

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

<p>I. IDPH License ID Number: <u>0054478</u></p> <p>Facility Name: <u>Saline Care Nursing & Rehab</u></p> <p>Address: <u>120 S Land St Bx 468</u> <u>Harrisburg</u> <u>62946</u> Number City Zip Code</p> <p>County: <u>Saline</u></p> <p>Telephone Number: <u>(618) 252-7405</u> Fax # <u>(618) 253-3418</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/1/2017</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>3/1/2017</u> to <u>12/31/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Larry Templin Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u>		(Telephone) <u>(630) 361-2868</u> Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing & Rehab

0054478 Report Period Beginning: 3/1/2017 Ending: 12/31/2017

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,876	2,876	8
9	SNF/PED					9
10	ICF	28,511	5,010		33,521	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,511	5,010	2,876	36,397	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.22%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 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

I. On what date did you start providing long term care at this location?
Date started 3/1/2017

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/1/2017 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 72 and days of care provided 2,572

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing & Rehab # 0054478 Report Period Beginning: 3/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	267,295	12,071	8,535	287,901		287,901		287,901		1
2	Food Purchase		233,094		233,094		233,094		233,094		2
3	Housekeeping	168,539	17,283		185,822		185,822	967	186,789		3
4	Laundry	105,252	11,546		116,798		116,798		116,798		4
5	Heat and Other Utilities			103,370	103,370		103,370	91	103,461		5
6	Maintenance	60,331	11,842	14,951	87,124		87,124	2,217	89,341		6
7	Other (specify):* Waste Rem/WLC Benefits All			12,162	12,162		12,162	134	12,296		7
8	TOTAL General Services	601,417	285,836	139,018	1,026,271		1,026,271	3,409	1,029,680		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,493,194	59,662	30,908	1,583,764		1,583,764		1,583,764		10
10a	Therapy										10a
11	Activities	63,762	4,018	1,364	69,144		69,144		69,144		11
12	Social Services	86,023	1,352	1,215	88,590		88,590		88,590		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,642,979	65,032	36,487	1,744,498		1,744,498		1,744,498		16
	C. General Administration										
17	Administrative	69,619		296,065	365,684		365,684	(249,092)	116,592		17
18	Directors Fees										18
19	Professional Services			66,977	66,977		66,977	1,683	68,660		19
20	Dues, Fees, Subscriptions & Promotions			20,022	20,022		20,022	255	20,277		20
21	Clerical & General Office Expenses	95,648	17,356	11,411	124,415		124,415	135,754	260,169		21
22	Employee Benefits & Payroll Taxes			295,417	295,417		295,417		295,417		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,721	3,721		3,721	1,090	4,811		24
25	Other Admin. Staff Transportation			3,948	3,948		3,948	3,103	7,051		25
26	Insurance-Prop.Liab.Malpractice			40,253	40,253		40,253	1,613	41,866		26
27	Other (specify):* WLC Benefits Alloc							24,272	24,272		27
28	TOTAL General Administration	165,267	17,356	737,814	920,437		920,437	(81,322)	839,115		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,409,663	368,224	913,319	3,691,206		3,691,206	(77,913)	3,613,293		29

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

SEE ACCOUNTANTS' PREPARATION 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 Nursing & Rehab

#0054478

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							2,691	2,691			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,714	8,714		8,714	512	9,226			32
33	Real Estate Taxes			42,957	42,957		42,957		42,957			33
34	Rent-Facility & Grounds			620,400	620,400		620,400	2,608	623,008			34
35	Rent-Equipment & Vehicles			5,555	5,555		5,555		5,555			35
36	Other (specify):* Loan Costs			667	667		667		667			36
37	TOTAL Ownership			678,293	678,293		678,293	5,811	684,104			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			238	238		238		238			38
39	Ancillary Service Centers		65,569	262,017	327,586		327,586		327,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			207,343	207,343		207,343		207,343			42
43	Other (specify):* Disallowed Costs			38,803	38,803		38,803	(38,803)				43
44	TOTAL Special Cost Centers		65,569	508,401	573,970		573,970	(38,803)	535,167			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,409,663	433,793	2,100,013	4,943,469		4,943,469	(110,905)	4,832,564			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(6,500)	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	368	30		9
10	Interest and Other Investment Income	(72)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(486)	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	(195)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(827)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(525)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,362)	43		24
25	Fund Raising, Advertising and Promotional	(9,492)	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	1,311			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,780)		\$	30

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	2	
		Amount	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)	(73,125)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (73,125)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (110,905)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Saline Care Nursing & Rehab

ID# 0054478

Report Period Beginning: 3/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gifts	\$ (136)	43	1
2	Miscellaneous income offset	(27)	21	2
3	Expense Leasehold Improvements under \$2,500	1,474	6	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,311		49

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
Scott Stout	100	Carrier Mills Nursing & Rehab Center	Carrier Mills	WLC Management Fir	Harrisburg	Management Co.
		Duquoin Nursing & Rehabilitation Center	Duquoin			
		Pinckneyville Nursing & Rehab Center	Pinckneyville			
		Stonebridge Nursing and Rehab Center	Benton			
		Eldorado Rehab and Healthcare	Eldorado			
		Greenville Nursing and Rehab Center	Greenville			

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	3 Housekeeping	\$	WLC Management Firm, LLC	100.00%	\$ 967	\$	967	1
2	V	5 Utilities		WLC Management Firm, LLC	100.00%	91		91	2
3	V	6 Maintenance		WLC Management Firm, LLC	100.00%	743		743	3
4	V	7 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	134		134	4
5	V	17 Administrative	296,065	WLC Management Firm, LLC	100.00%	46,973		(249,092)	5
6	V	19 Professional Services		WLC Management Firm, LLC	100.00%	2,208		2,208	6
7	V	20 Dues, Fees, Subs & Promotion		WLC Management Firm, LLC	100.00%	450		450	7
8	V	21 Clerical & General Office		WLC Management Firm, LLC	100.00%	135,781		135,781	8
9	V	24 Travel & Seminar		WLC Management Firm, LLC	100.00%	1,090		1,090	9
10	V	25 Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	3,103		3,103	10
11	V	26 Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	1,613		1,613	11
12	V	27 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	24,272		24,272	12
13	V	30 Depreciation		WLC Management Firm, LLC	100.00%	2,323		2,323	13
14	Total		\$ 296,065			\$ 219,748	\$ *	(76,317)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	32 Interest	\$	WLC Management Firm, LLC	100.00%	\$ 584	\$	584	15
16	V	34 Rent-Facility & Grounds		WLC Management Firm, LLC	100.00%	2,608		2,608	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		\$			\$ 3,192	\$ *	3,192	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Saline Care Nursing & Rehab

0054478

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Stout	Stockholder	Administrative	100.00	See Att Sch 7A	11.59	28.98	Alloc. Salary	\$ 46,973	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	\$ 46,973		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' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing & Rehab

0054478

Report Period Beginning:

3/1/2017

Ending: 2/31/2017

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 WLC Management Firm, LLC
 Street Address 105 South Commercial Street Suite 1
 City / State / Zip Code Harrisburg, IL 62946
 Phone Number (618) 294-8696
 Fax Number (618) 294-8699

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping	Census	125,586	7	\$ 3,337	\$ 3,337	36,397	\$ 967	1
2	5	Utilities	Census	125,586	7	315		36,397	91	2
3	6	Maintenance	Census	125,586	7	2,562		36,397	743	3
4	7	Mgmt Allocation of Benefits	Census	125,586	7	464		36,397	134	4
5	17	Administrative	Census	125,586	7	162,078	162,078	36,397	46,973	5
6	19	Professional Services	Census	125,586	7	7,618		36,397	2,208	6
7	20	Dues, Fees, Subs & Promotion	Census	125,586	7	1,551		36,397	450	7
8	21	Clerical & General Office	Census	125,586	7	468,507	440,248	36,397	135,781	8
9	24	Travel & Seminar	Census	125,586	7	3,760		36,397	1,090	9
10	25	Other Admin Staff Transport	Census	125,586	7	10,708		36,397	3,103	10
11	26	Insurance-Prop/Liab/Malprac	Census	125,586	7	5,565		36,397	1,613	11
12	27	Mgmt Allocation of Benefits	Census	125,586	7	83,750		36,397	24,272	12
13	30	Depreciation	Census	125,586	7	8,015		36,397	2,323	13
14	32	Interest	Census	125,586	7	2,016		36,397	584	14
15	34	Rent-Facility & Grounds	Census	125,586	7	9,000		36,397	2,608	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 769,246	\$ 605,663		\$ 222,940	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Saline Care Nursing & Rehab

0054478

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Legence Bank		X	Line of Credit		2/17/17	265,734		3/31/18	0.0275	3,532	6						
7	Legence Bank		X	Line of Credit		2/17/17	325,869		3/31/18	0.0475	2,891	7						
8	Legence Bank		X	Line of Credit		10/23/17	176,958	176,958	10/30/18	0.0475	2,291	8						
9	TOTAL Facility Related						\$ 768,561	\$ 176,958			\$ 8,714	9						
B. Non-Facility Related*																		
10												10						
11										Interest Income Offset	(72)	11						
12										WLC Benefits Alloc	584	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 512	14						
15	TOTALS (line 9+line14)						\$ 768,561	\$ 176,958			\$ 9,226	15						

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

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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.)		2016		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	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.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2012	8		
		2013	9		
		2014	10		
		2015	11		
		2016	51,984		
<u>Accrual based on prior year tax bill.</u>					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2016	\$		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' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Saline Care Nursing & Rehab COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0054478

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 294-8696 FAX #: (618) 294-8699

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>06-1-098-06</u>	<u>Long Term Care Property</u>	\$ <u>20,093.00</u>	\$ <u>20,093.00</u>
2.	<u>06-1-098-01</u>	<u>Long Term Care Property</u>	\$ <u>31,891.08</u>	\$ <u>31,891.08</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>51,984.08</u></u>	\$ <u><u>51,984.08</u></u>

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Nursing & Rehab

0054478

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

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? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 contains 'TOTALS'.

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11		WLC Management Allocation	2017		2,703						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

*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' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)	\$	2,703	\$		\$		\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Saline Care Nursing & Rehab

0054478

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>7,351</u>		<u>368</u>	<u>368</u>	<u>10 Yrs</u>	<u>368</u>	72
73	Fully Depreciated Assets							73
74	<u>WLC Mgmt Allocation</u>	<u>1,294</u>						74
75	TOTALS	\$ <u>8,645</u>	\$	\$ <u>368</u>	\$ <u>368</u>		\$ <u>368</u>	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				\$	\$	\$	\$		\$	76
77	<u>WLC Mgmt Allocation</u>			<u>16,429</u>		<u>2,323</u>	<u>2,323</u>			77
78										78
79										79
80	TOTALS			\$ <u>16,429</u>	\$	\$ <u>2,323</u>	\$ <u>2,323</u>		\$	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)	\$ <u>27,777</u>	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ <u>2,691</u>	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ <u>2,691</u>	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ <u>368</u>	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					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing & Rehab

0054478

Report Period Beginning: 3/1/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CTR Partnership, LP

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:	<u>1969</u>	<u>124</u>	<u>2/17/17</u>	\$ <u>620,400</u>			<u>3</u>
4	Additions	<u>1992</u>	<u>18</u>					<u>4</u>
5		<u>WLC Benefits Alloc</u>			<u>2,608</u>			<u>5</u>
6								<u>6</u>
7	TOTAL		142		\$ 623,008			7

10. Effective dates of current rental agreement:

Beginning 3/1/2017

Ending 2/29/2032

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

Fiscal Year Ending Annual Rent

12.	<u>2/28/2018</u>	\$ <u>744,480</u>
13.	<u>2/28/2019</u>	\$ <u>768,676</u>
14.	<u>2/29/2020</u>	\$ <u>793,658</u>

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 _____.

0
N/A

9. Option to Buy: YES NO Terms: _____*

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: \$ 5,555 Description: Medical Equipment \$5,323; Dietary Equipment \$232

(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			\$ _____	\$ _____	<u>17</u>
18			\$ _____	\$ _____	<u>18</u>
19			\$ _____	\$ _____	<u>19</u>
20			\$ _____	\$ _____	<u>20</u>
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' PREPARATION REPORT

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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' PREPARATION REPORT

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

	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(3)	hrs	\$		\$ 97,690	\$		\$ 97,690	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			35,217			35,217	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs			108,613			108,613	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 prescripts				65,569		65,569	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			\$		\$ 241,520	\$ 65,569		\$ 307,089	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' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing & Rehab

0054478

Report Period Beginning: 3/1/2017

Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 230,490	\$ 230,490	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>13,170</u>)	645,346	645,346	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,137	8,137	6
7	Other Prepaid Expenses	3,243	3,243	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Prior Owner</u>	51,984	51,984	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 939,200	\$ 939,200	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,474	2,703	15
16	Equipment, at Historical Cost	7,351	25,074	16
17	Accumulated Depreciation (book methods)		(368)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,825	\$ 27,409	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 948,025	\$ 966,609	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 140,790	\$ 140,790	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	176,958	176,958	29
30	Accrued Salaries Payable	104,038	104,038	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,646	2,646	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,957	42,957	32
33	Accrued Interest Payable			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)	\$ 467,389	\$ 467,389	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)	\$ 467,389	\$ 467,389	46
47	TOTAL EQUITY(page 18, line 24)	\$ 480,636	\$ 499,220	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 948,025	\$ 966,609	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	480,636	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	()	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)	\$ 480,636	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)	\$ 480,636	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,343,586	1
2	Discounts and Allowances for all Levels	(18,410)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,325,176	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,311	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 97,311	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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	1,519	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,519	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	72	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 72	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	27	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,424,105	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,026,271	31
32	Health Care	1,744,498	32
33	General Administration	920,437	33
B. Capital Expense			
34	Ownership	678,293	34
C. Ancillary Expense			
35	Special Cost Centers	366,627	35
36	Provider Participation Fee	207,343	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,943,469	40
41	Income before Income Taxes (line 30 minus line 40)**	480,636	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 480,636	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,420,693	44
45	Private Pay - Net Inpatient Revenue	666,800	45
46	Medicare - Net Inpatient Revenue	1,088,477	46
47	Other-(specify) <u>Insurance</u>	149,206	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,325,176	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' PREPARATION REPORT

Facility Name & ID Number **Saline Care Nursing & Rehab**

0054478

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,190	2,206	\$ 75,113	\$ 34.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,761	6,818	179,144	26.28	3
4	Licensed Practical Nurses	24,910	25,122	574,763	22.88	4
5	CNAs & Orderlies	54,750	55,214	664,174	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,840	1,856	23,980	12.92	9
10	Activity Assistants	3,960	3,993	39,782	9.96	10
11	Social Service Workers	4,363	4,435	86,023	19.40	11
12	Dietician					12
13	Food Service Supervisor	2,322	2,337	30,898	13.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,204	26,400	236,397	8.95	15
16	Dishwashers					16
17	Maintenance Workers	3,437	3,485	60,331	17.31	17
18	Housekeepers	18,497	18,629	168,539	9.05	18
19	Laundry	11,871	11,929	105,252	8.82	19
20	Administrator	1,456	1,456	66,419	45.62	20
21	Assistant Administrator	160	160	3,200	20.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,878	9,005	95,648	10.62	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)	171,599	173,045	\$ 2,409,663 *	\$ 13.93	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	177	\$ 8,535	L1, C3	35
36	Medical Director	Monthly	3,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	800	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	20	1,215	L11, C3	44
45	Social Service Consultant	20	1,215	L12, C3	45
46	Other(specify) <u>Psychiatric</u>	Monthly	7,470	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	217	\$ 22,235		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,194	\$ 22,638	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,194	\$ 22,638		53

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jason Quinn	Administrator	0	\$ 66,419	Workers' Compensation Insurance	\$ 79,071	IDPH License Fee	\$ 4,389	
Paula Lindsay	Asst Admin	0	3,200	Unemployment Compensation Insurance	16,694	Advertising: Employee Recruitment	222	
				FICA Taxes	181,116	Health Care Worker Background Check (Indicate # of checks performed <u>52</u>)	2,490	
				Employee Health Insurance	3,332	Patient Background Checks	2,385	
				Employee Meals	166	License & Permits	680	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,851	
				Employee Physicals/Drug Tests	4,745	IHCA	7,810	
				Life/Disability Insurance	6,353	Allocated From WLC Mgmt Firm	450	
				Other Employee Benefits	3,940			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 69,619			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 296,065					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 296,065	TOTAL (agree to Schedule V, line 22, col.8)	\$ 295,417	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,277	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Sandberg Phoenix & Von Gontard	Legal		\$ 7,720				Out-of-State Travel	\$
Thomas J. Wolf, Jr., P.C.	Legal		1,076					
Lawler Brown Law Office	Legal		525				In-State Travel	
E-Solutions, Inc.	Health Info Management		1,844					
American Healthtech	LTC Software		22,576				Seminar Expense	3,721
Information Controls	Payroll Service		3,656				Allocated From WLC Mgmt Firm	1,090
WH Administrators, Inc	ACA Compliance Consultant		29,580				Entertainment Expense	()
							TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 66,977	TOTAL		\$	TOTAL	\$ 4,811

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Saline Care Nursing & Rehab

0054478

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 7,810 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,089 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. _____
- (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. \$ 207,343
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. \$ 166 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: _____
- (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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Saline Care Nursing & Rehab
IDPH License ID Number: 0054478
Fiscal Year End: 12/31/2017

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	681
Fuel and miscellaneous supplies	2,979
Vehicle Repairs	288
Allocated from Mgmt Co	3,103
	<hr/>
	7,051
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