		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0044057

Facility Name: Salem Village Nursing Rehab

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

County: Will

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

HFS ID Number:

Date of Initial License for Current Owners: 8/31/1998

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	* *Subject to the attached Accountants' Consulting Report*	
	(Print Name and Title)	
	(Firm Name & Address)	Marcum, LLP 9 Parkway North, Suite 200 Deerfield, IL 60015
	(Telephone)	(847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	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	230	Skilled (SNF)	230	84,180	1
2		Skilled Pediatric (SNF/PED)			2
3	36	Intermediate (ICF)	36	13,176	3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,196	5
6		ICF/DD 16 or Less			6
7	272	TOTALS	272	99,552	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	38,553	5	9,178	47,736	8
9	SNF/PED					9
10	ICF	9,482	2,684	65	12,231	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,035	2,689	9,243	59,967	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.24%

D. How many bed reserve days during this year were paid by the Department?
None (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 8/31/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 230 and days of care provided 3,047

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number: Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	577,195	82,256	22,511	681,962		681,962		681,962			1
2	Food Purchase		310,306		310,306		310,306	(2,269)	308,037			2
3	Housekeeping	519,782	68,885		588,667		588,667		588,667			3
4	Laundry	173,501	19,995		193,496		193,496		193,496			4
5	Heat and Other Utilities			332,635	332,635		332,635		332,635			5
6	Maintenance	115,144	18,293	138,862	272,299		272,299	(39,881)	232,418			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,385,622	499,735	494,008	2,379,365		2,379,365	(42,150)	2,337,215			8
	B. Health Care and Programs											
9	Medical Director			102,000	102,000		102,000		102,000			9
10	Nursing and Medical Records	6,065,331	270,186	57,201	6,392,718		6,392,718	(1,054)	6,391,664			10
10a	Therapy	164,912			164,912		164,912		164,912			10a
11	Activities	206,476	10,030		216,506		216,506		216,506			11
12	Social Services	136,645		3,375	140,020		140,020		140,020			12
13	CNA Training											13
14	Program Transportation			449	449		449		449			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,573,364	280,216	163,025	7,016,605		7,016,605	(1,054)	7,015,551			16
	C. General Administration											
17	Administrative	121,510			121,510		121,510	22,697	144,207			17
18	Directors Fees											18
19	Professional Services			712,292	712,292		712,292	(341,194)	371,098			19
20	Dues, Fees, Subscriptions & Promotions			107,104	107,104		107,104	(35,233)	71,871			20
21	Clerical & General Office Expenses	543,899	23,801	319,828	887,528		887,528	166,363	1,053,891			21
22	Employee Benefits & Payroll Taxes			1,492,623	1,492,623		1,492,623		1,492,623			22
23	Inservice Training & Education											23
24	Travel and Seminar			659	659		659		659			24
25	Other Admin. Staff Transportation			9,699	9,699		9,699	4,088	13,787			25
26	Insurance-Prop.Liab.Malpractice			588,992	588,992		588,992	32,031	621,023			26
27	Other (specify):*							37,428	37,428			27
28	**TOTAL General Administration**	665,409	23,801	3,231,197	3,920,407		3,920,407	(113,819)	3,806,588			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,624,395	803,752	3,888,230	13,316,377		13,316,377	(157,024)	13,159,353			29

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

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

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			206,736	206,736		206,736	(44,619)	162,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,485	17,485		17,485	520,192	537,677			32
33	Real Estate Taxes							152,838	152,838			33
34	Rent-Facility & Grounds			1,426,234	1,426,234		1,426,234	(1,393,390)	32,844			34
35	Rent-Equipment & Vehicles			65,388	65,388		65,388	(18,143)	47,245			35
36	Other (specify):*							103,643	103,643			36
37	TOTAL Ownership			1,715,843	1,715,843		1,715,843	(679,480)	1,036,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	66,209	489,122	380,716	936,047		936,047		936,047			39
40	Barber and Beauty Shops			280	280		280	(280)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			488,219	488,219		488,219		488,219			42
43	Other (specify):*	164,359		9,000	173,359		173,359	(173,359)				43
44	TOTAL Special Cost Centers	230,568	489,122	878,215	1,597,905		1,597,905	(173,639)	1,424,266			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,854,963	1,292,874	6,482,288	16,630,125		16,630,125	(1,010,142)	15,619,983			45

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,130)	02		4
5	Telephone, TV & Radio in Resident Rooms	(35,208)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(258,040)	30		9
10	Interest and Other Investment Income	(34,042)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(139)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(60)	21		18
19	Entertainment	(436)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,458)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(384,010)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (727,523)		$	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)	(282,619)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (282,619)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,010,142)		37

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

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

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

STATE OF ILLINOIS

Salem Village Nursing Rehab

ID# 0044057

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Travel	$ (24)	25	1
2	Miscellaneous Income	(3,063)	21	2
3	Jury Duty Income	(12)	10	3
4	Medical Records Income	(772)	10	4
5	Rental Income - Beauty Chair	(280)	40	5
6	Misc Income	(3,346)	21	6
7	RFMS Petty Cash Clearing Acct	(642)	21	7
8	Resident Lost Items	(270)	10	8
9	Marketing Salaries	(164,359)	43	9
10	Sequestration	(13,843)	21	10
11	Bank Service Charges	(13,010)	21	11
12	Collection Fees/ Cc Fees	(9,660)	21	12
13	Late Fees	(81,326)	21	13
14	Taxes	(199)	21	14
15	Bldg Co - Amortization	(4,344)	36	15
16	Bldg Co - Accounting Fees	(22,248)	19	16
17	Bldg Co - Late Fee	(2,233)	21	17
18	Additional R&M	1,700	06	18
19	Capitalized R&M	(10,033)	06	19
20	Non Allowable Auto Lease	(25,135)	35	20
21	Non Allowable Expense	(9,000)	43	21
22	PAC Dues	(21,484)	20	22
23	Marketing Dues	(350)	20	23
24	Annual Report	(77)	20	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**	(384,010)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Salem Village Nursing Rehab

ID# 0044057

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(2,269)											(2,269)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(43,541)		3,660									(39,881)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(45,810)		3,660									(42,150)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,054)											(1,054)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(1,054)											(1,054)	16
	C. General Administration													
17	Administrative			22,697									22,697	17
18	Directors Fees													18
19	Professional Services	(22,248)	22,248	(341,194)									(341,194)	19
20	Fees, Subscriptions & Promotions	(35,369)		136									(35,233)	20
21	Clerical & General Office Expenses	(127,818)	2,233	291,948									166,363	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation	(24)		4,112									4,088	25
26	Insurance-Prop.Liab.Malpractice		29,063	2,968									32,031	26
27	Other (specify):*			37,428									37,428	27
28	**TOTAL General Administration**	(185,459)	53,544	18,095									(113,819)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(232,323)	53,544	21,755									(157,024)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(258,040)	213,421										(44,619)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(34,042)	552,215	2,019									520,192	32
33	Real Estate Taxes		152,838										152,838	33
34	Rent-Facility & Grounds		(1,426,234)	32,844									(1,393,390)	34
35	Rent-Equipment & Vehicles	(25,135)		6,992									(18,143)	35
36	Other (specify):*	(4,344)	107,987										103,643	36
37	TOTAL Ownership	(321,561)	(399,774)	41,855									(679,480)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(280)											(280)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(173,359)											(173,359)	43
44	TOTAL Special Cost Centers	(173,639)											(173,639)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(727,523)	(346,229)	63,610									(1,010,142)	45

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,426,234	Salem Village Property, LLC		$	$ (1,426,234)	1
2	V	32	Interest	1,094	Salem Village Property, LLC		553,309	552,215	2
3	V	30	Depreciation		Salem Village Property, LLC		213,421	213,421	3
4	V	36	Amortization		Salem Village Property, LLC		4,344	4,344	4
5	V	33	Real Estate Tax		Salem Village Property, LLC		152,838	152,838	5
6	V	36	Mortgage Insurance		Salem Village Property, LLC		103,643	103,643	6
7	V	19	Accounting Fees		Salem Village Property, LLC		22,248	22,248	7
8	V	26	Property Insurance		Salem Village Property, LLC		29,063	29,063	8
9	V	21	Late Fee		Salem Village Property, LLC		2,233	2,233	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,427,328			$ 1,081,099	$ * (346,229)	14

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

Facility Name & ID Number: Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES ACCUMULATION TRUST	5.00%	CORI MANOR	ST. LOUIS MO.	SALEM VILLAGE PROPERTIES	JOLIET	BUILDING CO.	1
2	DANIEL ROTHNER ACCUMULATION TRUST	5.00%	ELMWOOD NURSING & REHABILITATION CENTER, L.L.C.	MARYVILLE	HEALTHCARE ACCOUNTING S	ST. LOUIS MO.	BOOKEEPING/FINANCIAL	2
3	KATHRYN VALES ACCUMULATION TRUST	5.00%	GRAND MANOR NURSING AND REHAB	ST. LOUIS MO.	MS HEALTHCARE ACCT.	CHICAGO	ACCOUNTING	3
4	KIMBERLY RICHMAN ACCUMULATION TRUST	5.00%	NORTHVIEW VILLAGE	ST. LOUIS MO.				4
5	MAKHLOUF & LORRAINE SUISSA	45.00%	EDWARDSVILLE CARE CENTER	EDWARDSVILLE				5
6	MELISSA ROTHNER ACCUMULATION TRUST	5.00%	UNIVERSITY CARE CENTER	EDWARDSVILLE				6
7	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	10.00%						7
8	RACHEL ROTHNER ACCUMULATION TRUST	5.00%						8
9	SHOSHANA ARYEH	10.00%						9
10	WILLIAM ROTHNER ACCUMULATION TRUST	5.00%						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	$	HEALTHCARE ACCOUNTING SERVICES, LLC		$ 3,660	$ 3,660	15
16	V	19	Professional Fees		HEALTHCARE ACCOUNTING SERVICES, LLC		6,806	6,806	16
17	V	20	Dues, Subscriptions		HEALTHCARE ACCOUNTING SERVICES, LLC		136	136	17
18	V	21	Clerical & General		HEALTHCARE ACCOUNTING SERVICES, LLC		7,716	7,716	18
19	V	24	Seminar		HEALTHCARE ACCOUNTING SERVICES, LLC				19
20	V	25	Travel		HEALTHCARE ACCOUNTING SERVICES, LLC		4,112	4,112	20
21	V	26	Insurance		HEALTHCARE ACCOUNTING SERVICES, LLC		2,968	2,968	21
22	V	30	Depreciation		HEALTHCARE ACCOUNTING SERVICES, LLC				22
23	V	32	Interest		HEALTHCARE ACCOUNTING SERVICES, LLC		2,019	2,019	23
24	V	34	Office Space		HEALTHCARE ACCOUNTING SERVICES, LLC		32,844	32,844	24
25	V	35	Auto Rental		HEALTHCARE ACCOUNTING SERVICES, LLC		4,073	4,073	25
26	V	35	Equipment Rental		HEALTHCARE ACCOUNTING SERVICES, LLC		2,919	2,919	26
27	V	21	Clerical Salaries		HEALTHCARE ACCOUNTING SERVICES, LLC		157,639	157,639	27
28	V	27	G&A Employee Benefits		HEALTHCARE ACCOUNTING SERVICES, LLC		20,844	20,844	28
29	V	17	Admin. Salary - M. Suissa		HEALTHCARE ACCOUNTING SERVICES, LLC		22,697	22,697	29
30	V	27	Employee Benefits-M. Suissa		HEALTHCARE ACCOUNTING SERVICES, LLC		1,946	1,946	30
31	V								31
32	V	21	Clerical Salaries		HEALTHCARE ACCOUNTING SERVICES, LLC		126,593	126,593	32
33	V	27	G&A Employee Benefits		HEALTHCARE ACCOUNTING SERVICES, LLC		14,638	14,638	33
34	V								34
35	V	12	Social Service		HEALTHCARE ACCOUNTING SERVICES, LLC				35
36	V	15	Health Care Employee Benefits		HEALTHCARE ACCOUNTING SERVICES, LLC				36
37	V								37
38	V	19	Bookkeeping Services	348,000	HEALTHCARE ACCOUNTING SERVICES, LLC			(348,000)	38
39	Total			$ 348,000			$ 411,610	$ * 63,610	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Mark Suissa	Shareholder	Administrative	45.00%	See Attached	12.38	20.63%	Alloc Salary	$ 22,697	17-7	1
2	Lorraine Suissaa	Relative	Administrative	N/A	N/A	40.00	100.00%	Salary	46,120	21-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 68,817		13

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: HEALTHCARE ACCOUNTING SERVICES, LI
Street Address: 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code: BRENTWOOD, MO. 63144
Phone Number: (314) 963-7570
Fax Number: (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & Maintenance	IL & MO Patient Days	290,630	7	$ 17,739	$	59,967	$ 3,660	1
2	19	Professional Fees	IL & MO Patient Days	290,630	7	32,987		59,967	6,806	2
3	20	Dues, Subscriptions	IL & MO Patient Days	290,630	7	659		59,967	136	3
4	21	Clerical & General	IL & MO Patient Days	290,630	7	37,397		59,967	7,716	4
5	24	Seminar	IL & MO Patient Days	290,630	7			59,967		5
6	25	Travel	IL & MO Patient Days	290,630	7	19,930		59,967	4,112	6
7	26	Insurance	IL & MO Patient Days	290,630	7	14,386		59,967	2,968	7
8	30	Depreciation	IL & MO Patient Days	290,630	7			59,967		8
9	32	Interest	IL & MO Patient Days	290,630	7	9,786		59,967	2,019	9
10	34	Office Space	IL & MO Patient Days	290,630	7	159,180		59,967	32,844	10
11	35	Auto Rental	IL & MO Patient Days	290,630	7	19,739		59,967	4,073	11
12	35	Equipment Rental	IL & MO Patient Days	290,630	7	14,145		59,967	2,919	12
13	21	Clerical Salaries	IL & MO Patient Days	290,630	7	763,997	763,997	59,967	157,639	13
14	27	G&A Employee Benefits	IL & MO Patient Days	290,630	7	101,021		59,967	20,844	14
15	17	Admin. Salary - M. Suissa	IL & MO Patient Days	290,630	7	110,000	110,000	59,967	22,697	15
16	27	Employee Benefits-M. Suissa	IL & MO Patient Days	290,630	7	9,429		59,967	1,946	16
17										17
18	21	Clerical Salaries	Illinois Patient Days	140,721	4	297,069	297,069	59,967	126,593	18
19	27	G&A Employee Benefits	Illinois Patient Days	140,721	4	34,351		59,967	14,638	19
20										20
21	12	Social Service	Specific Facility Days	149,909	3	4,392	4,392			21
22	15	Health Care Employee Benefits	Specific Facility Days	149,909	3	674				22
23										23
24										24
25	TOTALS					$ 1,646,881	$ 1,175,458		$ 411,610	25

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number ( )

Fax Number ( )

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

Facility Name & ID Number: Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First Midwest Bank		X	Mortgage			$	$ 15,863,225			$ 553,309	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Select Rehabilitation		X	Note Payable				140,000				6
7	Advantage Leasing		X	Note Payable				279			642	7
8	See Supplemental Schedule							8,674			16,843	8
9	TOTAL Facility Related						$	$ 16,012,178			$ 570,794	9
	B. Non-Facility Related*											
10	Interest Income		X								(34,042)	10
11	Interest Income - Bldg Co.		X								(1,094)	11
12	Allocated from HAS	X									2,019	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (33,117)	14
15	TOTALS (line 9+line14)						$	$ 16,012,178			$ 537,677	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 103,643 Line # 36

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

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	165,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	152,838	2
3. Under or (over) accrual (line 2 minus line 1).	$	(12,162)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	165,000	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.	$	152,838	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	176,501	8
	2016	170,946	9
	2017	164,291	10
	2018	158,483	11
	2019	152,838	12

2020 Accrual = $152,838 x 1.08 = $165,000 (Rounded)

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing Rehab COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: (   )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	30-07-23-304-011-0000	Long Term Care Property	$ 151,885.60	$ 151,885.60
2.	30-07-23-304-007-0000	Long Term Care Property	$ 218.04	$ 218.04
3.	30-07-23-304-010-0000	Long Term Care Property	$ 734.16	$ 734.16
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 152,837.80	$ 152,837.80

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing Rehab COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 127,847 B. General Construction Type: Exterior Brick Frame Number of Stories 6

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1998	$ 408,000	1
2					2
3	TOTALS			$ 408,000	3

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	272		1998	1976	$ 8,021,280	$ 213,421	35	$	$ (213,421)	$ 8,021,280	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	108,515		20	3	3	108,515	9
10	Various			1999	240,599		20	27	27	240,599	10
11	Various			2000	193,202		20	4,154	4,154	193,202	11
12	Various			2001	97,999		20	4,558	4,558	96,198	12
13	Various			2002	88,413		20	46	46	88,329	13
14	Various			2003	45,533		20			45,533	14
15	Various			2004	113,428		20	544	544	111,489	15
16	Various			2005	141,584		20	1,719	1,719	134,344	16
17	Various			2006	207,635		20	1,355	1,355	200,632	17
18	Various			2007	18,325		20	445	445	17,337	18
19	Various			2008	92,767		20	131	131	91,728	19
20	Various			2009	72,175		20	1,483	1,483	65,496	20
21	Various			2010	276,387		20	5,959	5,959	264,909	21
22	Various			2011	311,964		20	12,849	12,849	271,510	22
23	Various			2012	362,318		20	17,856	17,856	254,449	23
24	Various			2013	406,637		20	16,830	16,830	293,418	24
25	Various			2014	155,227		20	7,762	7,762	78,214	25
26	Various			2015	44,128		20	2,207	2,207	20,231	26
27	Various			2016	114,627		20	5,732	5,732	56,762	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			206,736			(206,736)		69
70	TOTAL (lines 4 thru 69)		$ 11,112,744	$ 420,157		$ 83,660	$ (336,497)	$ 10,654,175	70

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 11,112,744	$ 420,157		$ 83,660	$ (336,497)	$ 10,654,175	1
2	New Water Heater	2017	6,891		20	345	345	1,350	2
3	A/C Unit	2017	3,426		20	171	171	642	3
4	Cable Lines To Resident Rooms	2017	16,439		20	822	822	3,014	4
5	A/C Unit	2017	3,591		20	180	180	659	5
6	Installation Of New Nurses Station 50% Down	2017	17,148		20	857	857	3,072	6
7	Electrical Rewiring Of Main Feeders - Mechanical Closet	2017	3,450		20	173	173	619	7
8	Humidifier Auto Control X 6	2017	4,781		20	239	239	857	8
9	Humidifier Auto Control X 6	2017	5,534		20	277	277	992	9
10	Ac Units	2017	4,116		20	206	206	721	10
11	New Nurses Station	2017	5,304		20	265	265	906	11
12	Blower Assembly And Installation	2017	2,979		20	149	149	472	12
13	A/C Unit	2017	3,571		20	179	179	566	13
14	Fire Alarm	2017	2,619		20	131	131	415	14
15	Replaced Hydraulic Cylinder, Cleaned Down Elevator Pits	2017	10,380		20	519	519	1,600	15
16	Back Flow Repair Grounds Water Sprinkler	2017	3,049		20	152	152	559	16
17	Fixed Main Water Pipe, Replaced Fire & Jockey Pump	2017	3,705		20	185	185	602	17
18	Installed Ac Units	2018	9,050		20	453	453	1,358	18
19	Ceiling Panels	2018	3,518		20	176	176	528	19
20	Installed Xp Card And Frm Modules To Fire Alarm System	2018	2,754		20	138	138	413	20
21	Elevator Repair - Replaced Roller Assembly, & Lower Guide	2018	3,446		20	172	172	517	21
22	Basement Air Handler Electric Heater Repair	2018	4,213		20	211	211	632	22
23	Hot Water Mixing Repair	2018	4,949		20	247	247	742	23
24	Remove & Replace Cast Iron Mop Basin, Patched Floor	2018	2,920		20	146	146	438	24
25	Repaired Kitchen Waste Line & Installed New Clean Out	2018	2,850		20	143	143	428	25
26	A, B, C Wings, Recreation Area, Nurses Station, Dining,	2018	174,138		20	8,707	8,707	26,121	26
27	Electrical/Lighting, Flooring, & Wall Surfaces	2018	100,874		20	5,044	5,044	15,131	27
28	10 Ac Units	2019	6,801		20	340	340	1,020	28
29	Installation Of New Call Light System On 3Rd Floor	2019	18,774		20	939	939	2,816	29
30	6 A/C Units	2019	4,210		20	210	210	350	30
31	Dialysis Department Architectural Design Fee	2019	12,500		20	625	625	1,042	31
32	Plumbing-4 Expansion Tanks, Back Flow Prevention,Pumps	2019	28,488		20	1,424	1,424	2,136	32
33	Basement Air Handler - New Blower/Heating Cabinet	2019	9,400		20	470	470	548	33
34	TOTAL (lines 1 thru 33)		$ 11,598,612	$ 420,157		$ 107,955	$ (312,202)	$ 10,725,441	34

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 11,598,612	$ 420,157		$ 107,955	$ (312,202)	$ 10,725,441	1
2	Plumbing - Point Of Use Mixing Valves	2019	25,000		20	1,250	1,250	3,542	2
3	1St - 6Th Floor Plumbing - P-Traps, Replace Angle Stops	2019	34,484		20	1,724	1,724	4,023	3
4	Replaced Boiler For Laundry Room	2019	10,752		20	538	538	1,076	4
5	Replaced Smoke Detectors	2019	6,816		20	341	341	682	5
6	Installation Of New Water Heaters In Basement	2019	4,280		20	214	214	428	6
7	Plumbing-Excavate & Install Two 2 Cleanout On Outside Of Bldg	2019	2,750		20	138	138	276	7
8	2Nd Flr Remodel - Flooring, Walls, Electrical Work	2019	13,042		20	652	652	1,304	8
9	Electronic Door Locks	2020	3,208		20	160	160	160	9
10	Heating Unit	2020	9,948		20	497	497	497	10
11	A/C Units	2020	6,648		20	332	332	332	11
12	Phone System	2020	7,455		20	373	373	373	12
13	Fire Sprinkler Repair - Replaced Pipe	2020	3,468		20	173	173	173	13
14	Descaled And Installed New Water Regulator On Walk In Cooler	2020	3,333		20	167	167	167	14
15	Repaired Toilet Leak	2020	2,775		20	139	139	139	15
16	Installed Basement Storage Room Door/Sensor Upgrade Program	2020	3,925		20	196	196	196	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)		$ 11,736,496	$ 420,157		$ 114,850	$ (305,307)	$ 10,738,810	34

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,736,496	$ 420,157		$ 114,850	$ (305,307)	$ 10,738,810	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,736,496	$ 420,157		$ 114,850	$ (305,307)	$ 10,738,810	34

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,736,496	$ 420,157		$ 114,850	$ (305,307)	$ 10,738,810	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,736,496	$ 420,157		$ 114,850	$ (305,307)	$ 10,738,810	34

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
1	Totals from Page 12H, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,312,532	$	$ 40,470	$ 40,470	10	$ 1,164,772	71
72	Current Year Purchases	67,883		6,788	6,788	10	6,788	72
73	Fully Depreciated Assets	1,860,627		9	9	10	1,860,627	73
74								74
75	TOTALS	$ 3,241,041	$	$ 47,267	$ 47,267		$ 3,032,187	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2011 LEXUS LS 460	2011	$ 30,000	$	$	$	5	$ 30,000	76
77										77
78										78
79										79
80	TOTALS			$ 30,000	$	$	$		$ 30,000	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)	$ 15,415,537	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 420,157	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 162,117	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (258,040)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,800,997	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2011 Lexus LS 460 - 2011	$ 39,141	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 39,141	$	$	91

G. Construction-in-Progress

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

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

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

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	Allocated from HAS				32,844			6
7	TOTAL				$ 32,844 **			7

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: *

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: $ 31,055 Description: See Attached
    (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			$	$	17
18	Resident Transport	Passenger Van	1,010	12,117	18
19	Allocated from HAS			4,073	19
20					20
21	TOTAL		$ 1,010	$ 16,190	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.

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 53,653	$		$ 53,653	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			18,440			18,440	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			285,940			285,940	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				148,035		148,035	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			66,209		22,683	341,087		429,979	13
14	TOTAL			$ 66,209		$ 380,716	$ 489,122		$ 936,047	14

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 786,584	$ 845,481	1
2	Cash-Patient Deposits	48,931	48,931	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,826,378	2,826,378	3
4	Supply Inventory (priced at)	61,243	61,243	4
5	Short-Term Investments			5
6	Prepaid Insurance	127,257	161,966	6
7	Other Prepaid Expenses	10,709	10,709	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	10,393	1,211,361	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,871,495	$ 5,166,069	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		408,000	13
14	Buildings, at Historical Cost		8,355,023	14
15	Leasehold Improvements, at Historical Cost	3,390,187	3,390,187	15
16	Equipment, at Historical Cost	2,843,205	3,659,205	16
17	Accumulated Depreciation (book methods)	(5,520,143)	(10,950,398)	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): See Attached	1,887,733	2,022,778	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,600,982	$ 6,884,795	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,472,477	$ 12,050,864	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,168,060	$ 2,187,185	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,431	47,431	28
29	Short-Term Notes Payable		288,147	29
30	Accrued Salaries Payable	626,972	626,972	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,813	29,813	31
32	Accrued Real Estate Taxes(Sch.IX-B)		165,000	32
33	Accrued Interest Payable		45,739	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,537,786	2,537,786	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,410,062	$ 5,928,073	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	148,953	148,953	39
40	Mortgage Payable		15,575,078	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	8,727,099	6,712,372	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,876,052	$ 22,436,403	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 14,286,114	$ 28,364,476	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,813,637)	$ (16,313,612)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,472,477	$ 12,050,864	48

*(See instructions.)

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,750,700)	1
2	Restatements (describe):		2
3	Office Supplies	208	3
4	Rounding	(5)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,750,497)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,063,140)	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)**	$ (1,063,140)	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)**	$ (7,813,637)	24 *

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 18,305,981	1
2	Discounts and Allowances for all Levels	(5,491,843)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,814,138	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	628,365	6
7	Oxygen	19,399	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 647,764	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	2,130	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	300	16
17	Sale of Drugs	129,494	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,074	19
20	Radiology and X-Ray	6,319	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 174,317	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,042	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,042	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	1,896,724	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,896,724	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,566,985	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,379,365	31
32	Health Care	7,016,605	32
33	General Administration	3,920,407	33
	B. Capital Expense		
34	Ownership	1,715,843	34
	C. Ancillary Expense		
35	Special Cost Centers	1,109,686	35
36	Provider Participation Fee	488,219	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,630,125	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,063,140)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,063,140)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,829,047	44
45	Private Pay - Net Inpatient Revenue	740,929	45
46	Medicare - Net Inpatient Revenue	1,473,171	46
47	Other-(specify) Hospice	998,796	47
48	Other-(specify) Insurance	6,772,195	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,814,138	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2,044	2,301	$ 133,532	$ 58.03	1
2	Assistant Director of Nursing	1,521	1,705	80,139	47.00	2
3	Registered Nurses	30,205	41,672	1,755,447	42.13	3
4	Licensed Practical Nurses	46,184	50,491	1,812,808	35.90	4
5	CNAs & Orderlies	107,598	112,441	2,184,271	19.43	5
6	CNA Trainees					6
7	Licensed Therapist	1,698	2,176	66,209	30.43	7
8	Rehab/Therapy Aides	6,912	7,907	164,912	20.86	8
9	Activity Director					9
10	Activity Assistants	13,488	14,482	206,476	14.26	10
11	Social Service Workers	5,919	7,064	136,645	19.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,590	34,521	577,195	16.72	15
16	Dishwashers					16
17	Maintenance Workers	6,519	7,104	115,144	16.21	17
18	Housekeepers	31,967	35,966	519,782	14.45	18
19	Laundry	11,377	12,779	173,501	13.58	19
20	Administrator	1,789	2,096	121,510	57.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,064	26,819	543,899	20.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,632	3,017	52,415	17.37	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	5,499	6,426	211,078	32.85	33
34	TOTAL (lines 1 - 33)	330,006	368,967	$ 8,854,963 *	$ 24.00	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	459	$ 22,511	01-03	35
36	Medical Director	Monthly	102,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	34,356	10-03	38
39	Pharmacist Consultant	2,286	22,845	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	45	3,375	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,790	$ 185,087		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Salem Village Nursing Rehab # 0044057 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Annette Gentile	Administrator	0	$ 121,510
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 121,510

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 22,042
Healthcare Accounting Svcs.	Bookkeeping/Accounting	348,000
National Datacare Corporation	Data Processing	3,151
Paycom	Payroll Processing	51,489
Personnel Planners	Unemployment Consultant	2,928
Capital Research Group	401K Recordkeeping	5,920
Achieve Accreditation	Accreditation	10,467
GCHMO	Managed Care Consultant	3,500
See Attached	Legal	264,795
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 712,292

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 268,675
Unemployment Compensation Insurance	59,180
FICA Taxes	677,405
Employee Health Insurance	351,564
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employer 401K Match/Pension	122,633
Holiday Expense	13,166
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,492,623

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 3,980
Advertising: Employee Recruitment		32,917
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks	158	1,218
Dues & Subscriptions		27,205
Licenses & Fees		6,415
See Supplemental Schedule		136
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 71,871

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	659
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 659

**See instructions.

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. **HCCI $42,968**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,493** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **488,219**
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. $ ____ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,130**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

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