

		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.

<p>I. IDPH License ID Number: <u>0054478</u></p> <p>Facility Name: <u>Saline Care Nursing Rehab</u></p> <p>Address: <u>120 S Land St Bx 468</u> <u>Harrisburg</u> <u>62946</u> Number City Zip Code</p> <p>County: <u>Saline</u></p> <p>Telephone Number: <u>(618) 252-7405</u> Fax # <u>(618) 253-3418</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/1/2017</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; border: 1px solid black;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="border: 1px solid black;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u> (Telephone) <u>(630) 361-2868</u> Fax # ()</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326</u> (Telephone) <u>(630) 361-2868</u> Fax # ()
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing Rehab

0054478 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,352	1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,620	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	142	TOTALS	142	51,972	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,855	3,855	8
9	SNF/PED					9
10	ICF	28,673	3,337		32,010	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,673	3,337	3,855	35,865	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.01%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 72 and days of care provided 3,686

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing Rehab # 0054478 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	307,937	13,180	6,992	328,109		328,109		328,109		1
2	Food Purchase		209,155		209,155		209,155		209,155		2
3	Housekeeping	180,742	15,158		195,900		195,900	953	196,853		3
4	Laundry	99,381	10,605		109,986		109,986		109,986		4
5	Heat and Other Utilities			129,652	129,652		129,652	1,021	130,673		5
6	Maintenance	110,744	24,846	63,314	198,904		198,904	(4,792)	194,112		6
7	Other (specify):* Waste Removal			17,634	17,634		17,634	109	17,743		7
8	TOTAL General Services	698,804	272,944	217,592	1,189,340		1,189,340	(2,709)	1,186,631		8
	B. Health Care and Programs										
9	Medical Director			7,500	7,500		7,500		7,500		9
10	Nursing and Medical Records	2,147,977	129,175	8,100	2,285,252		2,285,252	2,169	2,287,421		10
10a	Therapy			11,892	11,892		11,892		11,892		10a
11	Activities	71,948	3,876	2,936	78,760		78,760		78,760		11
12	Social Services	45,242	43	3,283	48,568		48,568		48,568		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* WLC Benefits Alloc							249	249		15
16	TOTAL Health Care and Programs	2,265,167	133,094	33,711	2,431,972		2,431,972	2,418	2,434,390		16
	C. General Administration										
17	Administrative	121,734		360,205	481,939		481,939	(322,886)	159,053		17
18	Directors Fees										18
19	Professional Services			32,941	32,941		32,941	(300)	32,641		19
20	Dues, Fees, Subscriptions & Promotions			20,398	20,398		20,398	(2,890)	17,508		20
21	Clerical & General Office Expenses	90,173	16,621	12,119	118,913		118,913	63,420	182,333		21
22	Employee Benefits & Payroll Taxes			338,216	338,216		338,216		338,216		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,115	2,115		2,115	27	2,142		24
25	Other Admin. Staff Transportation			7,631	7,631		7,631	1,419	9,050		25
26	Insurance-Prop.Liab.Malpractice			150,148	150,148		150,148	1,330	151,478		26
27	Other (specify):* WLC Benefits Alloc							12,629	12,629		27
28	TOTAL General Administration	211,907	16,621	923,773	1,152,301		1,152,301	(247,251)	905,050		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,175,878	422,659	1,175,076	4,773,613		4,773,613	(247,542)	4,526,071		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Saline Care Nursing Rehab

#0054478

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			313,541	313,541		313,541	(271,564)	41,977			30
31	Amortization of Pre-Op. & Org.							461	461			31
32	Interest			7,971	7,971		7,971	(67)	7,904			32
33	Real Estate Taxes			65,200	65,200		65,200	(11,588)	53,612			33
34	Rent-Facility & Grounds			790,621	790,621		790,621		790,621			34
35	Rent-Equipment & Vehicles			8,564	8,564		8,564	97	8,661			35
36	Other (specify):*											36
37	TOTAL Ownership			1,185,897	1,185,897		1,185,897	(282,661)	903,236			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			30	30		30		30			38
39	Ancillary Service Centers		66,624	457,237	523,861		523,861		523,861			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			295,010	295,010		295,010		295,010			42
43	Other (specify):* Disallowed Costs			200,101	200,101		200,101	(200,101)				43
44	TOTAL Special Cost Centers		66,624	952,378	1,019,002		1,019,002	(200,101)	818,901			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,175,878	489,283	3,313,351	6,978,512		6,978,512	(730,304)	6,248,208			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,429)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(296,452)	30		9
10	Interest and Other Investment Income	(167)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(452)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,436)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,020)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(166,724)	43		24
25	Fund Raising, Advertising and Promotional	(22,393)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(30,864)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (531,937)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(198,367)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (198,367)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (730,304)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Saline Care Nursing Rehab

ID# 0054478

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gifts	\$ (103)	43	1
2	Miscellaneous income offset	(867)	21	2
3	Disallow Marketing Wages	(10,391)	21	3
4	Nonallowable RE Taxes	(12,333)	33	4
5	Expense Repairs under \$2,500	480	6	5
6	Capitalize Repairs over \$2,500	(7,650)	6	6
7				7
8				8
9				9
10				10
11				11
12				12
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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	(30,864)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Scott Stout	100	See Page 6 Supp		WLC Management Fir	Harrisburg	Management Co.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	3 Housekeeping	\$	WLC Management Firm, LLC	100.00%	\$ 953	\$ 953	1
2	V	5 Utilities		WLC Management Firm, LLC	100.00%	1,021	1,021	2
3	V	6 Maintenance		WLC Management Firm, LLC	100.00%	2,378	2,378	3
4	V	7 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	109	109	4
5	V	10 Nursing and Medical Records		WLC Management Firm, LLC	100.00%	2,169	2,169	5
6	V	15 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	249	249	6
7	V	17 Administrative	360,205	WLC Management Firm, LLC	100.00%	37,319	(322,886)	7
8	V	19 Professional Services		WLC Management Firm, LLC	100.00%	720	720	8
9	V	20 Dues, Fees, Subs & Prom		WLC Management Firm, LLC	100.00%	546	546	9
10	V	21 Clerical & General Office		WLC Management Firm, LLC	100.00%	74,678	74,678	10
11	V	24 Travel & Seminar		WLC Management Firm, LLC	100.00%	27	27	11
12	V	25 Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	1,419	1,419	12
13	V	26 Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	1,330	1,330	13
14	Total		\$ 360,205			\$ 122,918	\$ * (237,287)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	27 Mgmt Allocation of Benefits	\$	WLC Management Firm, LLC	100.00%	\$ 12,629	\$	12,629	15
16	V	30 Depreciation		WLC Management Firm, LLC	100.00%	24,888		24,888	16
17	V	31 Amortization		WLC Management Firm, LLC	100.00%	461		461	17
18	V	32 Interest		WLC Management Firm, LLC	100.00%	100		100	18
19	V	33 Real Estate Taxes		WLC Management Firm, LLC	100.00%	745		745	19
20	V	35 Equipment Rental		WLC Management Firm, LLC	100.00%	97		97	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		\$			\$ 38,920	\$ *	38,920	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Saline Care Nursing Rehab

0054478

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			Alhambra Rehab and Healthcare	Alhambra	Acorn Estates	Mount Carmel	Supportive Living	1
2			Carrier Mills Nursing & Rehab Center	Carrier Mills				2
3			Duquoin Nursing & Rehabilitation Center	Duquoin				3
4			Eldorado Rehab and Healthcare	Eldorado				4
5			Fairview Rehab and Healthcare	DuQuoin				5
6			Greenville Nursing and Rehab Center	Greenville				6
7			Heartland Nursing and Rehab	Casey				7
8			Oakview Nursing and Rehab	Mt Carmel				8
9			Pinckneyville Nursing & Rehab Center	Pinckneyville				9
10			Stonebridge Nursing and Rehab Center	Benton				10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
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24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Saline Care Nursing Rehab

0054478

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Stout	Stockholder	Administrative	100.00	See Att Sch 7A	5.96	14.90	Alloc. Salary	\$ 37,319	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 37,319		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing Rehab

0054478

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization WLC Management Firm, LLC
 Street Address 215 East Locust Street
 City / State / Zip Code Harrisburg, IL 62946
 Phone Number (618) 294-8696
 Fax Number (618) 294-8699

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Weightd Avg Census 240,729	12	\$ 6,399	\$ 6,399	35,865	\$ 953	1
2	5	Utilities	Weightd Avg Census 240,729	12	6,853		35,865	1,021	2
3	6	Maintenance	Weightd Avg Census 240,729	12	15,959		35,865	2,378	3
4	7	Mgmt Allocation of Benefits	Weightd Avg Census 240,729	12	734		35,865	109	4
5	10	Nursing and Medical Records	Weightd Avg Census 240,729	12	14,557	14,557	35,865	2,169	5
6	15	Mgmt Allocation of Benefits	Weightd Avg Census 240,729	12	1,669		35,865	249	6
7	17	Administrative	Weightd Avg Census 240,729	12	250,490	250,490	35,865	37,319	7
8	19	Professional Services	Weightd Avg Census 240,729	12	4,836		35,865	720	8
9	20	Dues, Fees, Subscriptions & Prom	Weightd Avg Census 240,729	12	3,667		35,865	546	9
10	21	Clerical & General Office	Weightd Avg Census 240,729	12	501,243	488,721	35,865	74,678	10
11	24	Travel & Seminar	Weightd Avg Census 240,729	12	179		35,865	27	11
12	25	Other Admin Staff Transport	Weightd Avg Census 240,729	12	9,524		35,865	1,419	12
13	26	Insurance-Prop/Liab/Malprac	Weightd Avg Census 240,729	12	8,930		35,865	1,330	13
14	27	Mgmt Allocation of Benefits	Weightd Avg Census 240,729	12	84,770		35,865	12,629	14
15	30	Depreciation	Weightd Avg Census 240,729	12	167,061		35,865	24,888	15
16	31	Amortization	Weightd Avg Census 240,729	12	3,096		35,865	461	16
17	32	Interest	Weightd Avg Census 240,729	12	673		35,865	100	17
18	33	Real Estate Taxes	Weightd Avg Census 240,729	12	5,000		35,865	745	18
19	35	Equipment Rental	Weightd Avg Census 240,729	12	653		35,865	97	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,086,293	\$ 760,167		\$ 161,838	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Saline Care Nursing Rehab

0054478

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		7	8	9	10									
					Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES								NO	Original				Balance
A. Directly Facility Related																			
Long-Term																			
1						\$	\$			\$	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	Legence Bank		X	Line of Credit		11/27/19	65,000		6/30/21	4.7500	7,971	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 65,000	\$			\$ 7,971	9							
B. Non-Facility Related*																			
10												10							
11										Interest Income Offset	(167)	11							
12										WLC Mgmt Allocation	100	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (67)	14							
15	TOTALS (line 9+line14)						\$ 65,000	\$			\$ 7,904	15							

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

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

Facility Name & ID Number Saline Care Nursing Rehab# 0054478

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	52,705	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.)		2019	\$	52,867	2
3. Under or (over) accrual (line 2 minus line 1).			\$	162	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	52,705	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.		Allocation from Mgmt Co		745	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	745	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	53,612	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2015			8	
	2016	51,984		9	
	2017	52,626		10	
	2018	53,439		11	
	2019	52,867		12	
<u>Accrual based on prior year tax bill.</u>					
FOR BHF USE ONLY					
	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Saline Care Nursing Rehab COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0054478

CONTACT PERSON REGARDING THIS REPORT Scott Stout

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>06-1-098-06</u>	<u>Long Term Care Property</u>	\$ <u>20,434.46</u>	\$ <u>20,434.46</u>
2. <u>06-1-098-01</u>	<u>Long Term Care Property</u>	\$ <u>32,433.04</u>	\$ <u>32,433.04</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>52,867.50</u></u>	\$ <u><u>52,867.50</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach 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.**

Facility Name & ID Number Saline Care Nursing Rehab

0054478 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: Allocation from Mgmt Co 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 461 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Use, Square Feet, Year Acquired, Cost, 1. Row 2: Use, Square Feet, Year Acquired, Cost, 2. Row 3: TOTALS, Square Feet, Year Acquired, Cost, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Replace Water Heater		2018	5,920		20	296	296	740
10	Install Compressor for PT Room		2018	3,275		20	164	164	410
11	Offices/ Hallways/ Bath and Breakroom/Kitchen - Remove								
12	Wallcoverings, Repair Walls, Paint, New Window Treatments		2018	19,112		20	956	956	2,390
13	Facility Remodel:								
14	Resident Rms/Beauty Shop/Therapy Rm/Dining Rm/Admin								
15	Offices/Hallways/Lounges/Library/Conference Rm/Bathrooms -								
16	Remove Wallcoverings, Repair, Patch and Replace Drywall,								
17	Prime and Paint Walls and Doors								
18	Replace Flooring Throughout								
19	Relocate Sprinkler Heads								
20	Electrical/Recessed Lighting								
21	Plumbing Repairs								
22	Guardrails and Handrails		2019	377,158		20	18,858	18,858	28,287
23	Install Settlement Piers		2019	41,169		20	2,058	2,058	3,087
24	7.5 Ton Electric Furnace/Condensor/Compressor		2020	13,650		20	341	341	341
25	Facility Remodel Continued:								
26	Resident Rms/Beauty Shop/Therapy Rm/Dining Rm/Admin								
27	Offices/Hallways/Lounges/Library/Conference Rm/Bathrooms -								
28	Remove Wallcoverings, Repair, Patch and Replace Drywall,								
29	Prime and Paint Walls and Doors								
30	Replace Flooring Throughout								
31	Relocate Sprinkler Heads								
32	Electrical/Recessed Lighting								
33	Plumbing Repairs								
34	Guardrails and Handrails								
35	Replace AC Wall Units		2020	142,366		20	3,559	3,559	3,559
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Install New Roof - Non Mansard Section	2020	\$ 105,000	\$	20	\$ 2,625	\$ 2,625	\$ 2,625	37
38	Install New Roof - Mansard Section	2020	22,500		20	563	563	563	38
39	New Blinds/Window Treatments	2020	8,100		20	203	203	203	39
40									40
41									41
42									42
43									43
44									44
45									45
46	Allocated from WLC Management	2018	55,415		15-39	2,361	2,361	26,161	46
47	Allocated from WLC Management	2020	19,382		15	646	646	646	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57	Financial Statement Depreciation			313,541			(313,541)		57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 813,047	\$ 313,541		\$ 32,630	\$ (280,911)	\$ 69,012	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 14,201	\$	\$ 1,420	\$ 1,420	10 yrs	\$ 3,601	71
72	Current Year Purchases	20,937		1,047	1,047	10 yrs	1,047	72
73	Fully Depreciated Assets							73
74	Allocated from WLC Mgmt	664					664	74
75	TOTALS	\$ 35,802	\$	\$ 2,467	\$ 2,467		\$ 5,312	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78	Allocated from WLC Mgmt			34,045		6,880	6,880		34,045	78
79										79
80	TOTALS			\$ 34,045	\$	\$ 6,880	\$ 6,880		\$ 34,045	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)	\$ 882,894	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 313,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,977	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (271,564)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 108,369	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing Rehab

0054478

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1969</u>	<u>124</u>	<u>2/17/17</u>	\$ <u>790,621</u>			3
4	Additions	<u>1992</u>	<u>18</u>					4
5								5
6								6
7	TOTAL		142		\$ 790,621			7

10. Effective dates of current rental agreement:

Beginning 2/1/19

Ending 1/31/34

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

Fiscal Year Ending Annual Rent

12.	<u>1/31/2021</u>	\$ <u>792,096</u>
13.	<u>1/31/2022</u>	\$ <u>802,884</u>
14.	<u>1/31/2023</u>	\$ <u>828,978</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A

N/A

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,661 Description: Medical Equipment \$8,325; Dietary Equipment \$69; Office Equipment \$170; HO Allocation \$97

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3), 39(3)	hrs	\$	6,899	\$ 168,629	\$	6,899	\$ 168,629	1
2	Licensed Speech and Language Development Therapist	10A(3), 39(3)	hrs		2,926	90,017		2,926	90,017	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3), 39(3)	hrs		7,857	179,860		7,857	179,860	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				66,624		66,624	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	17,682	\$ 438,506	\$ 66,624	17,682	\$ 505,130	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing Rehab

0054478

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 341,091	\$ 341,091	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,204)	2,073,497	2,073,497	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,471	16,471	6
7	Other Prepaid Expenses	100,183	100,183	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,531,242	\$ 2,531,242	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	742,909	813,047	15
16	Equipment, at Historical Cost	14,201	69,847	16
17	Accumulated Depreciation (book methods)	(756,347)	(108,369)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 763	\$ 774,525	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,532,005	\$ 3,305,767	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 22,548	\$ 22,548	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,187	86,187	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,731	20,731	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,705	52,705	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	3,007	3,007	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 185,178	\$ 185,178	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	1,242,308	1,242,308	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,242,308	\$ 1,242,308	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,427,486	\$ 1,427,486	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,104,519	\$ 1,878,281	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,532,005	\$ 3,305,767	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 884,112	1
2	Restatements (describe):		2
3	Prior Period Adjustment - Depreciation	(372,216)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 511,896	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	636,035	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	(43,412)	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)	\$ 592,623	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,104,519	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Saline Care Nursing Rehab

0054478

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,771,121	1
2	Discounts and Allowances for all Levels	1,300,577	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,071,698	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	221,301	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 221,301	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	307,610	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,231	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	337	19
20	Radiology and X-Ray		20
21	Other Medical Services	(859)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 311,319	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	167	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 167	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	867	28
28a	<u>PY Depreciation Adjustment</u>	9,195	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,062	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,614,547	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,189,340	31
32	Health Care	2,431,972	32
33	General Administration	1,152,301	33
B. Capital Expense			
34	Ownership	1,185,897	34
C. Ancillary Expense			
35	Special Cost Centers	723,992	35
36	Provider Participation Fee	295,010	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,978,512	40
41	Income before Income Taxes (line 30 minus line 40)**	636,035	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 636,035	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 4,280,817	44
45	Private Pay - Net Inpatient Revenue	513,698	45
46	Medicare - Net Inpatient Revenue	2,208,085	46
47	Other-(specify) <u>Insurance</u>	69,098	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,071,698	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

0054478

Report Period Beginning: **1/1/2020**

Ending:

12/31/2020

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	1,707	1,795	\$ 65,193	\$ 36.32	1
2	Assistant Director of Nursing	1,424	1,456	45,540	31.28	2
3	Registered Nurses	14,129	14,696	467,828	31.83	3
4	Licensed Practical Nurses	22,373	23,947	550,353	22.98	4
5	CNAs & Orderlies	64,756	67,899	1,019,063	15.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,086	1,099	16,869	15.35	9
10	Activity Assistants	5,222	5,358	55,079	10.28	10
11	Social Service Workers	2,810	2,846	45,242	15.90	11
12	Dietician					12
13	Food Service Supervisor	2,165	2,310	33,140	14.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,295	26,420	274,797	10.40	15
16	Dishwashers					16
17	Maintenance Workers	5,583	5,837	110,744	18.97	17
18	Housekeepers	16,142	17,228	180,742	10.49	18
19	Laundry	8,343	8,888	99,381	11.18	19
20	Administrator	2,179	2,366	86,981	36.76	20
21	Assistant Administrator	2,074	2,114	34,753	16.44	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,954	7,390	90,173	12.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,242	191,649	\$ 3,175,878 *	\$ 16.57	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	144	\$ 6,992	L1, C3	35
36	Medical Director	Monthly	7,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,600	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,796	L11, C3	44
45	Social Service Consultant	61	3,283	L12, C3	45
46	Other(specify) <u>Psychiatric</u>	Monthly	5,500	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	236	\$ 27,671		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Saline Care Nursing Rehab

0054478

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jason Powell	Administrator	0	\$ 10,391	Workers' Compensation Insurance	\$ 61,232	IDPH License Fee	\$	
Steve Marlow	Administrator	0	62,567	Unemployment Compensation Insurance	17,356	Advertising: Employee Recruitment	649	
Whitney Roberts	Asst Admin	0	15,262	FICA Taxes	236,553	Health Care Worker Background Check		
June Greene	Asst Admin	0	19,491	Employee Health Insurance	12,799	(Indicate # of checks performed 60)	3,906	
Merle Taylor	Admin Reg Exec	0	13,123	Employee Meals	819	Patient Background Checks	2,109	
Lon Linder	VP Operations	0	900	Illinois Municipal Retirement Fund (IMRF)*		License & Permits	610	
				Employee Physicals/Drug Tests	5,110	Dues & Subscriptions	2,900	
				Life/Disability Insurance	4,533	IHCA	10,224	
				Other Employee Benefits	(186)			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 121,734					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 360,205					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 360,205					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Solutions, Inc.	Health Info Management		\$ 1,450			\$	Out-of-State Travel	\$
American Healthtech	LTC Software		12,140					
Information Controls	Payroll Service		4,734					
Prime Care Technologies	Computer Services		3,790				In-State Travel	
Templin Healthcare Accounting	Accounting Services		4,980					
Kemper CPA Group	Accounting Services		2,115					
Sandberg Phoenix & Von Gontard	Legal Services		3,732				Seminar Expense	2,115
							Allocated From WLC Mgmt Firm	27
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 32,941				TOTAL	\$ 2,142

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Saline Care Nursing Rehab

0054478

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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. 10,224 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 810 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 295,010
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. \$ 819 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' PREPARATION REPORT