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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0044057

Facility Name: Salem Village Nursing

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

County: Will

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

HFS ID Number:

Date of Initial License for Current Owners: 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) 282-6300
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 01/01/15 to 12/31/15 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) Partner
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	44,157	7,452	20,075	71,684	8
9	SNF/PED					9
10	ICF	11,505	713	594	12,812	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,662	8,165	20,669	84,496	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.11%

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 11,438

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	520,806	113,203	29,457	663,466		663,466		663,466			1
2	Food Purchase		543,046		543,046		543,046	(12,154)	530,892			2
3	Housekeeping	449,253	122,718		571,971		571,971		571,971			3
4	Laundry	149,656	78,399	1,450	229,505		229,505		229,505			4
5	Heat and Other Utilities			327,185	327,185		327,185		327,185			5
6	Maintenance	158,750	42,624	248,058	449,432		449,432	30,235	479,667			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,278,465	899,990	606,150	2,784,605		2,784,605	18,081	2,802,686			8
	B. Health Care and Programs											
9	Medical Director			71,300	71,300		71,300		71,300			9
10	Nursing and Medical Records	5,861,103	174,911	324,706	6,360,720		6,360,720	(2,573)	6,358,147			10
10a	Therapy											10a
11	Activities	266,697	32,273		298,970		298,970		298,970			11
12	Social Services	158,288		12,674	170,962		170,962		170,962			12
13	CNA Training											13
14	Program Transportation			20,776	20,776		20,776		20,776			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,286,088	207,184	429,456	6,922,728		6,922,728	(2,573)	6,920,155			16
	C. General Administration											
17	Administrative	200,573		120,000	320,573		320,573	16,651	337,224			17
18	Directors Fees											18
19	Professional Services			637,756	637,756		637,756	(419,753)	218,003			19
20	Dues, Fees, Subscriptions & Promotions			73,677	73,677		73,677	(48,024)	25,653			20
21	Clerical & General Office Expenses	477,899	94,060	1,477,212	2,049,171		2,049,171	(1,159,159)	890,012			21
22	Employee Benefits & Payroll Taxes			1,965,633	1,965,633		1,965,633	(32,150)	1,933,483			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,816	7,816		7,816	93	7,909			24
25	Other Admin. Staff Transportation			52,117	52,117		52,117	(4,581)	47,536			25
26	Insurance-Prop.Liab.Malpractice			404,971	404,971		404,971	1,102	406,073			26
27	Other (specify):*							33,714	33,714			27
28	**TOTAL General Administration**	678,472	94,060	4,739,182	5,511,714		5,511,714	(1,612,107)	3,899,607			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,243,025	1,201,234	5,774,788	15,219,047		15,219,047	(1,596,598)	13,622,449			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 Nursing #0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			429,582	429,582		429,582	385,014	814,596			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,849	31,849		31,849	771,936	803,785			32
33	Real Estate Taxes			188,534	188,534		188,534		188,534			33
34	Rent-Facility & Grounds			1,525,000	1,525,000		1,525,000	(1,470,983)	54,017			34
35	Rent-Equipment & Vehicles			51,114	51,114		51,114	(28,335)	22,779			35
36	Other (specify):*											36
37	TOTAL Ownership			2,226,079	2,226,079		2,226,079	(342,368)	1,883,711			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	554,159	1,222,286	2,142,165	3,918,610		3,918,610		3,918,610			39
40	Barber and Beauty Shops			1,135	1,135		1,135	(75)	1,060			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			593,698	593,698		593,698		593,698			42
43	Other (specify):*	179,692		228,000	407,692		407,692	(407,692)				43
44	TOTAL Special Cost Centers	733,851	1,222,286	2,964,998	4,921,135		4,921,135	(407,767)	4,513,368			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,976,876	2,423,520	10,965,865	22,366,261		22,366,261	(2,346,734)	20,019,527			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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,629)	02		4
5	Telephone, TV & Radio in Resident Rooms	(27,783)	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	179,351	30		9
10	Interest and Other Investment Income	(5,986)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(525)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(11,456)	21		19
20	Contributions	(10,920)	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	(1,119,110)	21		24
25	Fund Raising, Advertising and Promotional	(38,299)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(17,079)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(752,266)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,815,702)		$	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)	(531,032)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (531,032)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,346,734)		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

Salem Village Nursing

ID# 0044057

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Out of State Auto & Travel	$ (9,552)	25	1
2	Dividend Income	(4,382)	21	2
3	Medical Records Income	(2,381)	10	3
4	Rental Income	(750)	06	4
5	RFMS Petty Cash Clearing Acct.	(828)	21	5
6	Marketing Salaries	(179,692)	43	6
7	Sequestration Expense	(119,087)	21	7
8	Bank Service Charges	(5,623)	21	8
9	Collection Fees	(426)	21	9
10	Insurance- Officer's Life	(32,150)	22	10
11	Late Fees	(62,522)	21	11
12	Beauty Shop Rent	(75)	40	12
13	Misc. Income	(5,450)	21	13
14	Building Co. - Bank Service Charges	(353)	21	14
15	Building Co. - Amortization	(58,125)	36	15
16	Non-Allowable Auto Lease	(23,472)	35	16
17	Non-Allowable Office Expense	(17,500)	21	17
18	Non-Allowable Fees	(228,000)	43	18
19	Non-Care Depreciation	(189)	30	19
20	Non-Allowable Legal Fees	(55,100)	19	20
21	Additional R&M	53,583	06	21
22	Resident Lost Items	(192)	10	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**	(752,266)		49

Salem Village Nursing

ID# 0044057

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Salem Village Nursing **#** 0044057 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(12,154)											(12,154)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	25,050		5,185									30,235	6
7	Other (specify):*													7
8	**TOTAL General Services**	12,896		5,185									18,081	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,573)											(2,573)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,573)											(2,573)	16
	C. General Administration													
17	Administrative			16,651									16,651	17
18	Directors Fees													18
19	Professional Services	(55,100)		(364,653)									(419,753)	19
20	Fees, Subscriptions & Promotions	(49,219)		1,195									(48,024)	20
21	Clerical & General Office Expenses	(1,363,816)	353	204,304									(1,159,159)	21
22	Employee Benefits & Payroll Taxes	(32,150)											(32,150)	22
23	Inservice Training & Education													23
24	Travel and Seminar			93									93	24
25	Other Admin. Staff Transportation	(9,552)		4,971									(4,581)	25
26	Insurance-Prop.Liab.Malpractice			1,102									1,102	26
27	Other (specify):*			33,714									33,714	27
28	**TOTAL General Administration**	(1,509,837)	353	(102,623)									(1,612,107)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,499,513)	353	(97,438)									(1,596,598)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	179,162	205,674	178									385,014	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,986)	776,164	1,758									771,936	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,500,000)	29,017									(1,470,983)	34
35	Rent-Equipment & Vehicles	(23,472)		(4,863)									(28,335)	35
36	Other (specify):*	(58,125)	58,125											36
37	**TOTAL Ownership**	91,579	(460,037)	26,090									(342,368)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(75)											(75)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(407,692)											(407,692)	43
44	**TOTAL Special Cost Centers**	(407,767)											(407,767)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,815,702)	(459,684)	(71,348)									(2,346,734)	45

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	6,758	Salem Village Property, LLC	100.00%	98,750	91,992	2
3	V	32	Mortgage Interest Expense		Salem Village Property, LLC	100.00%	684,172	684,172	3
4	V	21	Bank Service Charge		Salem Village Property, LLC	100.00%	353	353	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			$ 1,506,758			$ 1,047,074	$ * (459,684)	14

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 5,185	$ 5,185	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	5,495	5,495	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,195	1,195	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	14,104	14,104	18
19	V	24	SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	93	93	19
20	V	25	TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,971	4,971	20
21	V	26	INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,102	1,102	21
22	V	30	DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	178	178	22
23	V	32	INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,758	1,758	23
24	V	34	OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	29,017	29,017	24
25	V	35	AUTO RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	3,619	3,619	25
26	V	35	EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	(8,482)	(8,482)	26
27	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	190,200	190,200	27
28	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	32,027	32,027	28
29	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	16,651	16,651	29
30	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,687	1,687	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V	19	BOOKEEPING SERVICES	370,148	HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%		(370,148)	38
39	Total			$ 370,148			$ 298,800	$ * (71,348)	39

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 25,000	MS HEALTHCARE ACCOUNTING	100.00%	$ 25,000	$	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			$ 25,000			$ 25,000	$ *	39

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 2,103,565	TOWN AND COUNTRY REHAB., LLC	100.00%	$ 2,103,565	$	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			$ 2,103,565			$ 2,103,565	$ *	39

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	5.00%	ADVANCED NURSING AND REHABILITATION CENTER, LLC	NEW HAVEN, CT	SALEM VILLAGE PROPERTIES,	JOLIET	BUILDING CO.	1
2	DANIEL ROTHNER ACCUMULATION TRUST	5.00%	CORI MANOR	ST. LOUIS MO.	HEALTHCARE ACCOUNTING S	ST. LOUIS MO.	BOOKEEPING/FINANCIAL	2
3	KATHRYN VALES ACCUMULATION TRUST	5.00%	ELMWOOD NURSING & REHABILITATION CENTER, L.L.C.	MARYVILLE	TOWN AND COUNTRY REHAB.,	CHESTERFIELD, MO	THERAPY CO.	3
4	KIMBERLY RICHMAN ACCUMULATION TRUST	5.00%	GRAND MANOR NURSING AND REHAB	ST. LOUIS MO.	MS HEALTHCARE ACCT.	CHICAGO	ACCOUNTING	4
5	MARK SUISSA	45.00%	NORTHVIEW VILLAGE	ST. LOUIS MO.				5
6	MELISSA ROTHNER ACCUMULATION TRUST	5.00%	THE CEDARS OF TOWN AND COUNTRY	CHESTERFIELD, MO				6
7	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	10.00%						7
8	RACHEL ROTHNER ACCUMULATION TRUST	5.00%						8
9	SHOSHANA ARYEH	10.00%						9
10	WILLIAM ROTHNER ACCUMULATION TRUST	5.00%						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Mark Suissa	Owner	Administrative	45.00%	See Attached	12.49	20.82%	Alloc. Sal/Fee	$ 136,651	17-3/17-7	1
2	Lorraine Suissa	Relative	Administrative	N/A	N/A	40.00	100.00%	Salary	42,374	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	$ 179,025		13

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	405,004	7	$ 24,913	$	84,294	$ 5,185	1
2	19	PROFESSIONAL FEES	ILL, CT & MO. PAT. DAYS	405,004	7	26,402		84,294	5,495	2
3	20	DUES, SUBSCRIPTIONS	ILL, CT & MO. PAT. DAYS	405,004	7	5,742		84,294	1,195	3
4	21	CLERICAL & GENERAL	ILL, CT & MO. PAT. DAYS	405,004	7	67,763		84,294	14,104	4
5	24	SEMINAR	ILL, CT & MO. PAT. DAYS	405,004	7	445		84,294	93	5
6	25	TRAVEL	ILL, CT & MO. PAT. DAYS	405,004	7	23,886		84,294	4,971	6
7	26	INSURANCE	ILL, CT & MO. PAT. DAYS	405,004	7	5,293		84,294	1,102	7
8	30	DEPRECIATION	ILL, CT & MO. PAT. DAYS	405,004	7	853		84,294	178	8
9	32	INTEREST	ILL, CT & MO. PAT. DAYS	405,004	7	8,445		84,294	1,758	9
10	34	OFFICE SPACE	ILL, CT & MO. PAT. DAYS	405,004	7	139,418		84,294	29,017	10
11	35	AUTO RENTAL	ILL, CT & MO. PAT. DAYS	405,004	7	17,387		84,294	3,619	11
12	35	EQUIPMENT RENTAL	ILL, CT & MO. PAT. DAYS	405,004	7	(40,754)		84,294	(8,482)	12
13	21	CLERICAL SALARIES	ILL, CT & MO. PAT. DAYS	405,004	7	913,845	913,845	84,294	190,200	13
14	27	EMP. BEN. GEN. & ADMIN.	ILL, CT & MO. PAT. DAYS	405,004	7	153,881		84,294	32,027	14
15	17	ADMIN. SALARY - M. SUISSA	ILL, CT & MO. PAT. DAYS	405,004	7	80,000	80,000	84,294	16,651	15
16	27	EMP. BEN.-M. SUISSA	ILL, CT & MO. PAT. DAYS	405,004	7	8,105		84,294	1,687	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,435,624	$ 993,845		$ 298,800	25

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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				$	$		$ 25,000	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					$	$		$ 25,000	25

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 2,103,565	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					$	$		$ 2,103,565	25

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$ 684,172	1
2	First Midwest Bank		X	Note Payable				14,000,000			98,750	2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit	Interest Only	11/5/2013	500,000	500,000	1/15/2016	4.4280	31,849	6
7	Twin Med		X	Note Payable				120,144				7
8	See Supplemental Schedule							140,000				8
9	**TOTAL Facility Related**						$ 500,000	$ 20,760,144			$ 814,771	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,986)	10
11	Interest Income - Bldg. Co.		X								(6,758)	11
12	Alloc. Health Care Accounting		X								1,758	12
13												13
14	**TOTAL Non-Facility Related**						$	$			$ (10,986)	14
15	**TOTALS (line 9+line14)**						$ 500,000	$ 20,760,144			$ 803,784	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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Select Rehabilitation		X	Note Payable			$	$ 140,000			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							140,000				14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing # 0044057 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 173,561	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.)		$ 176,632	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,071	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 185,463	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.		$ 188,534	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	121,960	8
	2011	133,510	9
	2012	150,552	10
	2013	165,694	11
	2014	176,632	12

2015 Accrual = $176,632 x 1.05 = $185,464 (Rounding)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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	$ 175,531.30	$ 175,531.30
2.	30-07-23-304-007-0000	Long Term Care Property	$ 251.98	$ 251.98
3.	30-07-23-304-010-0000	Long Term Care Property	$ 848.46	$ 848.46
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 176,631.74	$ 176,631.74

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Nursing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	272		1998	1976	$ 8,021,280	$ 205,674	35	$ 401,064	$ 195,390	$ 6,951,776	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	108,515		20	5,426	5,426	93,355	9
10	Various			1999	240,599		20	11,864	11,864	194,993	10
11	Various			2000	193,202		20	9,660	9,660	152,439	11
12	Various			2001	97,999		20	4,689	4,689	72,881	12
13	Various			2002	88,413		20	474	474	87,672	13
14	Various			2003	45,533		20	567	567	44,211	14
15	Various			2004	113,428		20	1,272	1,272	107,689	15
16	Various			2005	141,584		20	3,879	3,879	123,924	16
17	Various			2006	207,635		20	12,236	12,236	191,389	17
18	Various			2007	18,325		20	995	995	13,011	18
19	Various			2008	92,767		20	8,727	8,727	90,860	19
20	Various			2009	72,175		20	7,210	7,210	46,955	20
21	Various			2010	276,387		20	29,540	29,540	175,959	21
22	Various			2011	311,964		20	28,786	28,786	151,631	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			429,393			(429,393)		69
70	TOTAL (lines 4 thru 69)		$ 10,029,807	$ 635,067		$ 526,390	$ (108,677)	$ 8,498,746	70

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 10,029,807	$ 635,067		$ 526,390	$ (108,677)	$ 8,498,746	1
2	Remove And Install New Radiator	2012	7,641		20	764	764	3,056	2
3	Custom Doors On 3Rd And 4Th Floors	2012	8,925		20	893	893	3,496	3
4	Flooring In 4Th Floor Resident Rooms	2012	32,821		20	3,282	3,282	12,855	4
5	Doors	2012	4,645		20	465	465	1,781	5
6	Windows	2012	15,045		20	1,505	1,505	5,517	6
7	Hanging Doors & Header Installation	2012	2,970		20	297	297	1,089	7
8	Remodel Dishwashing Room	2012	11,945		20	1,195	1,195	4,380	8
9	Flood Lights On Outside Of Building	2012	2,540		20	508	508	1,736	9
10	Closet Organizers For 51 Resident Rooms	2012	16,737		20	1,674	1,674	5,719	10
11	Shaft Walls	2012	2,935		20	294	294	978	11
12	Room & Common Area Signs	2012	4,314		20	431	431	1,438	12
13	Centrifugal Roof Exhauster	2012	14,203		20	1,420	1,420	4,734	13
14	Concrete Gravel For The Sunken Garden	2012	10,800		20	1,080	1,080	3,510	14
15	Painting Work On 2Nd Floor	2012	5,225		20	523	523	1,698	15
16	Blinds For Resident Rooms On 4Th And 5Th Floors	2012	4,025		20	403	403	1,308	16
17	Door Materials For Parrish Construction Project	2012	4,829		20	483	483	1,569	17
18	Lighting Fixtures For Corridors	2012	2,853		20	571	571	1,807	18
19	4Th Floor Common Crown Moulding, Wallcoverings, Chair Rail A	2012	12,779		20	1,278	1,278	4,473	19
20	Plastering And Priming Basement Walls	2012	4,999		20	500	500	1,625	20
21	Install Flooring On 5Th Floor Common Areas	2012	34,640		20	3,464	3,464	11,258	21
22	Closet Organizers For Resident Rooms	2012	16,680		20	1,668	1,668	5,143	22
23	Ceiling Tiles	2012	3,037		20	152	152	607	23
24	Custom Handrail & Bumper Guard	2012	3,700		20	370	370	1,480	24
25	Vinyl Wood Plank Flooring For 4Th Floor Common Area	2012	3,055		20	306	306	1,197	25
26	Tile Flooring For 1St Floor Alzheimer'S Unit	2012	21,780		20	1,452	1,452	5,566	26
27	4Th Floor Common Area Bumper Guards	2012	4,029		20	403	403	1,477	27
28	Resident Room Remodel Supplies	2012	2,815		20	281	281	938	28
29	Closet Doors Supplies	2012	4,840		20	484	484	1,613	29
30	Crown Moulding And Wallcoverings	2012	9,402		20	940	940	3,761	30
31	4Th Floor Common Crown Moulding, Wallcoverings, Chair Rail A	2012	22,129		20	2,213	2,213	8,114	31
32	Work Completed On 1St Floor	2012	4,365		20	437	437	1,419	32
33	Correction To 2011 Medallion Services Invoices	2012	(20,487)		20	(2,049)	(2,049)	(8,195)	33
34	TOTAL (lines 1 thru 33)		$ 10,310,023	$ 635,067		$ 554,073	$ (80,994)	$ 8,595,892	34

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 10,310,023	$ 635,067		$ 554,073	$ (80,994)	$ 8,595,892	1
2	Bumper Guards On 1St And 3Rd Floors	2012	2,616		20	131	131	469	2
3	Corner Guards & Crash Rails	2012	3,979		20	199	199	713	3
4	New Windows	2012	9,855		20	493	493	1,766	4
5	Flooring 4Th Floor Hallway & Dining Room	2012	40,223		20	2,011	2,011	7,207	5
6	Installation Of Handrail On 1St Floor	2012	5,850		20	293	293	1,048	6
7	Wallcovering & Crown Molding On 1St Floor	2012	12,816		20	641	641	2,296	7
8	Installed 9 Electric Resistant Heating Units	2012	6,963		20	348	348	1,219	8
9	Basement Flooring	2013	22,995		20	4,599	4,599	13,797	9
10	5Th Floor Rooms And Hall - Painting, Door Headers, Electric Wo	2013	30,732		20	3,073	3,073	8,964	10
11	Smoke Detectors	2013	4,043		20	404	404	1,179	11
12	5Th Floor Remodeling - Painting 17 Rooms, Lights, Switches, Out	2013	44,113		20	4,411	4,411	12,499	12
13	Crashrails	2013	3,809		20	381	381	1,079	13
14	Flooring - Hallways, Dining Room And Resident Rooms On The 5	2013	35,758		20	7,152	7,152	20,263	14
15	Tektone System	2013	4,276		20	855	855	2,352	15
16	Flooring - Breakroom, 2 Bathrooms And 4 Elevatrs	2013	3,100		20	620	620	1,653	16
17	Crash Rails	2013	3,809		20	381	381	1,016	17
18	3Rd & 4Th Floor Office - Painting, Reistall Outletts, Lights, Etc.	2013	4,935		20	494	494	1,316	18
19	Nurses Station Remodeling	2013	6,110		20	611	611	1,629	19
20	Water Heater	2013	7,442		20	744	744	1,922	20
21	Crashrails	2013	3,809		20	381	381	984	21
22	3Rd Floor Room Remodeling - Install Closets And Header Blocks	2013	3,379		20	338	338	873	22
23	New Water Heater	2013	6,379		20	638	638	1,648	23
24	Installation Of Closet Shelving Units	2013	3,550		20	355	355	888	24
25	Installation Of Sprinkler Heads	2013	3,334		20	333	333	834	25
26	Installation Of Additional Fire Alarms	2013	7,575		20	758	758	1,894	26
27	Exterior Patio Entrance Door	2013	13,000		20	1,300	1,300	3,142	27
28	Installation Of Closet Shelving Units	2013	3,738		20	374	374	903	28
29	4Th & 5Th Floor Dining Room And Nurses Station - Wall Coverir	2013	16,914		20	1,691	1,691	3,947	29
30	Crash Rails In Hallways	2013	3,097		20	310	310	723	30
31	Fire Dampers	2013	4,900		20	490	490	1,143	31
32	Security Camera System	2013	5,497		20	550	550	1,237	32
33	Installation Of 14 Closet Organizers	2013	4,962		20	496	496	1,116	33
34	TOTAL (lines 1 thru 33)		$ 10,643,580	$ 635,067		$ 589,926	$ (45,140)	$ 8,697,609	34

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 10,643,580	$ 635,067		$ 589,926	$ (45,140)	$ 8,697,609	1
2	Installation Of 16 Closet Organizers	2013	5,448		20	545	545	1,226	2
3	Ao Smith Water Heater Model #Btr197	2013	6,250		20	625	625	1,354	3
4	Installation Of 17 Closet Organizers	2013	5,501		20	550	550	1,192	4
5	Light Fixtures	2013	11,643		20	1,164	1,164	2,426	5
6	Convection Pellet Heater	2013	3,950		20	790	790	1,646	6
7	600 Crashrails And 200 Retainers	2013	3,959		20	396	396	825	7
8	Closet Organizers	2013	23,645		20	2,364	2,364	5,320	8
9	Cylinder With Code Compliant Cylinder	2013	46,495		20	4,650	4,650	10,074	9
10	12 Lighting Unfinished Crown Molding	2013	2,614		20	261	261	610	10
11	12 Lighting Unfinished Crown Molding	2013	2,614		20	261	261	588	11
12	Closet Organizers	2013	16,627		20	1,663	1,663	4,573	12
13	Correction To 2012 Roof Exhauster Paid Twice	2013	(7,101)		20	(710)	(710)	(2,130)	13
14	Elevator Repairs	2013	5,100		20	255	255	553	14
15	Sprinkler Head In Pit Of 2 Elevator Shafts	2013	6,450		20	323	323	779	15
16	Heating / Cooling Units For Resident Rooms	2013	22,187		20	1,109	1,109	2,311	16
17	New Doors And Security Pads	2014	8,349		20	835	835	1,670	17
18	Crashrail C400 Aluminum Retainer	2014	4,135		20	414	414	827	18
19	Door Alarms And Reactivation Of Magnetic Locks	2014	8,887		20	889	889	1,629	19
20	Kitchen Water Heater	2014	9,949		20	995	995	1,907	20
21	Crashrail And Aluminum Retainer	2014	4,135		20	414	414	758	21
22	Ejector Pump	2014	4,137		20	414	414	621	22
23	Basement Flooring For Sunken Garden	2014	10,115		20	1,012	1,012	1,433	23
24	Shower Room Doors	2014	14,976		20	1,498	1,498	1,872	24
25	Dementia Unit Doors, Oxygen Storage, Rooftop	2014	7,357		20	736	736	981	25
26	Flooring And Carpet In 6Th Floor Hallways And Elevator Floors	2014	30,407		20	3,041	3,041	3,547	26
27	Elevator Repair	2014	3,081		20	154	154	308	27
28	Sprinkler System Repair	2014	15,247		20	762	762	1,016	28
29	Replace Retaining Wall	2014	9,000		20	450	450	600	29
30	Crackfilling In Parking Lot	2014	3,937		20	197	197	262	30
31	Asphalt Repairs	2014	2,750		20	138	138	195	31
32	Repair A/C	2014	3,150		20	158	158	210	32
33	Replace Heater	2014	3,384		20	169	169	226	33
34	TOTAL (lines 1 thru 33)		$ 10,941,958	$ 635,067		$ 616,445	$ (18,622)	$ 8,747,016	34

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 10,941,958	$ 635,067		$ 616,445	$ (18,622)	$ 8,747,016	1
2	Hvac / Boiler	2014	4,014		20	201	201	385	2
3	Hvac / Boiler	2014	3,226		20	161	161	202	3
4	Painting	2014	4,991		20	250	250	270	4
5	Light Fixtures	2015	5,073		20	338	338	338	5
6	Remove Old And Install New Door /Frame	2015	3,154		20	131	131	131	6
7	Install Stoves, Exterior Lights And Panels	2015	8,238		20	206	206	206	7
8	Elevator Work - Motor And Pump	2015	8,972		20	150	150	150	8
9	Rerouting & Rewiring Conduit 8 Rooms	2015	12,525		20	104	104	104	9
10	Entry Door On Dock Entrance	2015	2,721		20	91	91	91	10
11	Installed And Finished Dock Door Interior	2015	3,445		20	172	172	172	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)		$ 10,998,317	$ 635,067		$ 618,249	$ (16,818)	$ 8,749,065	34

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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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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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,136,343	$ 178	$ 168,695	$ 168,517	10	$ 768,770	71
72	Current Year Purchases	176,777		22,551	22,551	10	22,551	72
73	Fully Depreciated Assets	1,582,805		180	180	10	1,582,805	73
74								74
75	TOTALS	$ 2,895,925	$ 178	$ 191,426	$ 191,248		$ 2,374,126	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	$ 25,694	76
77										77
78										78
79										79
80	TOTALS			$ 30,000	$	$ 4,921	$ 4,921		$ 25,694	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)	$ 14,332,242	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 635,245	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 814,596	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 179,351	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,148,885	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	$ 189	$ 39,141	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 39,141	$ 189	$ 39,141	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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				29,017			5
6	Allocated from MS Healthcare Accounting				25,000			6
7	TOTAL				$ 54,017 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 13,972 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	Honda	$ 493.51	$ 5,187	17
18	Alllocated from H.A.S			3,619	18
19					19
20					20
21	TOTAL		$ 493.51	$ 8,806	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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Salem Village Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$		$ 847,033	$		$ 847,033	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			374,712			374,712	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			881,820			881,820	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				458,589		458,589	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			554,159		38,600	763,697		1,356,456	13
14	TOTAL			$ 554,159		$ 2,142,165	$ 1,222,286		$ 3,918,610	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 Nursing # 0044057 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 98,376	$ 7,688,516	1
2	Cash-Patient Deposits	22,108	22,108	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,628,081	6,628,081	3
4	Supply Inventory (priced at)	73,354	73,354	4
5	Short-Term Investments			5
6	Prepaid Insurance	40,465	40,465	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,286,169	3,899,352	8
9	Other(specify):	8,610	8,610	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,157,163	$ 18,360,486	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	2,960,077	2,960,077	15
16	Equipment, at Historical Cost	2,393,811	3,209,811	16
17	Accumulated Depreciation (book methods)	(3,661,477)	(8,042,491)	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	353,977	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,939,825	$ 6,910,654	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,096,988	$ 25,271,140	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,211,723	$ 1,632,683	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	727,263	727,263	30
31	Accrued Taxes Payable (excluding real estate taxes)	50,170	50,170	31
32	Accrued Real Estate Taxes(Sch.IX-B)	185,463	185,463	32
33	Accrued Interest Payable		56,233	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	17,000	17,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	652,445	692,445	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,348,612	$ 3,865,805	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	260,144	14,260,144	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)**	$ 260,144	$ 20,260,144	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,608,756	$ 24,125,949	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,488,232	$ 1,145,191	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,096,988	$ 25,271,140	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,562,829	1
2	Restatements (describe):		2
3	**Late Entries - supplies, bad debt, sequestration,**	7,274	3
4	**legal fees, donations, taxes, food, other misc.**		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,570,103	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	43,129	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	(125,000)	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)**	$ (81,871)	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)**	$ 2,488,232	24 *

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

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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	$ 24,957,691	1
2	Discounts and Allowances for all Levels	(7,381,805)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,575,886	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,102,990	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,102,990	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	75	13
14	Non-Patient Meals	11,629	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	750	16
17	Sale of Drugs	493,186	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	131,710	19
20	Radiology and X-Ray	39,395	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 676,745	23
	D. Non-Operating Revenue		
24	Contributions	35,570	24
25	Interest and Other Investment Income***	5,986	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,556	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	12,213	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,213	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 22,409,390	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,784,605	31
32	Health Care	6,922,728	32
33	General Administration	5,511,714	33
	B. Capital Expense		
34	Ownership	2,226,079	34
	C. Ancillary Expense		
35	Special Cost Centers	4,327,437	35
36	Provider Participation Fee	593,698	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 22,366,261	40
41	**Income before Income Taxes (line 30 minus line 40)****	43,129	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 43,129	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,323,982	44
45	Private Pay - Net Inpatient Revenue	1,864,918	45
46	Medicare - Net Inpatient Revenue	4,772,180	46
47	Other-(specify) Hospice	91,858	47
48	Other-(specify) Insurance	522,948	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,575,886	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.**

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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	1,728	2,080	$ 93,297	$ 44.85	1
2	Assistant Director of Nursing	3,840	4,438	174,998	39.43	2
3	Registered Nurses	48,333	53,163	1,636,513	30.78	3
4	Licensed Practical Nurses	54,902	59,385	1,587,499	26.73	4
5	CNAs & Orderlies	157,582	168,348	2,286,538	13.58	5
6	CNA Trainees					6
7	Licensed Therapist	18,789	20,191	554,159	27.45	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	24,301	26,420	266,697	10.09	10
11	Social Service Workers	9,705	10,898	158,288	14.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,216	43,083	520,806	12.09	15
16	Dishwashers					16
17	Maintenance Workers	10,114	10,891	158,750	14.58	17
18	Housekeepers	39,101	42,076	449,253	10.68	18
19	Laundry	12,927	14,098	149,656	10.62	19
20	Administrator	1,864	2,120	158,199	74.62	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	42,374	20.37	22
23	Office Manager					23
24	Clerical	25,755	28,175	477,899	16.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,742	4,246	63,014	14.84	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,542	6,204	198,937	32.07	33
34	TOTAL (lines 1 - 33)	460,521	497,896	$ 8,976,877 *	$ 18.03	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	627	$ 29,457	01-03	35
36	Medical Director	Monthly	69,500	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	487	19,840	10-03	38
39	Pharmacist Consultant	348	13,925	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	197	12,674	12-03	45
46	Other(specify)				46
47	Medical Director Consultant	Per Visit	1,800	09-03	47
48					48
49	TOTAL (lines 35 - 48)	1,659	$ 151,996		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	13,008	286,141	10-03	52
53	TOTAL (lines 50 - 52)	13,008	$ 286,141		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kelly Covarrubias	Administrator	0	$ 158,200
Lorraine Suissa	Administrative	0	42,374
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 200,574

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
Frost/Marcum	Accounting	$ 45,000
Healthcare Accounting Svcs.	Bookkeeping/Accounting	370,148
Personnel Planners	Unemployment Tax Cons.	3,400
American Data	Computer Services	6,240
E-Health Data Solutions	Computer Services	4,455
National Datacare	Computer Services	4,644
See Attached	Legal	146,859
Paychex	Payroll Processing	28,048
Legat Architects	Architectural Services	1,960
Rehab Management System	Rehab Billing Review	17,600
Achieve Accreditation	Joint Commision Consult	5,902
See Supplemental Schedule		3,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 637,756

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 424,672
Unemployment Compensation Insurance	136,686
FICA Taxes	671,513
Employee Health Insurance	564,347
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	7,270
Employee Benefit Plan	128,994
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,933,483

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,468
Health Care Worker Background Check	
(Indicate # of checks performed 543)	7,812
Patient Background Checks 300	3,000
Dues & Subscriptions	2,237
License & Fees	3,941
Allocated from Healthcare Accounting	1,195
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,653

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,816
Allocated from Healthcare Accounting	93
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,909

**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													
7													
8													
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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,964** 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. $ **593,698**
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? **Yes** Indicate the amount. $ **11,629**

(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.