

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0044057</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Salem Village Nursing</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1314 Rowell Ave</u> <u>Joliet</u> <u>60433</u>																									
Number City Zip Code																									
County: <u>Will</u>																									
Telephone Number: <u>(815) 727-5451</u> Fax # <u>(815) 727-9413</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Cary Drazner, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Cary Drazner, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>												
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	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																								
Date of Initial License for Current Owners: <u>08/31/98</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Salem Village Nursing

0044057 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	<u>230</u>	Skilled (SNF)	<u>230</u>	<u>84,180</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>36</u>	Intermediate (ICF)	<u>36</u>	<u>13,176</u>	3
4		Intermediate/DD			4
5	<u>6</u>	Sheltered Care (SC)	<u>6</u>	<u>2,196</u>	5
6		ICF/DD 16 or Less			6
7	<u>272</u>	TOTALS	<u>272</u>	<u>99,552</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>16,716</u>	<u>16,716</u>	8
9	SNF/PED					9
10	ICF	<u>41,518</u>	<u>6,092</u>	<u>340</u>	<u>47,950</u>	10
11	ICF/DD					11
12	SC	<u>10,444</u>	<u>1,844</u>	<u>127</u>	<u>12,415</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>51,962</u>	<u>7,936</u>	<u>17,183</u>	<u>77,081</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.43%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

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 08/31/98

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 8/31/98 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 230 and days of care provided 12,686

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

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

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	466,330	157,995	26,649	650,974		650,974		650,974			1
2	Food Purchase		478,483		478,483		478,483	(1,543)	476,940			2
3	Housekeeping	478,592	118,436		597,028		597,028		597,028			3
4	Laundry	188,020	131,290		319,310		319,310		319,310			4
5	Heat and Other Utilities			300,953	300,953		300,953	(24,337)	276,616			5
6	Maintenance	139,869	150,938	249,464	540,271		540,271	50,097	590,368			6
7	Other (specify):*											7
8	TOTAL General Services	1,272,811	1,037,142	577,066	2,887,019		2,887,019	24,217	2,911,236			8
	B. Health Care and Programs											
9	Medical Director			27,500	27,500		27,500		27,500			9
10	Nursing and Medical Records	4,478,817	499,447	19,617	4,997,881		4,997,881	(980)	4,996,901			10
10a	Therapy	186,604		84,644	271,248		271,248		271,248			10a
11	Activities	233,867	15,668		249,535		249,535		249,535			11
12	Social Services	132,936		14,255	147,191		147,191		147,191			12
13	CNA Training											13
14	Program Transportation			23,939	23,939		23,939		23,939			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,032,224	515,115	169,955	5,717,294		5,717,294	(980)	5,716,314			16
	C. General Administration											
17	Administrative	163,924		164,000	327,924		327,924	15,776	343,700			17
18	Directors Fees											18
19	Professional Services			739,473	739,473		739,473	(453,531)	285,942			19
20	Dues, Fees, Subscriptions & Promotions			133,954	133,954		133,954	(100,708)	33,246			20
21	Clerical & General Office Expenses	351,006	60,695	453,171	864,872		864,872	(165,286)	699,586			21
22	Employee Benefits & Payroll Taxes			1,533,094	1,533,094		1,533,094		1,533,094			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,396	1,396		1,396	248	1,644			24
25	Other Admin. Staff Transportation			46,107	46,107		46,107	4,029	50,136			25
26	Insurance-Prop.Liab.Malpractice			408,234	408,234		408,234	304	408,538			26
27	Other (specify):*							27,920	27,920			27
28	TOTAL General Administration	514,930	60,695	3,479,429	4,055,054		4,055,054	(671,248)	3,383,806			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,819,965	1,612,952	4,226,450	12,659,367		12,659,367	(648,011)	12,011,356			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			323,500	323,500		323,500	388,132	711,632			30
31	Amortization of Pre-Op. & Org.							0	0			31
32	Interest			8,262	8,262		8,262	377,833	386,095			32
33	Real Estate Taxes			145,821	145,821		145,821		145,821			33
34	Rent-Facility & Grounds			1,150,000	1,150,000		1,150,000	(1,131,934)	18,066			34
35	Rent-Equipment & Vehicles			51,476	51,476		51,476	(31,612)	19,864			35
36	Other (specify):*											36
37	TOTAL Ownership			1,679,059	1,679,059		1,679,059	(397,581)	1,281,478			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		838,879	1,892,854	2,731,733		2,731,733		2,731,733			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,215	1,215		1,215		1,215			41
42	Provider Participation Fee			537,405	537,405		537,405		537,405			42
43	Other (specify):*	97,779		184,000	281,779		281,779	(281,778)	1			43
44	TOTAL Special Cost Centers	97,779	838,879	2,615,474	3,552,132		3,552,132	(281,778)	3,270,354			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,917,744	2,451,831	8,520,983	17,890,558		17,890,558	(1,327,369)	16,563,189			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(24,337)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	187,710	30		9
10	Interest and Other Investment Income	(10,357)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(493)	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	(600)	21		18
19	Entertainment	(15,254)	21		19
20	Contributions	(20,300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(263,658)	21		24
25	Fund Raising, Advertising and Promotional	(80,830)	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	(368,963)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (597,081)		\$	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)	(730,288)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (730,288)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,327,369)		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

ID#

0044057

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medical Records	\$ (980)	10	1
2	Vendor Income	(1,050)	02	2
3	Rental Income	(80)	06	3
4	Lost Items	(161)	21	4
5	Marketing Salary	(97,778)	43	5
6	Bank Service Charges	(13,580)	21	6
7	Collections	(4,477)	21	7
8	Late Fees	(4,483)	21	8
9	Taxes	(16,088)	21	9
10	Miscellaneous Income	(28,304)	21	10
11	Amortization - Bldg. Co.	(9,688)	31	11
12	Replacement Tax - Bldg. Co.	(298)	21	12
13	Non-Allowable Fees	(184,000)	43	13
14	Non- Allowable Auto Lease	(34,934)	35	14
15	Non-Allowable Legal	(14,027)	19	15
16	Noncare Depreciation	(6,492)	30	16
17	Additional R&M	47,852	06	17
18	Non-Allowable Renewal Fees	(396)	20	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(368,963)		49

ID#0044057

Report Period Beginning:01/01/12

Ending:12/31/12

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
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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			49

Summary A

12/31/12

[illegible]

Summary B

Facility Name & ID Number	Salem Village Nursing	#	0044057	Report Period Beginning:	01/01/12	Ending:	12/31/12
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,150,000	Salem Village Property, LLC	100.00%	\$	\$ (1,150,000)	1
2	V	32	Interest Income	2,905	Salem Village Property, LLC	100.00%		(2,905)	2
3	V	30	Depreciation		Salem Village Property, LLC	100.00%	205,674	205,674	3
4	V	31	Amortization		Salem Village Property, LLC	100.00%	9,688	9,688	4
5	V	32	Mortgage Interest Expense		Salem Village Property, LLC	100.00%	390,489	390,489	5
6	V	21	Replacement Taxes		Salem Village Property, LLC	100.00%	298	298	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,152,905			\$ 606,149	\$ * (546,756)	14

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

SEE ACCOUNTANTS' COMPILATION 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	6	REPAIRS & MAINTENANCE	\$	HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	\$ 2,325	\$ 2,325	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	6,725	6,725	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	818	818	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	22,512	22,512	18
19	V	24	SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	248	248	19
20	V	25	TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,029	4,029	20
21	V	26	INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	304	304	21
22	V	30	DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,240	1,240	22
23	V	32	INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	606	606	23
24	V	34	OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	18,066	18,066	24
25	V	35	EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	3,322	3,322	25
26	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	112,137	112,137	26
27	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	21,947	21,947	27
28	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	15,776	15,776	28
29	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,533	1,533	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	46,669	46,669	32
33	V	27	EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,440	4,440	33
34	V								34
35	V	19	BOOKEEPING SERVICES	446,229				(446,229)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 446,229			\$ 262,697	\$ * (183,532)	39

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	39	THERAPY	\$ 230,255	TOWN AND COUNTRY REHAB., LLC	100.00%	\$ 230,255	\$	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			\$ 230,255			\$ 230,255	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION 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			\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION 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			\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION 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			\$			\$	\$	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

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

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

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.

SEE ACCOUNTANTS' COMPILATION 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			\$			\$	\$	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

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	5.000%	ADVANCED NURSING AND REHABILITATION CENTER, LLC	NEW HAVEN, CT	SALEM VILLAGE PROPERTIES	JOLIET	BUILDING CO.	1
2	DANIEL ROTHNER ACCUMULATION	5.000%	CORI MANOR	ST. LOUIS MO.	HEALTHCARE ACCOUNTING S	ST. LOUIS MO.	BOOKEEPING/FINANCIAL	2
3	KATHRYN VALES ACCUMULATION	5.000%	ELMWOOD NURSING & REHABILITATION CENTER, L.L.C.	MARYVILLE	TOWN AND COUNTRY REHAB.,	CHESTERFIELD, MO	THERAPY CO.	3
4	KIMBERLY RICHMAN ACCUMULATION	5.000%	GRAND MANOR NURSING AND REHAB	ST. LOUIS MO.				4
5	MAKHLOUF & LORRAINE SUISSA	45.000%	NORTHVIEW VILLAGE	ST. LOUIS MO.				5
6	MELISSA ROTHNER ACCUMULATION	5.000%	THE CEDARS OF TOWN AND COUNTRY	CHESTERFIELD, MO				6
7	NATHAN & SHIRLEY ROTHNER	10.000%						7
8	RACHEL ROTHNER ACCUMULATION	5.000%						8
9	SHOSHANA ARYEH	10.000%						9
10	WILLIAM ROTHNER ACCUMULATION	5.000%						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

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

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	Mark Suissa	Owner	Administrative	45.00	See Attached	11.83	19.72%	Alloc. Sal/Fee	\$ 119,776	17-3/17-7	1
2	Lorraine Suissa	Relative	Administrative	N/A	N/A	10	100.00%	Salary	36,939	17-1	2
3	David Aryeh	Relative	Administrative	N/A	See Attached	5	14.29%	Mgmt Fee	60,000	17-3	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	\$ 216,715		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

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS & MAINTENANCE	ILL, CT & MO. PAT. DAYS	389,781	6	\$ 11,789	\$	76,866	\$ 2,325	1
2	19	PROFESSIONAL FEES	ILL, CT & MO. PAT. DAYS	389,781	6	34,101		76,866	6,725	2
3	20	DUES, SUBSCRIPTIONS	ILL, CT & MO. PAT. DAYS	389,781	6	4,149		76,866	818	3
4	21	CLERICAL & GENERAL	ILL, CT & MO. PAT. DAYS	389,781	6	114,154		76,866	22,512	4
5	24	SEMINAR	ILL, CT & MO. PAT. DAYS	389,781	6	1,257		76,866	248	5
6	25	TRAVEL	ILL, CT & MO. PAT. DAYS	389,781	6	20,432		76,866	4,029	6
7	26	INSURANCE	ILL, CT & MO. PAT. DAYS	389,781	6	1,544		76,866	304	7
8	30	DEPRECIATION	ILL, CT & MO. PAT. DAYS	389,781	6	6,287		76,866	1,240	8
9	32	INTEREST	ILL, CT & MO. PAT. DAYS	389,781	6	3,073		76,866	606	9
10	34	OFFICE SPACE	ILL, CT & MO. PAT. DAYS	389,781	6	91,613		76,866	18,066	10
11	35	EQUIPMENT RENTAL	ILL, CT & MO. PAT. DAYS	389,781	6	16,845		76,866	3,322	11
12	21	CLERICAL SALARIES	ILL, CT & MO. PAT. DAYS	389,781	6	568,636	568,636	76,866	112,137	12
13	27	EMP. BEN. GEN. & ADMIN.	ILL, CT & MO. PAT. DAYS	389,781	6	111,290		76,866	21,947	13
14	17	ADMIN. SALARY - M. SUISSA	ILL, CT & MO. PAT. DAYS	389,781	6	80,000	80,000	76,866	15,776	14
15	27	EMP. BEN.-M. SUISSA	ILL, CT & MO. PAT. DAYS	389,781	6	7,772		76,866	1,533	15
16						-				16
17						-				17
18	21	CLERICAL SALARIES	IL PAT.DAYS	99,282	2	60,279	60,279	76,866	46,669	18
19	27	EMPLOYEE BEN. GEN. & ADM	IL PAT.DAYS	99,282	2	5,734		76,866	4,440	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,138,955	\$ 708,915		\$ 262,697	25

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization	<u>TOWN AND COUNTRY REHAB., LLC</u>
Street Address	<u>13190 S. OUTER FORTY ROAD</u>
City / State / Zip Code	<u>CHESTERFIELD, MO 63017-5917</u>
Phone Number	<u>(314) 434-3330</u>
Fax Number	<u>(314) 434-9179</u>

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	THERAPY	DIRECT			\$	\$		\$ 230,255	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					\$	\$		\$ 230,255	25

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	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						\$	\$			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

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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

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	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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

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

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

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

	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						\$	\$			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

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

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	Chase Bank		X	Mortgage			\$				\$	276,149	1
2	Bank Popular -4616		X	Mortgage				6,000,000		1.5000		13,250	2
3	Bank Popular -4568		X	Note Payable				13,939,352		4.8200		101,090	3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Omnicare		X	Note Payable				232,656				8,262	6
7	Alloc. Health Care Accounting	X										606	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	20,172,008			\$	399,357	9
	B. Non-Facility Related*												
10	Interest Income		X									(10,357)	10
11	Interest Income - Bldg. Co.											(2,905)	11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(13,262)	14
15	TOTALS (line 9+line14)						\$	20,172,008			\$	386,095	15

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		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
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	127,874	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.)				\$	133,510	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	5,636	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	140,186	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.				\$	145,822	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:		2007	107,254	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
	2008	108,442	9																							
	2009	112,438	10																							
	2010	121,960	11																							
	2011	133,510	12																							
2012 Accrual = \$133,510 x 1.05 = \$140,186																										

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME Salem Village Nursing COUNTY Will

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)		(C)		(D)	
<u>Tax Index Number</u>		<u>Property Description</u>		<u>Total Tax</u>		<u>Tax Applicable to Nursing Home</u>	
1.	<u>30-07-23-304-011-0000</u>	<u>Long Term Care Property</u>		\$	<u>132,678.22</u>	\$	<u>132,678.22</u>
2.	<u>30-07-23-304-007-0000</u>	<u>Long Term Care Property</u>		\$	<u>190.46</u>	\$	<u>190.46</u>
3.	<u>30-07-23-304-010-0000</u>	<u>Long Term Care Property</u>		\$	<u>641.32</u>	\$	<u>641.32</u>
4.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
5.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
6.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
7.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
8.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
9.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
10.	<u></u>	<u></u>		\$	<u></u>	\$	<u></u>
TOTALS				\$	<u><u>133,510.00</u></u>	\$	<u><u>133,510.00</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? X YES NO

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nursing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

☒

(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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION 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	204		1998	1976	\$ 8,021,280	\$ 205,674	35	\$ 401,064	\$ 195,390	\$ 5,748,584
5										
6										
7										
8										
	Improvement Type**									
9	Various		1998		108,515		20	5,426	5,426	77,077
10	Various		1999		240,599		20	11,864	11,864	159,400
11	Various		2000		193,202		20	9,660	9,660	123,459
12	Various		2001		97,999		20	4,689	4,689	58,814
13	Various		2002		88,413		20	3,644	3,644	85,098
14	Various		2003		45,533		20	2,805	2,805	41,557
15	Various		2004		113,428		20	7,918	7,918	94,498
16	Various		2005		141,584		20	5,918	5,918	109,606
17	Various		2006		207,635		20	21,424	21,424	152,241
18	Various		2007		18,325		20	1,605	1,605	10,026
19	Various		2008		92,767		20	12,676	12,676	55,389
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			317,008			(317,008)		69
70	TOTAL (lines 4 thru 69)		\$ 9,369,281	\$ 522,682		\$ 488,693	\$ (33,989)	\$ 6,715,749	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing

0044057

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,369,281	\$ 522,682		\$ 488,693	\$ (33,989)	\$ 6,715,749	1
2	<u>Dock Door</u>	2009	5,148		20	515	515	1,973	2
3	<u>Flooring</u>	2009	9,476		20	632	632	2,316	3
4	<u>Modifications To Fire Pump</u>	2009	8,659		20	1,237	1,237	4,433	4
5	<u>Evaporator Coil</u>	2009	2,680		20	268	268	938	5
6	<u>Fire Pump</u>	2009	7,300		20	1,043	1,043	3,650	6
7	<u>Kitchen Floor Drain</u>	2009	6,417		20	642	642	2,246	7
8	<u>Flooring</u>	2009	5,985		20	399	399	1,397	8
9	<u>Switches And Valve</u>	2009	5,163		20	738	738	2,520	9
10	<u>Water Cooler Condesor</u>	2009	7,150		20	715	715	2,443	10
11	<u>Water Heater</u>	2009	3,971		20	331	331	1,103	11
12	<u>Water Heater</u>	2009	4,069		20	339	339	1,130	12
13	<u>Tile Flooring</u>	2009	2,700		20	180	180	555	13
14	<u>A/C Repair</u>	2009	3,458		20	173	173	620	14
15	<u>90 Heating/Cooling Units (Parial Pmt 1)</u>	2010	35,820		20	5,117	5,117	15,351	15
16	<u>90 Heating/Cooling Units (Parial Pmt 2)</u>	2010	8,010		20	1,144	1,144	3,433	16
17	<u>3 Zoneline Heating/Cooling Units</u>	2010	4,820		20	689	689	2,066	17
18	<u>6 Heating/Cooling Units</u>	2010	3,384		20	484	484	1,451	18
19	<u>Heat/Ac Circuits, Upgrading Circuits For Coffee Maker, Coffee M</u>	2010	4,435		20	887	887	2,513	19
20	<u>Replace 10 Showers</u>	2010	25,060		20	2,506	2,506	7,100	20
21	<u>Kitchen Doors</u>	2010	5,593		20	559	559	1,585	21
22	<u>Tile Flooring</u>	2010	6,855		20	457	457	1,295	22
23	<u>Parking Lot</u>	2010	72,675		20	7,268	7,268	19,986	23
24	<u>Sunken Garden</u>	2010	12,000		20	1,200	1,200	3,300	24
25	<u>Repair & Paint Drywall In 29 Rooms</u>	2010	11,600		20	1,160	1,160	3,093	25
26	<u>509' Privacy Curtain</u>	2010	5,082		20	1,016	1,016	2,626	26
27	<u>Repair/Overhaul Of Radiator</u>	2010	5,371		20	448	448	1,156	27
28	<u>Drywall Exposed Beams</u>	2010	4,760		20	476	476	1,190	28
29	<u>Install 4 Sprinkler Heads</u>	2010	2,675		20	382	382	955	29
30	<u>Install Fire Alarm Devices</u>	2010	14,080		20	2,011	2,011	5,028	30
31	<u>Installation Of New Floor In Dining Room</u>	2010	20,661		20	1,377	1,377	3,214	31
32	<u>275" Privacy Curtain</u>	2010	2,744		20	549	549	1,280	32
33	<u>Cafeteria Opening #1</u>	2010	5,617		20	562	562	1,264	33
34	TOTAL (lines 1 thru 33)		\$ 9,692,698	\$ 522,682		\$ 524,195	\$ 1,513	\$ 6,818,959	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing

0044057

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,692,698	\$ 522,682		\$ 524,195	\$ 1,513	\$ 6,818,959	1
2	Cafeteria Opening #2	2010	4,934		20	493	493	1,110	2
3	Replaced Exhaust Fan	2010	4,837		20	322	322	725	3
4	Carpet Conference Room, Hall, Offices	2010	4,675		20	668	668	1,503	4
5	Door Security (Keypad, Locks, Etc.)	2010	4,900		20	700	700	1,633	5
6	Drywall Repair And Painting.	2010	5,800		20	580	580	1,450	6
7	3Rd Floor Cabinetry	2011	19,793		20	1,979	1,979	3,959	7
8	Dining Room, Bathrooms Trim And Millwork	2011	7,103		20	355	355	651	8
9	Dryer Ventilation	2011	6,959		20	696	696	1,160	9
10	Walk Out Patio	2011	3,938		20	263	263	438	10
11	Install Transformed On Roof And Addt'L Outlets	2011	19,750		20	1,975	1,975	3,292	11
12	3Rd Flr Corridor/Resident Rooms Remodel	2011	65,287		20	6,529	6,529	10,337	12
13	5Th Floor Corridor Sink, Various Trimwork	2011	2,834		20	283	283	449	13
14	Crashrails	2011	3,240		20	162	162	257	14
15	Accutech Alarm System	2011	5,682		20	812	812	1,353	15
16	Replaced Hot Water Tank	2011	11,864		20	1,186	1,186	1,681	16
17	Install Smoke Detectors	2011	5,125		20	732	732	1,037	17
18	Light Fixtures In Various Areas	2011	4,218		20	422	422	562	18
19	Water Softener	2011	3,188		20	319	319	425	19
20	Electrical, Plumbing, Heating Remodel	2011	64,005		20	6,401	6,401	8,534	20
21	Crown Moulding, Wallpaper 3Rd Floor	2011	18,004		20	900	900	1,200	21
22	Water Heater	2011	4,161		20	832	832	1,110	22
23	Room Signs	2011	3,470		20	347	347	434	23
24	3Rd Floor Handrail, Bumpers	2011	8,172		20	817	817	1,022	24
25	Vent Alarm/Paging System	2011	5,843		20	835	835	1,043	25
26	Smoke Detectors	2011	6,782		20	969	969	1,211	26
27	Handrails And Bumper Guards	2011	3,700		20	185	185	216	27
28	2 Concrete Slabs	2011	8,020		20	802	802	936	28
29	Wallpaper, Blinds, Drapes, Lighting - Includes Taxes	2011	22,903		20	19,085	19,085	22,903	29
30	Install 3 Flood Lights In Parking Lot	2011	3,425		20	343	343	371	30
31	Installed 19 Smoke Detectors	2011	4,498		20	643	643	696	31
32	Remove & Install New Radiator	2012	7,641		20	764	764	764	32
33	Custom Doors On 3Rd And 4Th Floors	2012	8,925		20	818	818	818	33
34	TOTAL (lines 1 thru 33)		\$ 10,046,373	\$ 522,682		\$ 576,412	\$ 53,730	\$ 6,892,237	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing

0044057

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,046,373	\$ 522,682		\$ 576,412	\$ 53,730	\$ 6,892,237	1
2	Flooring In 4Th Floor Resident Rooms	2012	32,821		20	2,970	2,970	2,970	2
3	New Doors On 3Rd & 4Th Floors	2012	4,645		20	387	387	387	3
4	New Windows	2012	15,045		20	1,139	1,139	1,139	4
5	Remodel Dishwashing Room	2012	11,945		20	796	796	796	5
6	Flood Lights On Outside Of Building	2012	2,540		20	212	212	212	6
7	Closet Organizers For 51 Resident Rooms	2012	16,737		20	697	697	697	7
8	Shaft Walls	2012	2,935		20	98	98	98	8
9	Room & Common Area Signs	2012	4,314		20	144	144	144	9
10	Centrifugal Roof Exhauster	2012	14,203		20	473	473	473	10
11	Concrete Gravel For The Sunken Garden	2012	10,800		20	270	270	270	11
12	Painting Work On 2Nd Floor	2012	5,225		20	131	131	131	12
13	Blinds For Resident Rooms On 4Th And 5Th Floors	2012	4,025		20	101	101	101	13
14	Door Materials For Parrish Construction Project	2012	4,829		20	121	121	121	14
15	Lighting Fixtures For Corridors	2012	2,853		20	95	95	95	15
16	4Th Floor Common Crown Moulding, Wallcoverings, Chair Rail /	2012	12,779		20	639	639	639	16
17	Plastering And Priming Basement Walls	2012	4,999		20	125	125	125	17
18	Install Flooring On 5Th Floor Common Areas	2012	34,640		20	866	866	866	18
19	Closet Organizers For Resident Rooms	2012	16,680		20	139	139	139	19
20	Ceiling Tiles	2012	3,037		20	152	152	152	20
21	Custom Handrail & Bumper Guard	2012	3,700		20	370	370	370	21
22	Vinyl Wood Plank Flooring For 4Th Floor Common Area	2012	3,055		20	280	280	280	22
23	Flooring In 1St Floor Alzheimers Unit	2012	21,780		20	1,269	1,269	1,269	23
24	4Th Floor Common Area Bumper Guards	2012	4,029		20	269	269	269	24
25	Resident Room Remodel	2012	2,815		20	94	94	94	25
26	Closet Doors Supplies	2012	4,840		20	161	161	161	26
27	1St Floor Handrails, Crown Moulding And Wallpaper	2012	9,402		20	1,138	1,138	1,138	27
28	4Th Floor Common Crown Moulding, Wallcoverings, Chair Rail /	2012	22,129		20	1,475	1,475	1,475	28
29	Work Completed On 1St Floor	2012	4,365		20	109	109	109	29
30	Correction To 2011 Medallion Services Invoices	2012	(20,487)		20	(2,049)	(2,049)	(2,049)	30
31	Bumper Guards On 1St And 3Rd Floor	2012	2,616		20	131	131	131	31
32	Corner Guards And Crash Rails	2012	3,979		20	199	199	199	32
33	New Windows	2012	9,855		20	493	493	493	33
34	TOTAL (lines 1 thru 33)		\$ 10,323,503	\$ 522,682		\$ 589,905	\$ 67,223	\$ 6,905,730	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Salem Village Nursing

0044057

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,323,503	\$ 522,682		\$ 589,905	\$ 67,223	\$ 6,905,730	1
2	Flooring 4Th Floor Hallway And Dining Room	2012	40,223		20	2,011	2,011	2,011	2
3	Installation Of Handrail On 1St Floor	2012	5,850		20	293	293	293	3
4	Wallcovering And Crown Molding On 1St Floor	2012	12,816		20	641	641	641	4
5	Installed 9 Electric Resistant Heating Units	2012	6,963		20	348	348	348	5
6	Hanging Doors & Header Installation	2012	2,970		20	149	149	149	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)		\$ 10,392,325	\$ 522,682		\$ 593,346	\$ 70,664	\$ 6,909,172	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 Information								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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Building Company Information Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Related Party Information Continued								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 (12H & 12I lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION 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	\$691,116	\$208	\$82,945	\$82,737	10	\$465,026	71
72	Current Year Purchases	219,279	1,032	26,641	25,609	10	26,641	72
73	Fully Depreciated Assets	1,397,049		38	38	10	1,397,049	73
74								74
75	TOTALS	\$2,307,444	\$1,240	\$109,624	\$108,384		\$1,888,716	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	\$	\$8,663	\$8,663	5	\$9,788	76
77										77
78										78
79										79
80	TOTALS			\$30,000	\$	\$8,663	\$8,663		\$9,788	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$13,137,769	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$523,922	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$711,632	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$187,710	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$8,807,675	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	\$6,492	\$25,968	86
87					87
88					88
89					89
90					90
91	TOTALS	\$39,141	\$6,492	\$25,968	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	Allocated from Healthcare Accounting Services				18,066			5
6								6
7	TOTAL				\$ 18,066			7

**

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

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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: \$ 14,435
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	GMAC Mountaineer	\$ 500.00	\$ 5,429	17
18					18
19					19
20					20
21	TOTAL		\$ 500.00	\$ 5,429	21

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$		\$ 728,157	\$		\$ 728,157	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			235,916			235,916	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			927,386			927,386	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				789,824		789,824	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,395	49,055		50,450	13
14	TOTAL			\$		\$ 1,892,854	\$ 838,879		\$ 2,731,733	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 362,203	\$ 7,293,662	1
2	Cash-Patient Deposits	77,364	77,364	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,454,303	5,454,303	3
4	Supply Inventory (priced at)	56,635	56,635	4
5	Short-Term Investments			5
6	Prepaid Insurance	64,680	64,680	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	721,739	721,739	8
9	Other(specify): See Attached Schedule	62,199	62,199	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,799,123	\$ 13,730,582	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		408,000	13
14	Buildings, at Historical Cost		8,021,280	14
15	Leasehold Improvements, at Historical Cost	2,386,101	2,386,101	15
16	Equipment, at Historical Cost	1,736,684	2,552,684	16
17	Accumulated Depreciation (book methods)	(2,486,862)	(6,250,854)	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 Schedule	650	281,588	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,636,573	\$ 7,398,799	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,435,696	\$ 21,129,381	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,702,618	\$ 6,702,619	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,594	75,594	28
29	Short-Term Notes Payable	232,656	1,204,084	29
30	Accrued Salaries Payable	461,223	461,223	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,625	33,625	31
32	Accrued Real Estate Taxes(Sch.IX-B)	140,186	140,186	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	25,000	25,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	245,606	(7,586,104)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,916,508	\$ 1,056,227	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		12,967,924	39
40	Mortgage Payable		6,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 18,967,924	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,916,508	\$ 20,024,151	46
47	TOTAL EQUITY(page 18, line 24)	\$ 519,188	\$ 1,105,230	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,435,696	\$ 21,129,381	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 288,967	1
2	Restatements (describe):		2
3	Rounding	7	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 288,974	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	930,214	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	(700,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 230,214	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)	\$ 519,188	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 17,760,193	1
2	Discounts and Allowances for all Levels	(3,928,652)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,831,541	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,195,541	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,195,541	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	80	16
17	Sale of Drugs	603,711	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	95,932	19
20	Radiology and X-Ray	41,352	20
21	Other Medical Services	11,924	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 752,999	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,357	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,357	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	30,334	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,334	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,820,772	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,887,019	31
32	Health Care	5,717,294	32
33	General Administration	4,055,054	33
	B. Capital Expense		
34	Ownership	1,679,059	34
	C. Ancillary Expense		
35	Special Cost Centers	3,014,727	35
36	Provider Participation Fee	537,405	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,890,558	40
41	Income before Income Taxes (line 30 minus line 40)**	930,214	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 930,214	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,377,400	44
45	Private Pay - Net Inpatient Revenue	1,564,601	45
46	Medicare - Net Inpatient Revenue	2,867,380	46
47	Other-(specify) HMO	520,698	47
48	Other-(specify) Hospice	501,462	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,831,541	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.

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	1,920	2,108	\$ 80,450	\$ 38.16	1
2	Assistant Director of Nursing	3,880	4,310	151,548	35.16	2
3	Registered Nurses	42,313	46,599	1,243,286	26.68	3
4	Licensed Practical Nurses	36,413	41,515	1,005,080	24.21	4
5	CNAs & Orderlies	136,518	156,288	1,938,887	12.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,372	14,228	186,604	13.12	8
9	Activity Director	3,808	4,259	52,902	12.42	9
10	Activity Assistants	19,346	20,194	180,965	8.96	10
11	Social Service Workers	7,406	8,273	132,936	16.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,762	42,639	466,330	10.94	15
16	Dishwashers					16
17	Maintenance Workers	11,628	12,670	139,869	11.04	17
18	Housekeepers	47,561	52,036	478,592	9.20	18
19	Laundry	16,686	18,168	188,020	10.35	19
20	Administrator	1,880	2,152	126,985	59.01	20
21	Assistant Administrator					21
22	Other Administrative	535	724	36,939	51.02	22
23	Office Manager					23
24	Clerical	14,183	15,900	351,006	22.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,814	4,251	59,566	14.01	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,923	4,447	97,778	21.99	33
34	TOTAL (lines 1 - 33)	402,948	450,761	\$ 6,917,743 *	\$ 15.35	34

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	Monthly	\$ 26,649	01-03	35
36	Medical Director	Monthly	27,500	09-03	36
37	Medical Records Consultant	Monthly	4,608	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,009	10-03	39
40	Physical Therapy Consultant	Monthly	37,885	10a-03	40
41	Occupational Therapy Consultant	Monthly	25,975	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	4,419	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	14,255	12-03	45
46	Other(specify)				46
47	Therapy Consultant	Monthly	16,365	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 172,665		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberSalem Village Nursing# 0044057Report Period Beginning:01/01/12Ending:12/31/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kelly Covarrubias	Administrator	0	\$ 126,984
Lorraine Suissa	Administrative	0	36,939
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 163,923

B. Administrative - Other

Description	Amount
Management Fees - Mark Suissa	\$ 104,000
Management Fees - David Aryeh	60,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	\$ 68,450
Healthcare Accounting Svcs.	Bookkeeping/Accounting	446,229
Honkamp, Krueger & Co	Accounting	731
Paychex	Payroll Processing	40,318
Personnel Planners	Unemployment Tax Cons.	3,503
Legat	Architectural Services	3,954
eHealth Data Solutions	Computer Services	4,680
American Data	Computer Services	3,546
National Data Care	Computer Services	3,456
Keane Care	Data Processing	229
See Attached	Legal	163,010
See Supplemental Schedule		1,369
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 739,474

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 253,819
Unemployment Compensation Insurance	131,116
FICA Taxes	529,008
Employee Health Insurance	603,511
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	189
Life Insurance	1,443
Dental Insurance	14,008
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	8,615
Health Care Worker Background Check (Indicate # of checks performed 143)	7,869
Patient Background Checks	200
Dues & Subscriptions	7,695
License & Fees	2,269
Allocated from Healthcare Accounting	818
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,396
Allocated from Healthcare Accounting	248
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,644

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$405
- (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. \$ 10,914 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. \$ 537,405
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT