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: 0051920

Facility Name: Saline Care Center

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

County: Saline

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

HFS ID Number:

Date of Initial License for Current Owners: 31182

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/15 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	142	TOTALS	142	51,830	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		1,173	3,250	4,423	8
9	SNF/PED					9
10	ICF	37,449	4,565		42,014	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,449	5,738	3,250	46,437	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.59%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 5/15/1985

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 3,125

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	326,327	16,230	13,686	356,243		356,243		356,243			1
2	Food Purchase		287,601		287,601		287,601	(6,271)	281,330			2
3	Housekeeping	228,476	25,486		253,962		253,962	936	254,898			3
4	Laundry	92,220	17,945		110,165		110,165		110,165			4
5	Heat and Other Utilities			137,975	137,975		137,975	640	138,615			5
6	Maintenance	66,982	23,739	39,177	129,898		129,898	1,281	131,179			6
7	Other (specify):* Waste Rem/RDK/SI Benefits A			10,093	10,093		10,093	43	10,136			7
8	TOTAL General Services	714,005	371,001	200,931	1,285,937		1,285,937	(3,371)	1,282,566			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,799,631	84,795	31,391	1,915,817		1,915,817	47,220	1,963,037			10
10a	Therapy			247,028	247,028		247,028		247,028			10a
11	Activities	68,690			68,690		68,690		68,690			11
12	Social Services	106,854	5,617	14,157	126,628		126,628		126,628			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RDK/SI Benefits Alloc							5,647	5,647			15
16	TOTAL Health Care and Programs	1,975,175	90,412	296,176	2,361,763		2,361,763	52,867	2,414,630			16
	C. General Administration											
17	Administrative	93,825		592,023	685,848		685,848	(283,791)	402,057			17
18	Directors Fees											18
19	Professional Services			91,161	91,161		91,161	(2,525)	88,636			19
20	Dues, Fees, Subscriptions & Promotions			23,333	23,333		23,333	(582)	22,751			20
21	Clerical & General Office Expenses	103,476	31,179	19,235	153,890		153,890	70,624	224,514			21
22	Employee Benefits & Payroll Taxes			368,443	368,443		368,443		368,443			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,395	1,395		1,395	608	2,003			24
25	Other Admin. Staff Transportation			7,215	7,215		7,215	4,813	12,028			25
26	Insurance-Prop.Liab.Malpractice			125,110	125,110		125,110	780	125,890			26
27	Other (specify):* RDK/SI Benefits Alloc							27,427	27,427			27
28	TOTAL General Administration	197,301	31,179	1,227,915	1,456,395		1,456,395	(182,646)	1,273,749			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,886,481	492,592	1,725,022	5,104,095		5,104,095	(133,150)	4,970,945			29

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

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

Facility Name & ID Number Saline Care Center #0051920 Report Period Beginning: 1/1/15 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			77,113	77,113		77,113	42,994	120,107			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,025	24,025		24,025	(245)	23,780			32
33	Real Estate Taxes			49,349	49,349		49,349	351	49,700			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,852	7,852		7,852		7,852			35
36	Other (specify):*											36
37	**TOTAL Ownership**			158,339	158,339		158,339	43,100	201,439			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,061		117,061		117,061		117,061			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,743	345,743		345,743		345,743			42
43	Other (specify):* Non-allowable Costs			36,688	36,688		36,688	(36,688)				43
44	**TOTAL Special Cost Centers**		117,061	382,431	499,492		499,492	(36,688)	462,804			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,886,481	609,653	2,265,792	5,761,926		5,761,926	(126,738)	5,635,188			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,122)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	40,931	30		9
10	Interest and Other Investment Income	(245)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(661)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(950)	20		17
18	Fines and Penalties				18
19	Entertainment	(292)	43		19
20	Contributions	(833)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,849)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,572)	43		24
25	Fund Raising, Advertising and Promotional	(6,600)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(13,491)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,684)		$	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)	(118,054)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (118,054)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (126,738)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Saline Care Center

ID# 0051920

Report Period Beginning: 1/1/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Funeral Expense	$ (1,169)	43	1
2	Birthday Expense	(5,177)	43	2
3	Gifts	(262)	43	3
4	Miscellaneous income offset	(1,697)	21	4
5	Vending Machine income offset	(6,271)	2	5
6	Expense Roof repair	1,085	6	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,491)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Saline Care Center # 0051920 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,271)	0	0	0	0	0	0	0	0	0	0	(6,271)	2
3	Housekeeping	0	0	936	0	0	0	0	0	0	0	0	936	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	640	0	0	0	0	0	0	0	0	640	5
6	Maintenance	1,085	0	196	0	0	0	0	0	0	0	0	1,281	6
7	Other (specify):*	0	0	43	0	0	0	0	0	0	0	0	43	7
8	**TOTAL General Services**	(5,186)	0	1,815	0	0	0	0	0	0	0	0	(3,371)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	47,220	0	0	0	0	0	0	0	0	0	47,220	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	5,647	0	0	0	0	0	0	0	0	0	5,647	15
16	**TOTAL Health Care and Programs**	0	52,867	0	0	0	0	0	0	0	0	0	52,867	16
	C. General Administration													
17	Administrative	0	(102,944)	(180,847)	0	0	0	0	0	0	0	0	(283,791)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,849)	861	1,463	0	0	0	0	0	0	0	0	(2,525)	19
20	Fees, Subscriptions & Promotions	(950)	170	198	0	0	0	0	0	0	0	0	(582)	20
21	Clerical & General Office Expenses	(1,697)	65,946	6,375	0	0	0	0	0	0	0	0	70,624	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	22	586	0	0	0	0	0	0	0	0	608	24
25	Other Admin. Staff Transportation	0	2,150	2,663	0	0	0	0	0	0	0	0	4,813	25
26	Insurance-Prop.Liab.Malpractice	0	780	0	0	0	0	0	0	0	0	0	780	26
27	Other (specify):*	0	18,980	8,447	0	0	0	0	0	0	0	0	27,427	27
28	**TOTAL General Administration**	(7,496)	(14,035)	(161,115)	0	0	0	0	0	0	0	0	(182,646)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,682)	38,832	(159,300)	0	0	0	0	0	0	0	0	(133,150)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Saline Care Center # 0051920 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	40,931	0	2,063	0	0	0	0	0	0	0	0	42,994	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(245)	0	0	0	0	0	0	0	0	0	0	(245)	32
33	Real Estate Taxes	0	0	351	0	0	0	0	0	0	0	0	351	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	40,686	0	2,414	0	0	0	0	0	0	0	0	43,100	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(36,688)	0	0	0	0	0	0	0	0	0	0	(36,688)	43
44	**TOTAL Special Cost Centers**	(36,688)	0	0	0	0	0	0	0	0	0	0	(36,688)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,684)	38,832	(156,886)	0	0	0	0	0	0	0	0	(126,738)	45

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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
Dr. Larry Jones	50	Carrier Mills Nursing & Rehab	Carrier Mills	RDK Management, In	Harrisburg	Management Co.
Dr. Roger Herrin	50	Stonebridge Senior Living Center, LLC	Benton	SI Management Svc, L	Harrisburg	Management Co.
		Pinckneyville Nursing & Rehab	Pinckneyville			
		DuQuoin Nursing & Rehab	DuQuoin			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing Wages	$	SI Management Services, LLC	100.00%	$ 47,220	$ 47,220	1
2	V	15	Health Care and Prog Emp. Ben.		SI Management Services, LLC	100.00%	5,647	5,647	2
3	V	17	Administrative	196,773	SI Management Services, LLC	100.00%	93,829	(102,944)	3
4	V	19	Professional Fees		SI Management Services, LLC	100.00%	861	861	4
5	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	170	170	5
6	V	21	Clerical And General		SI Management Services, LLC	100.00%	65,946	65,946	6
7	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	22	22	7
8	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	2,150	2,150	8
9	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	780	780	9
10	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	18,980	18,980	10
11	V								11
12	V								12
13	V								13
14	Total			$ 196,773			$ 235,605	$ * 38,832	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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	3	Housekeeping	$	RDK Management, Inc.	100.00%	$ 936	$ 936	15
16	V	5	Utilities		RDK Management, Inc.	100.00%	640	640	16
17	V	6	Maintenance		RDK Management, Inc.	100.00%	196	196	17
18	V	7	General Svcs. Emp. Ben.		RDK Management, Inc.	100.00%	43	43	18
19	V	17	Administrative	395,250	RDK Management, Inc.	100.00%	214,403	(180,847)	19
20	V	19	Professional Services		RDK Management, Inc.	100.00%	1,463	1,463	20
21	V	20	Dues, Fees, Subs & Promotions		RDK Management, Inc.	100.00%	198	198	21
22	V	21	Clerical and General Office		RDK Management, Inc.	100.00%	6,375	6,375	22
23	V	24	Travel and Seminar		RDK Management, Inc.	100.00%	586	586	23
24	V	25	Other Admin. Staff Transport.		RDK Management, Inc.	100.00%	2,663	2,663	24
25	V	27	Mgmt. Allocation of Benefits		RDK Management, Inc.	100.00%	8,447	8,447	25
26	V	30	Depreciation		RDK Management, Inc.	100.00%	2,063	2,063	26
27	V	33	Real Estate Taxes		RDK Management, Inc.	100.00%	351	351	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			$ 395,250			$ 238,364	$ * (156,886)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dr. Roger Herrin	Stockholder	Administrative	50.00	See Att Sch 7A	21.99	32.34	Alloc. Salary	$ 194,037	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 194,037		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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: SI Management Services, LLC
Street Address: 607 South Commercial
City / State / Zip Code: Harrisburg, Illinois
Phone Number: (618) 252-7707
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Wages	Census	126,706	5	128,842	128,842	46,437	$ 47,220	1
2	15	Health Care and Prog Emp. Ben.	Census	126,706	5	15,408		46,437	5,647	2
3	17	Administrative	Census	126,706	5	256,018	256,018	46,437	93,829	3
4	19	Professional Fees	Census	126,706	5	2,350		46,437	861	4
5	20	Fees, Subscriptions	Census	126,706	5	465		46,437	170	5
6	21	Clerical And General	Census	126,706	5	179,937	177,087	46,437	65,946	6
7	24	Travel and Seminar	Census	126,706	5	61		46,437	22	7
8	25	Admin. Staff Trans.	Census	126,706	5	5,866		46,437	2,150	8
9	26	Insurance-Prop./Liab./Malprac.	Census	126,706	5	2,129		46,437	780	9
10	27	Gen. Admin. Emp. Ben.	Census	126,706	5	51,789		46,437	18,980	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					$ 642,865	$ 561,947		$ 235,605	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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: RDK Management, Inc.
Street Address: 607 South Commercial
City / State / Zip Code: Harrisburg, Illinois
Phone Number: (618) 252-7707
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Census	126,706	5	2,554	2,554	46,437	$ 936	1
2	5	Utilities	Census	126,706	5	1,746		46,437	640	2
3	6	Maintenance	Census	126,706	5	535	379	46,437	196	3
4	7	General Svcs. Emp. Ben.	Census	126,706	5	117		46,437	43	4
5	17	Administrative	Census	126,706	5	585,011	585,011	46,437	214,403	5
6	19	Professional Services	Census	126,706	5	3,992		46,437	1,463	6
7	20	Dues, Fees, Subs & Promotions	Census	126,706	5	540		46,437	198	7
8	21	Clerical and General Office	Census	126,706	5	17,394		46,437	6,375	8
9	24	Travel and Seminar	Census	126,706	5	1,600		46,437	586	9
10	25	Other Admin. Staff Transport.	Census	126,706	5	7,267		46,437	2,663	10
11	27	Mgmt. Allocation of Benefits	Census	126,706	5	23,048		46,437	8,447	11
12	30	Depreciation	Census	126,706	5	5,630		46,437	2,063	12
13	33	Real Estate Taxes	Census	126,706	5	957		46,437	351	13
14								46,437		14
15								46,437		15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 650,391	$ 587,944		$ 238,364	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Farmer's State Bank		X	Line of Credit	Interest Only	8/27/12	1,150,000	499,894	8/27/16	0.0475	24,025	6
7												7
8												8
9	TOTAL Facility Related						$ 1,150,000	$ 499,894			$ 24,025	9
	B. Non-Facility Related*											
10												10
11								Offset Interest Income			(245)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (245)	14
15	TOTALS (line 9+line14)						$ 1,150,000	$ 499,894			$ 23,780	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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.**		$ 52,630	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.)	2014	$ 50,989	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,641)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 50,990	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.)**	**Allocated from RDK** 351	$ 351	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 49,700	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	48,657	8
	2011	49,823	9
	2012	50,704	10
	2013	51,601	11
	2014	50,989	12

2015 Accrual based on prior year tax

	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Saline Care Center COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0051920

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.	06-1-098-06	Long Term Care Property	$ 19,708.54	$ 19,708.54
2.	06-1-098-01	Long Term Care Property	$ 31,281.00	$ 31,281.00
3.	06-2-275-02	Home Office Allocation	$ 958.10	$ 958.10
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,947.64	$ 51,947.64

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred:
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	514,920	1985	$ 50,000	1
2	Home Office Allocation			8,406	2
3	TOTALS	514,920		$ 58,406	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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	124		1985	1969	$ 1,230,310	$	30	$ 15,389	$ 15,389	$ 1,230,310	4
5	18		1992	1992	700,233		30	23,341	23,341	540,982	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	131,167		20			131,167	9
10	Various			1986	80,813		20			80,813	10
11	Various			1987	7,050		20			7,050	11
12	Various			1988	15,938		20			15,938	12
13	Various			1992	10,381		20			10,381	13
14	Various			1994	1,859		20			1,859	14
15	Various			1997	14,650		20	733	733	13,919	15
16	Various			1998	4,557		20	228	228	4,102	16
17	Various			2000	72,282		20	3,614	3,614	57,825	17
18	Various			2001	7,245		20	362	362	5,433	18
19	Various			2004	4,333		20	217	217	2,601	19
20	Various			2006	1,523		20	76	76	761	20
21	Various			2009	16,374		20	819	819	5,732	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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	Wallpaper	2011	$ 12,591	$	20	$ 630	$ 630	$ 3,149	37
38	Tile	2011	8,438		20	422	422	2,110	38
39	Window Sheers	2011	2,338		20	117	117	585	39
40	Valances	2011	8,361		20	418	418	2,090	40
41	Remodeling-Lights, Flooring, Windows	2011	15,015		20	751	751	3,754	41
42	Remodeling-Painting, Flooring, Wallcovering,	2011	27,547		20	1,377	1,377	6,886	42
43	Install New Exit/Emergency Lighting, Wiring In Family Room & F	2011	2,604		20	130	130	651	43
44	Architectural Fees	2011	2,752		20	138	138	689	44
45	Painting & Hanging Of Wallcovering	2011	3,001		20	150	150	750	45
46	Electrical -Family Room-Outlets & Circuits For Lighting & Wired	2011	3,065		20	153	153	766	46
47	New Panel Feeds To Family Room, Exit Lighting In Halls, Lighting	2011	3,145		20	157	157	786	47
48	Painting & Hanging Of Wallcovering	2011	3,196		20	160	160	799	48
49	Architectural Documents	2011	3,398		20	170	170	850	49
50	Painting & Vinyl Hanging	2011	4,253		20	213	213	1,064	50
51	Remove Old And Install New Overhead Lights In Dining Room, Ne	2011	4,276		20	214	214	1,069	51
52	Architectural Fees	2011	4,350		20	218	218	1,089	52
53	Remote Sensor Alarm In Nurse Station, Rewired Front Entry Alar	2011	5,153		20	258	258	1,289	53
54	Replace Entrance Door And Frame	2011	6,186		20	309	309	1,546	54
55	Cabinets & Countertops	2011	47,500		20	2,375	2,375	11,875	55
56	Architectural Fees	2011	12,126		20	606	606	3,031	56
57	Sprinkler System	2011	48,400		20	2,420	2,420	12,100	57
58	Sprinkler Work	2011	24,200		20	1,210	1,210	6,050	58
59	Architect / Design Fees	2011	10,553		20	528	528	2,639	59
60	Sign	2011	8,638		20	432	432	2,160	60
61	Smoke Detectors, Sprinkler Heads, Rire Alarm Panel	2012	13,616		20	681	681	2,724	61
62	Smoke Detectors & Sprinkler Work	2012	7,297		20	365	365	1,460	62
63	Architect / Design Fees	2012	8,363		20	418	418	1,672	63
64	Carpeting & Wallcovering - 20 Resident Rooms And Offices	2012	67,342		20	3,367	3,367	13,468	64
65	Telephone System	2012	10,198		20	510	510	2,040	65
66	Built In Cabinets	2012	15,800		20	790	790	3,160	66
67	Nurse Call System	2012	21,254		20	1,063	1,063	4,251	67
68	Security System	2012	20,245		20	1,012	1,012	4,049	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,733,916	$		$ 66,541	$ 66,541	$ 2,209,474	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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		$ 2,733,916	$		$ 66,541	$ 66,541	$ 2,209,474	1
2	Hellitech-Waterproofing & Structural Repair	2012	10,631		20	532	532	2,127	2
3	Hellitech-Waterproofing & Structural Repair	2012	15,784		20	789	789	3,156	3
4	Asphalt Parking Lot Resurfacing	2014	31,687		20	1,584	1,584	2,376	4
5	AC Wiring - Laundry Room	2014	667		20	33	33	50	5
6	7 Room Screens	2014	2,192		20	110	110	165	6
7	Resident Bathrooms - Install new cabinets, toilets, flooring,								7
8	fixtures, shower tile, trim, repair walls & ceiling, paint	2015	36,105		20	903	903	903	8
9	New wallcovering, bumper guards, window coverings								9
10	& privacy curtains in 2 resident rooms - 300 wing	2015	3,238		20	81	81	81	10
11	Remove and replace concrete pads & install carport	2015	4,697		20	117	117	117	11
12	2 new Security Cameras & 5 new Security keypads	2015	4,325		20	108	108	108	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,843,242	$		$ 70,798	$ 70,798	$ 2,218,557	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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		$ 2,843,242	$		$ 70,798	$ 70,798	$ 2,218,557	1
2									2
3									3
4									4
5									5
6									6
7	Leasehold Information								7
8	Allocated From RDK Management	1993	48,193		20	754	754	36,122	8
9	Allocated From RDK Management	1994	2,083		20			2,083	9
10	Allocated From RDK Management	1996	77		20	4	4	78	10
11	Allocated From RDK Management	1998	351		20	18	18	315	11
12	Allocated From RDK Management	2000	7,742		20	387	387	6,193	12
13									13
14									14
15									15
16									16
17	Financial Statement Depreciation			77,113			(77,113)		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,901,688	$ 77,113		$ 71,961	$ (5,152)	$ 2,263,348	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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	$ 384,363	$	$ 29,405	$ 29,405	10	$ 231,444	71
72	Current Year Purchases	60,537		4,951	4,951	5-7 yrs	4,951	72
73	Fully Depreciated Assets	431,220				10	431,220	73
74	Allocated from Mgmt Co.	21,304		2,368	2,368	5-10	20,107	74
75	TOTALS	$ 897,424	$	$ 36,724	$ 36,724		$ 687,722	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		See Attached Sch 13A	Various	$ 88,248	$	$ 11,422	$ 11,422	5	$ 73,263	76
77										77
78										78
79		Allocated from Mgmt Co		37,092				5	37,092	79
80	TOTALS			$ 125,340	$	$ 11,422	$ 11,422		$ 110,355	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,982,858	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 77,113	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,107	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 42,994	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,061,425	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Saline Care Center

Period Beginning **1/1/15**
Period End **12/31/15**

Schedule XI D. Ownership Costs - Vehicles

Use	Make, Model and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Facility	1998 Ford Truck	1998	26,502			-	5	26,502
Facility	2005 Ford Ranger	2005	13,770			-	5	13,770
Facility	2012 Kia Sedona-disposed	2012	-		1,827	1,827	5	-
Facility	2012 Dodge Grand Caravan	2012	36,479		7,296	7,296	5	29,184
Administrative	2015 Kia Sorrento	2014	10,017		2,003	2,003	5	3,338
Administrative	2001 Ford Mustang	2014	1,480		296	296	5	469
	Total		**$ 88,248**	**$ -**	**$ 11,422**	**$ 11,422**		**$ 73,263**

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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: $ 7,852 Description: Medical Equipment $7,569 ; Office Equipment $283
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$		$ 108,234	$		$ 108,234	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			24,281			24,281	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			114,513			114,513	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				117,061		117,061	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 247,028	$ 117,061		$ 364,089	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 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	$ 247,069	$ 247,069	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,108,718	1,108,718	3
4	Supply Inventory (priced at)	3,500	3,500	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	78,844	78,844	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,438,131	$ 1,438,131	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,401	9,401	12
13	Land	20,000	58,406	13
14	Buildings, at Historical Cost	2,053,251	1,930,543	14
15	Leasehold Improvements, at Historical Cost	636,021	971,145	15
16	Equipment, at Historical Cost	1,217,412	1,022,764	16
17	Accumulated Depreciation (book methods)	(2,918,260)	(3,061,425)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	100	100	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,017,925	$ 930,934	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,456,056	$ 2,369,065	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 127,226	$ 127,226	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	499,894	499,894	29
30	Accrued Salaries Payable	16,581	16,581	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,921	2,921	31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,990	50,990	32
33	Accrued Interest Payable	6,926	6,926	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 704,538	$ 704,538	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 704,538	$ 704,538	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,751,518	$ 1,664,527	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,456,056	$ 2,369,065	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,752,099	1
2	Restatements (describe):		2
3	**Prior period adjustment**	14,716	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,766,815	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	787,412	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(802,709)	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)**	$ (15,297)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,751,518	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,474,401	1
2	Discounts and Allowances for all Levels	(3,682)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,470,719	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,846	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 65,846	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,271	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,271	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	245	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 245	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	6,257	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,257	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,549,338	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,285,937	31
32	Health Care	2,361,763	32
33	General Administration	1,456,395	33
	B. Capital Expense		
34	Ownership	158,339	34
	C. Ancillary Expense		
35	Special Cost Centers	153,749	35
36	Provider Participation Fee	345,743	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,761,926	40
41	**Income before Income Taxes (line 30 minus line 40)****	787,412	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 787,412	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,454,833	44
45	Private Pay - Net Inpatient Revenue	708,370	45
46	Medicare - Net Inpatient Revenue	1,044,414	46
47	Other-(specify) Insurance	263,102	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,470,719	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name: **Saline Care Center**
IDPH License ID Number: **0051920**
Fiscal Year End: **12/31/15**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Transportation Income	1,623
Miscellaneous Income	1,697
SI Mgmt Income/Loss	(5,315)
Gain on Sale of asset	8,252
Total - Line 28	**6,257**

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,136	2,220	$ 66,572	$ 29.99	1
2	Assistant Director of Nursing	2,784	2,992	71,868	24.02	2
3	Registered Nurses	11,245	11,787	278,094	23.59	3
4	Licensed Practical Nurses	32,065	33,917	527,615	15.56	4
5	CNAs & Orderlies	76,349	78,788	855,482	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,031	7,480	68,690	9.18	10
11	Social Service Workers	8,182	8,678	106,854	12.31	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,048	26,361	12.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,419	34,361	299,966	8.73	15
16	Dishwashers					16
17	Maintenance Workers	5,891	6,154	66,982	10.88	17
18	Housekeepers	24,418	25,572	228,476	8.93	18
19	Laundry	10,327	10,706	92,220	8.61	19
20	Administrator	2,232	2,408	78,286	32.51	20
21	Assistant Administrator	784	808	15,539	19.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,036	10,419	103,476	9.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	228,907	238,338	$ 2,886,481 *	$ 12.11	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	294	$ 13,686	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	66	4,067	L12, C3	45
46	Other(specify) Psychiatric	Monthly	10,090	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	360	$ 32,043		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	1,569	30,791	L10, C3	52
53	TOTAL (lines 50 - 52)	1,569	$ 30,791		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Virginia Pierce	Administrator	0	$ 32,714
Mary Daubert	Administrator	0	45,572
Paula Lindsey	Asst Admin	0	15,539
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,825

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 592,023
TOTAL (agree to Schedule V, line 17, col. 3)	$ 592,023
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Adam Lawler Law Firm	Legal	$ 4,849
Daniel Maher Law Office	Legal	282
Kerns Frost & Pearlman	Legal	2,153
Templin Healthcare Accounting	Accounting	4,083
James Henson PC	Accounting	3,681
Payroll Services by Extra Help	Payroll Service	3,477
IT Next Gen	Web Hosting Service	190
Galaxy Hosted Software	Web Hosting Service	1,200
Lintech	LTC Software	17,424
Ability Network	Health Info Management	1,188
WH Administrators, Inc	ACA Compliance Consultant	42,438
Total per attached Pg 21C		10,196
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 91,161

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,311
Unemployment Compensation Insurance	23,136
FICA Taxes	220,054
Employee Health Insurance	15,262
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Incentive Expenses	4,931
Personal/Funeral Day Expense	1,410
Life Insurance / Disability	1,313
Other Employee Benefits	2,026
TOTAL (agree to Schedule V, line 22, col.8)	$ 368,443

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	3,149
Health Care Worker Background Check	
(Indicate # of checks performed 46)	1,985
Patient Background Checks 177	3,358
License & Permits	690
Dues & Subcriptions	701
IHCA	8,520
Allocated From RDK/SI Management	368
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,751

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	250
Seminar Expense	1,145
Allocated From RDK/SI Management	608
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,003

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name: **Saline Care Center**
IDPH License ID Number: **0051920**
Fiscal Year End: **12/31/15**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
American Health Tech	LTC Software	7,540
Esolutions	Health Info Management	2,033
Passport Software	Accounting Software	623
	Total	**10,196**

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center # 0051920 Report Period Beginning: 1/1/15 Ending: 12/31/15

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **8,520 IHCA**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,989** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **345,743**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **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% Line 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

Saline Care Center

Period Beginning	**1/1/15**
Period End	**12/31/15**

ATTACHED SCHEDULE I

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Misc Repairs	**1,857**
Fuel and miscellaneous supplies	**5,358**
Allocated from Mgmt Co	**4,813**
	12,028