overhead Lights In Dining Room, Ne	2011	4,276		20	214	214	855	51
52	Architectural Fees	2011	4,350		20	218	218	871	52
53	Remote Sensor Alarm In Nurse Station, Rewired Front Entry Alar	2011	5,153		20	258	258	1,031	53
54	Replace Entrance Door And Frame	2011	6,186		20	309	309	1,237	54
55	Cabinets & Countertops	2011	47,500		20	2,375	2,375	9,500	55
56	Architectural Fees	2011	12,126		20	606	606	2,425	56
57	Sprinkler System	2011	48,400		20	2,420	2,420	9,680	57
58	Sprinkler Work	2011	24,200		20	1,210	1,210	4,840	58
59	Architect / Design Fees	2011	10,553		20	528	528	2,111	59
60	Sign	2011	8,638		20	432	432	1,728	60
61	Smoke Detectors, Sprinkler Heads, Rire Alarm Panel	2012	13,616		20	681	681	2,043	61
62	Smoke Detectors & Sprinkler Work	2012	7,297		20	365	365	1,095	62
63	Architect / Design Fees	2012	8,363		20	418	418	1,254	63
64	Carpeting & Wallcovering - 20 Resident Rooms And Offices	2012	67,342		20	3,367	3,367	10,101	64
65	Telephone System	2012	10,198		20	510	510	1,530	65
66	Built In Cabinets	2012	15,800		20	790	790	2,370	66
67	Nurse Call System	2012	21,254		20	1,063	1,063	3,188	67
68	Security System	2012	20,245		20	1,012	1,012	3,037	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,733,916	$		$ 92,162	$ 92,162	$ 2,142,933	70

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 2,733,916	$		$ 92,162	$ 92,162	$ 2,142,933	1
2	Hellitech-Waterproofing & Structural Repair	2012	10,631		20	532	532	1,595	2
3	Hellitech-Waterproofing & Structural Repair	2012	15,784		20	789	789	2,367	3
4	Asphalt Parking Lot Resurfacing	2014	31,687		20	792	792	792	4
5	AC Wiring - Laundry Room	2014	667		20	17	17	17	5
6	7 Room Screens	2014	2,192		20	55	55	55	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,794,877	$		$ 94,347	$ 94,347	$ 2,147,759	34

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 2,794,877	$		$ 94,347	$ 94,347	$ 2,147,759	1
2									2
3									3
4									4
5									5
6									6
7	Leasehold Information								7
8	Allocated From RDK Management	1993	48,193		20	754	754	35,368	8
9	Allocated From RDK Management	1994	2,083		20			2,083	9
10	Allocated From RDK Management	1996	77		20	4	4	74	10
11	Allocated From RDK Management	1998	351		20	18	18	297	11
12	Allocated From RDK Management	2000	7,742		20	387	387	5,806	12
13									13
14									14
15									15
16									16
17	Financial Statement Depreciation			76,388			(76,388)		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)		$ 2,853,323	$ 76,388		$ 95,510	$ 19,122	$ 2,191,387	34

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 372,595	$	$ 37,260	$ 37,260	10	$ 201,451	71
72	Current Year Purchases	11,768		588	588	10	588	72
73	Fully Depreciated Assets	431,220				10	431,220	73
74	Allocated from Mgmt Co.	21,304		5,762	5,762	5-10	19,802	74
75	TOTALS	$ 836,887	$	$ 43,610	$ 43,610		$ 653,061	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		See Attached Sch 13A	Various	$ 110,167	$	$ 13,188	$ 13,188	5	$ 81,203	76
77										77
78										78
79		Allocated from Mgmt Co		37,092				5	37,092	79
80	TOTALS			$ 147,259	$	$ 13,188	$ 13,188		$ 118,295	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,895,875	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 76,388	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,308	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 75,920	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,962,743	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.

Saline Care Center

Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule XI D. Ownership Costs - Vehicles

Use	Make, Model and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Facility	1998 Ford Truck	1998	26,502			-	5	26,502
Facility	2005 Ford Ranger	2005	13,770			-	5	13,770
Facility	2012 Kia Sedona	2012	21,919		4,384	4,384	5	17,535
Facility	2012 Dodge Grand Caravan	2012	36,479		7,296	7,296	5	21,888
Administrative	2015 Kia Sorrento	2014	10,017		1,335	1,335	5	1,335
Administrative	2001 Ford Mustang	2014	1,480		173	173	5	173
	Total		**$ 110,167**	**$ -**	**$ 13,188**	**$ 13,188**		**$ 81,203**

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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								5
6								6
7	TOTAL				$ **			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: $ 9,197 Description: Medical Equipment $8,730; Office Equipment $467
    (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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

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

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

It is the policy of this facility to only hire certified nurses aides.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$		$ 132,230	$		$ 132,230	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			24,004			24,004	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			147,126			147,126	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				129,243		129,243	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 303,360	$ 129,243		$ 432,603	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.

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 468,752	$ 468,752	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,074,947	1,074,947	3
4	Supply Inventory (priced at)	3,500	3,500	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	30,750	30,750	7
8	Accounts Receivable (owners or related parties)	500,000	500,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,077,949	$ 2,077,949	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	58,406	13
14	Buildings, at Historical Cost	2,053,251	1,930,543	14
15	Leasehold Improvements, at Historical Cost	586,256	922,780	15
16	Equipment, at Historical Cost	1,179,178	984,146	16
17	Accumulated Depreciation (book methods)	(2,858,318)	(2,962,743)	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): Goodwill	100	100	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 980,467	$ 933,232	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,058,416	$ 3,011,181	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 181,375	$ 181,375	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,049,604	1,049,604	29
30	Accrued Salaries Payable	8,725	8,725	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,922	2,922	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,630	52,630	32
33	Accrued Interest Payable	11,061	11,061	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,306,317	$ 1,306,317	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,306,317	$ 1,306,317	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,752,099	$ 1,704,864	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,058,416	$ 3,011,181	48

*(See instructions.)

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,372,344	1
2	Restatements (describe):		2
3	**Rounding**	7	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,372,351	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,182,208	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	(802,460)	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)**	$ 379,748	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)**	$ 1,752,099	24 *

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,628,768	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,628,768	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	90,142	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 90,142	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	6,650	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,650	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	493	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 493	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	3,135	28
28a	Miscellaneous Income	88	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,223	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,729,276	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,185,431	31
32	Health Care	2,183,517	32
33	General Administration	1,425,850	33
	B. Capital Expense		
34	Ownership	166,790	34
	C. Ancillary Expense		
35	Special Cost Centers	222,045	35
36	Provider Participation Fee	363,435	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,547,068	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,182,208	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,182,208	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,285,549	44
45	Private Pay - Net Inpatient Revenue	811,127	45
46	Medicare - Net Inpatient Revenue	1,422,071	46
47	Other-(specify) Insurance	110,021	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,628,768	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 Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	1,928	2,080	$ 53,317	$ 25.63	1
2	Assistant Director of Nursing	1,747	1,895	38,488	20.31	2
3	Registered Nurses	8,099	8,309	153,874	18.52	3
4	Licensed Practical Nurses	37,926	39,405	587,480	14.91	4
5	CNAs & Orderlies	79,710	82,449	784,966	9.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,689	7,023	59,895	8.53	10
11	Social Service Workers	8,493	8,991	86,603	9.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,844	32,829	293,788	8.95	15
16	Dishwashers					16
17	Maintenance Workers	5,067	5,339	57,341	10.74	17
18	Housekeepers	24,327	25,440	215,895	8.49	18
19	Laundry	9,591	9,928	79,803	8.04	19
20	Administrator	2,048	2,080	53,811	25.87	20
21	Assistant Administrator					21
22	Other Administrative	1,196	1,196	61,516	51.43	22
23	Office Manager					23
24	Clerical	11,370	11,704	113,044	9.66	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	230,035	238,668	$ 2,639,821 *	$ 11.06	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	240	$ 11,402	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant	Monthly	750	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	L10, C3	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	48	3,233	L12, C3	45
46	Other(specify) Psychiatric	Monthly	8,470	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	$ 28,055		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Virginia Pierce	Administrative	0	$ 42,339
Mary Daubert	Administrator	0	53,811
Scott E. Stout	Executive Dir.	0	15,585
Penny Sisk	Administrative	0	3,592
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,327

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 556,182
TOTAL (agree to Schedule V, line 17, col. 3)	$ 556,182
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Adam Lawler Law Firm	Legal	$ 2,784
Daniel Maher Law Office	Legal	68
Frost, Ruttenberg & Rothblatt	Accounting	9,300
James Henson PC	Accounting	13,190
Payroll Services by Extra Help	Payroll Service	4,487
IL Health Information Exchange	Health Information Network	248
Galaxy Hosted Software	Web Hosting Service	8,318
Lintech	LTC Software	12,091
Ability Network	Health Info Management	2,057
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 52,543

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,358
Unemployment Compensation Insurance	27,096
FICA Taxes	203,929
Employee Health Insurance	47,899
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Personal Days	9,772
Payroll Incentives	6,317
Employee Life & STD Insurance	2,009
Other Employee Benefits	(122)
TOTAL (agree to Schedule V, line 22, col.8)	$ 408,258

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	6,062
Health Care Worker Background Check	
(Indicate # of checks performed 63)	2,325
Patient Background Checks 121	2,442
License & Permits	1,443
Dues & Subcriptions	525
IHCA	7,838
Allocated From RDK/SI Management	852
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,467

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	246
Seminar Expense	842
Allocated From SI Management	753
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,841

**See instructions.

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Saline Care Center # 0051920 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **7,838 IHCA**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,633** 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. $ **363,435**
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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **3,135**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Line 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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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.