

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0044057

Facility Name: Salem Village Nrsing & Rehab

Address: 1314 Rowell Avenue Joliet 60433
Number City Zip Code

County: Will

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

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) *
* Subject to the attached Accountants Consulting Report (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Salem Village Nrsing & Rehab

0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 <u>N/A</u>					
	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	272	TOTALS	272	99,552	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>32,724</u>	<u>6,534</u>	<u>27,875</u>	<u>67,133</u>	8
9	SNF/PED					9
10	ICF	<u>9,063</u>	<u>571</u>	<u>4,085</u>	<u>13,719</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,787	7,105	31,960	80,852	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.22%

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 8/31/1998

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 8/31/1998 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 8,975

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	551,202	108,023	28,412	687,637		687,637		687,637			1
2	Food Purchase		507,704		507,704		507,704	(2,677)	505,027			2
3	Housekeeping	456,783	92,923		549,706		549,706		549,706			3
4	Laundry	180,940	71,059		251,999		251,999		251,999			4
5	Heat and Other Utilities			298,853	298,853		298,853		298,853			5
6	Maintenance	165,707	30,962	240,417	437,086		437,086	33,112	470,198			6
7	Other (specify):*											7
8	TOTAL General Services	1,354,632	810,671	567,682	2,732,985		2,732,985	30,435	2,763,420			8
	B. Health Care and Programs											
9	Medical Director			84,000	84,000		84,000		84,000			9
10	Nursing and Medical Records	5,847,994	193,198	976,311	7,017,503		7,017,503	(5,708)	7,011,795			10
10a	Therapy	209,798			209,798		209,798		209,798			10a
11	Activities	236,706	33,033		269,739		269,739		269,739			11
12	Social Services	156,676		14,663	171,339		171,339		171,339			12
13	CNA Training											13
14	Program Transportation			11,517	11,517		11,517		11,517			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,451,174	226,231	1,086,491	7,763,896		7,763,896	(5,708)	7,758,188			16
	C. General Administration											
17	Administrative	243,351		120,000	363,351		363,351	22,437	385,788			17
18	Directors Fees											18
19	Professional Services			955,944	955,944		955,944	(468,761)	487,183			19
20	Dues, Fees, Subscriptions & Promotions			140,742	140,742		140,742	(59,850)	80,892			20
21	Clerical & General Office Expenses	588,040	98,548	1,407,898	2,094,486		2,094,486	(840,162)	1,254,324			21
22	Employee Benefits & Payroll Taxes			1,836,326	1,836,326		1,836,326		1,836,326			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,270	15,270		15,270	1,016	16,286			24
25	Other Admin. Staff Transportation			36,734	36,734		36,734	(6,184)	30,550			25
26	Insurance-Prop.Liab.Malpractice			434,756	434,756		434,756	(10,531)	424,225			26
27	Other (specify):*							50,418	50,418			27
28	TOTAL General Administration	831,391	98,548	4,947,670	5,877,609		5,877,609	(1,311,617)	4,565,992			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,637,197	1,135,450	6,601,843	16,374,490		16,374,490	(1,286,890)	15,087,600			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			413,029	413,029		413,029	393,946	806,975			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,369	31,369		31,369	766,239	797,608			32
33	Real Estate Taxes			170,708	170,708		170,708	361	171,069			33
34	Rent-Facility & Grounds			1,517,000	1,517,000		1,517,000	(1,459,249)	57,751			34
35	Rent-Equipment & Vehicles			60,869	60,869		60,869	(23,249)	37,620			35
36	Other (specify):*			10,000	10,000		10,000	(10,000)				36
37	TOTAL Ownership			2,202,975	2,202,975		2,202,975	(331,952)	1,871,023			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	612,753	1,009,071	1,641,308	3,263,132		3,263,132		3,263,132			39
40	Barber and Beauty Shops			1,555	1,555		1,555		1,555			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			590,069	590,069		590,069		590,069			42
43	Other (specify):*	175,843		88,000	263,843		263,843	(263,843)				43
44	TOTAL Special Cost Centers	788,596	1,009,071	2,320,932	4,118,599		4,118,599	(263,843)	3,854,756			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,425,793	2,144,521	11,125,750	22,696,064		22,696,064	(1,882,685)	20,813,379			45

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

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	(2,231)	02		4
5	Telephone, TV & Radio in Resident Rooms	(29,613)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	188,099	30		9
10	Interest and Other Investment Income	(6,518)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(446)	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	(418)	21		18
19	Entertainment	(7,985)	21		19
20	Contributions	(12,700)	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	(1,075,347)	21		24
25	Fund Raising, Advertising and Promotional	(31,634)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,414)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(538,061)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,524,268)		\$	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)	(358,417)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (358,417)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,882,685)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Dividend Income	\$ (5,280)	21	1
2	Medical Records Income	(5,430)	10	2
3	Rental Income	(375)	06	3
4	RFMS Petty Cash Clearing Acct.	(1,225)	21	4
5	Resident Lost Item	(278)	10	5
6	Marketing Salaries	(175,843)	43	6
7	Amortization Expense	(10,000)	36	7
8	Sequestration Expense	(112,002)	21	8
9	Bank Service Charges	(10,649)	21	9
10	Collection Fees	(953)	21	10
11	Late Fees	(10,213)	21	11
12	PAC Dues	(17,520)	20	12
13	Non-Allowable Seminar	(199)	24	13
14	Marketing & Out- of State Travel	(13,622)	25	14
15	Bulding Co - Loan Fee	(58,125)	36	15
16	Non-Allowable Legal	(22,256)	19	16
17	Capitalized R&M	(7,752)	06	17
18	Additional R&M	62,555	06	18
19	Misc. Income	(15,749)	21	19
20	Non-allowable Auto Lease	(31,968)	35	20
21	Non-Allowable Fees	(88,000)	43	21
22	Settlement Income	(13,538)	26	22
23	R/E Tax Expense Adjustment	361	33	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(538,061)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(2,677)											(2,677)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	24,815		8,297									33,112	6
7	Other (specify):*													7
8	TOTAL General Services	22,138		8,297									30,435	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,708)											(5,708)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(5,708)											(5,708)	16
	C. General Administration													
17	Administrative			22,437									22,437	17
18	Directors Fees													18
19	Professional Services	(22,256)		(446,505)									(468,761)	19
20	Fees, Subscriptions & Promotions	(61,854)		2,004									(59,850)	20
21	Clerical & General Office Expenses	(1,247,235)		407,073									(840,162)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(199)		1,215									1,016	24
25	Other Admin. Staff Transportation	(13,622)		7,438									(6,184)	25
26	Insurance-Prop.Liab.Malpractice	(13,538)		3,007									(10,531)	26
27	Other (specify):*			50,418									50,418	27
28	TOTAL General Administration	(1,358,704)		47,087									(1,311,617)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(1,342,274)		55,384									(1,286,890)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	188,099	205,674	173									393,946	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,518)	772,757										766,239	32
33	Real Estate Taxes	361											361	33
34	Rent-Facility & Grounds		(1,500,000)	40,751									(1,459,249)	34
35	Rent-Equipment & Vehicles	(31,968)		8,719									(23,249)	35
36	Other (specify):*	(68,125)	58,125										(10,000)	36
37	TOTAL Ownership	81,849	(463,444)	49,643									(331,952)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(263,843)											(263,843)	43
44	TOTAL Special Cost Centers	(263,843)											(263,843)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,524,268)	(463,444)	105,027									(1,882,685)	45

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	\$ 1,500,000	Salem Village Property, LLC	100.00%	\$	\$ (1,500,000)	1
2	V	32	Interest	287	Salem Village Property, LLC	100.00%	91,500	91,213	2
3	V	32	Mortgage Interest Expense		Salem Village Property, LLC	100.00%	681,544	681,544	3
4	V								4
5	V	30	Depreciation		Salem Village Property, LLC	100.00%	205,674	205,674	5
6	V	36	Loan Fee		Salem Village Property, LLC	100.00%	58,125	58,125	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,500,287			\$ 1,036,843	\$ * (463,444)	14

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 REPAIRS & MAINTENANCE	\$	HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	\$ 8,297	\$ 8,297	15
16	V	19 PROFESSIONAL FEES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	8,037	8,037	16
17	V	20 DUES, SUBSCRIPTIONS		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	2,004	2,004	17
18	V	21 CLERICAL & GENERAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	20,479	20,479	18
19	V	24 SEMINAR		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	1,215	1,215	19
20	V	25 TRAVEL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	7,438	7,438	20
21	V	26 INSURANCE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	3,007	3,007	21
22	V	30 DEPRECIATION		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	173	173	22
23	V	32 INTEREST		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%			23
24	V	34 OFFICE SPACE		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	40,751	40,751	24
25	V	35 AUTO RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	4,876	4,876	25
26	V	35 EQUIPMENT RENTAL		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	3,843	3,843	26
27	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	219,114	219,114	27
28	V	27 EMP. BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	36,028	36,028	28
29	V	17 ADMIN. SALARY - M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	22,437	22,437	29
30	V	27 EMP. BEN.-M. SUISSA		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	2,024	2,024	30
31	V							31
32	V	21 CLERICAL SALARIES		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	167,480	167,480	32
33	V	27 EMPLOYEE BEN. GEN. & ADMIN.		HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%	12,366	12,366	33
34	V							34
35	V							35
36	V							36
37	V							37
38	V	19 BOOKEEPING SERVICES	454,542	HEALTHCARE ACCOUNTING SERVICES, LLC	100.00%		(454,542)	38
39	Total		\$ 454,542			\$ 559,569	\$ * 105,027	39

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

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	34	Office Space	\$ 17,000	MS HEALTHCARE ACCOUNTING	100.00%	\$ 17,000	\$	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			\$ 17,000			\$ 17,000	\$ *	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		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	\$ 1,625,200	TOWN AND COUNTRY REHAB., LLC	100.00%	\$ 1,625,200	\$	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			\$ 1,625,200			\$ 1,625,200	\$ *	39

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

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.

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.

YESNO

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.

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.

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.

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.

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.

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	16.83	28.05%	Alloc. Sal/Fee	\$ 142,437	17-3/17-7	1
2	Lorraine Suissa	Relative	Administrative	N/A	N/A	40	100.00%	Salary	67,481	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 209,918		13

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

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

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 12/31/16

(314) 963-9030

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 MS HEALTHCARE ACCOUNTING
Street Address 3535 WEST GLENLAKE
City / State / Zip Code CHICAGO, IL 60659
Phone Number (917) 744-8688
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	OFFICE SPACE				\$	\$		\$ 17,000	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					\$	\$		\$ 17,000	25

Ending: 12/31/16

(314) 434-9179

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 12/31/16

Fax Number

()

()

IL478-2471

Facility Name & ID Number Salem Village Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Nrsing & Rehab # 0044057 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	First Midwest Bank		X	Mortgage			\$	6,000,000			\$	681,544	1		
2	First Midwest Bank		X	Note Payable				13,686,245				91,500	2		
3													3		
4													4		
5					-								5		
	Working Capital														
6	First Midwest Bank		X	Line of Credit	Interest Only	11/5/2013	500,000	1,000,000	1/15/2016	4.4280		20,802	6		
7	Select Rehabilitation		X	Note Payable				140,000					7		
8	See Supplemental Schedule				-							10,567	8		
9	TOTAL Facility Related						\$	500,000	\$	20,826,245			\$	804,413	9
	B. Non-Facility Related*														
10	Interest Income		X									(6,518)	10		
11	Interest Income - Bldg. Co.		X									(287)	11		
12	Alloc. Health Care Accounting		X										12		
13					-								13		
14	TOTAL Non-Facility Related						\$		\$				\$	(6,805)	14
15	TOTALS (line 9+line14)						\$	500,000	\$	20,826,245			\$	797,608	15

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

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

** 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 - 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	Popular Bank		X	Line of Credit			\$		\$			\$ 1,827	8
9	IPFS Corporation		X	Finance Agreement								8,740	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital											10,567	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

[illegible]

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Salem Village Nrsing & Rehab COUNTY Will

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>30-07-23-304-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>175,401.68</u>	\$ <u>175,401.68</u>
2. <u>30-07-23-304-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>251.80</u>	\$ <u>251.80</u>
3. <u>30-07-23-304-010-0000</u>	<u>Long Term Care Property</u>	\$ <u>847.84</u>	\$ <u>847.84</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>176,501.32</u></u>	\$ <u><u>176,501.32</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMESalem Village Nrsing & RehabCOUNTYWill

FACILITY IDPH LICENSE NUMBER0044057

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

TELEPHONE(847) 236-6300FAX #:(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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:

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

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	272		1998	1976	\$ 8,021,280	\$ 205,674	35	\$ 401,064	\$ 195,390	\$ 7,352,840
5										
6										
7										
8										
	Improvement Type**									
9	Various		1998		108,515		20	5,426	5,426	98,780
10	Various		1999		240,599		20	11,864	11,864	206,857
11	Various		2000		193,202		20	9,660	9,660	162,100
12	Various		2001		97,999		20	4,689	4,689	77,570
13	Various		2002		88,413		20	474	474	88,146
14	Various		2003		45,533		20	567	567	44,777
15	Various		2004		113,428		20	1,092	1,092	108,780
16	Various		2005		141,584		20	2,679	2,679	126,603
17	Various		2006		207,635		20	3,617	3,617	195,007
18	Various		2007		18,325		20	995	995	14,007
19	Various		2008		92,767		20	348	348	91,208
20	Various		2009		72,175		20	5,660	5,660	52,615
21	Various		2010		276,387		20	28,603	28,603	204,562
22	Various		2011		311,964		20	28,508	28,508	180,139
23	Various		2012		362,518		20	31,798	31,798	143,661
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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Salem Village Nrsing & Rehab

0044057

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 12A, Carried Forward		\$ 10,392,325	\$ 618,703		\$ 537,045	\$ (81,659)	\$ 9,147,654	1
2	Basement Flooring	2013	22,995		20	4,599	4,599	18,396	2
3	5Th Floor Rooms And Hall - Painting, Door Headers, Electric Wo	2013	30,732		20	3,073	3,073	12,037	3
4	Smoke Detectors	2013	4,043		20	404	404	1,583	4
5	5Th Floor Remodeling - Painting 17 Rooms, Lights, Switches, Out	2013	44,113		20	4,411	4,411	16,910	5
6	Crashrails	2013	3,809		20	381	381	1,460	6
7	Flooring - Hallways, Dining Room And Resident Rooms On The 5	2013	35,758		20	7,152	7,152	27,414	7
8	Tektone System	2013	4,276		20	855	855	3,207	8
9	Flooring - Breakroom, 2 Bathrooms And 4 Elevatrs	2013	3,100		20	620	620	2,273	9
10	Crash Rails	2013	3,809		20	381	381	1,397	10
11	3Rd & 4Th Floor Office - Painting, Reinstall Outlets, Lights, Etc.	2013	4,935		20	494	494	1,810	11
12	Nurses Station Remodeling	2013	6,110		20	611	611	2,240	12
13	Water Heater	2013	7,442		20	744	744	2,667	13
14	Crashrails	2013	3,809		20	381	381	1,365	14
15	3Rd Floor Room Remodeling - Install Closets And Header Blocks	2013	3,379		20	338	338	1,211	15
16	New Water Heater	2013	6,379		20	638	638	2,286	16
17	Installation Of Closet Shelving Units	2013	3,550		20	355	355	1,243	17
18	Installation Of Sprinkler Heads	2013	3,334		20	333	333	1,167	18
19	Installation Of Additional Fire Alarms	2013	7,575		20	758	758	2,651	19
20	Exterior Patio Entrance Door	2013	13,000		20	1,300	1,300	4,442	20
21	Installation Of Closet Shelving Units	2013	3,738		20	374	374	1,277	21
22	4Th & 5Th Floor Dining Room And Nurses Station - Wall Coverin	2013	16,914		20	1,691	1,691	5,638	22
23	Crash Rails In Hallways	2013	3,097		20	310	310	1,032	23
24	Fire Dampers	2013	4,900		20	490	490	1,633	24
25	Security Camera System	2013	5,497		20	550	550	1,787	25
26	Installation Of 14 Closet Organizers	2013	4,962		20	496	496	1,613	26
27	Installation Of 16 Closet Organizers	2013	5,448		20	545	545	1,771	27
28	Ao Smith Water Heater Model #Btr197	2013	6,250		20	625	625	1,979	28
29	Installation Of 17 Closet Organizers	2013	5,501		20	550	550	1,742	29
30	Light Fixtures	2013	11,643		20	1,164	1,164	3,590	30
31	Convection Pellet Heater	2013	3,950		20	790	790	2,436	31
32	600 Crashrails And 200 Retainers	2013	3,959		20	396	396	1,221	32
33	Closet Organizers	2013	23,645		20	2,364	2,364	7,684	33
34	TOTAL (lines 1 thru 33)		\$ 10,703,976	\$ 618,703		\$ 575,218	\$ (43,486)	\$ 9,286,815	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab

0044057

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 10,703,976	\$ 618,703		\$ 575,218	\$ (43,486)	\$ 9,286,815	1
2	Cylinder With Code Compliant Cylinder	2013	46,495		20	4,650	4,650	14,723	2
3	12 Lighting Unfinished Crown Molding	2013	2,614		20	261	261	871	3
4	12 Lighting Unfinished Crown Molding	2013	2,614		20	261	261	849	4
5	Closet Organizers	2013	16,627		20	1,663	1,663	6,235	5
6	Correction To 2012 Roof Exhauster Paid Twice	2013	(7,101)		20	(710)	(710)	(2,841)	6
7	Elevator Repairs	2013	5,100		20	255	255	808	7
8	Sprinkler Head In Pit Of 2 Elevator Shafts	2013	6,450		20	323	323	1,102	8
9	Heating / Cooling Units For Resident Rooms	2013	22,187		20	1,109	1,109	3,421	9
10	New Doors And Security Pads	2014	8,349		20	835	835	2,505	10
11	Crashrail C400 Aluminum Retainer	2014	4,135		20	414	414	1,241	11
12	Door Alarms And Reactivation Of Magnetic Locks	2014	8,887		20	889	889	2,518	12
13	Kitchen Water Heater	2014	9,949		20	995	995	2,902	13
14	Crashrail And Aluminum Retainer	2014	4,135		20	414	414	1,172	14
15	Ejector Pump	2014	4,137		20	414	414	1,034	15
16	Basement Flooring For Sunken Garden	2014	10,115		20	1,012	1,012	2,444	16
17	Shower Room Doors	2014	14,976		20	1,498	1,498	3,370	17
18	Dementia Unit Doors, Oxygen Storage, Rooftop	2014	7,357		20	736	736	1,717	18
19	Flooring And Carpet In 6Th Floor Hallways And Elevator Floors	2014	30,407		20	3,041	3,041	6,588	19
20	Elevator Repair	2014	3,081		20	154	154	462	20
21	Sprinkler System Repair	2014	15,247		20	762	762	1,779	21
22	Replace Retaining Wall	2014	9,000		20	450	450	1,050	22
23	Crackfilling In Parking Lot	2014	3,937		20	197	197	459	23
24	Asphalt Repairs	2014	2,750		20	138	138	332	24
25	Repair A/C	2014	3,150		20	158	158	368	25
26	Replace Heater	2014	3,384		20	169	169	395	26
27	Hvac / Boiler	2014	4,014		20	201	201	585	27
28	Hvac / Boiler	2014	3,226		20	161	161	363	28
29	Painting	2014	4,991		20	250	250	520	29
30	Light Fixtures	2015	5,073		20	507	507	846	30
31	Remove Old And Install New Door /Frame	2015	3,154		20	315	315	447	31
32	Install Stoves, Exterior Lights And Panels	2015	8,238		20	824	824	1,030	32
33	Elevator Motor And Pump	2015	8,972		20	897	897	1,047	33
34	TOTAL (lines 1 thru 33)		\$ 10,979,626	\$ 618,703		\$ 598,457	\$ (20,247)	\$ 9,347,155	34

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

Facility Name & ID Number Salem Village Nrsing & Rehab

0044057

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 12C, Carried Forward		\$ 10,979,626	\$ 618,703		\$ 598,457	\$ (20,247)	\$ 9,347,155	1
2	Rerouting & Rewiring Conduit 8 Rooms	2015	12,525		20	1,253	1,253	1,357	2
3	Entry Door On Dock Entrance	2015	2,721		20	272	272	363	3
4	Installed And Finished Dock Door Interior	2015	3,445		20	172	172	215	4
5	3Rd Floor Complete Circuit	2016	6,750		20	675	675	675	5
6	5 A/C Wall Units	2016	3,419		20	313	313	313	6
7	Nurse Call Station	2016	5,355		20	893	893	893	7
8	Air Conditioner With Heat Pump X5	2016	3,459		20	434	434	434	8
9	Compressor	2016	2,665		20	355	355	355	9
10	Generator Engine	2016	3,459		20	461	461	461	10
11	Electrical Upgrade	2016	4,463		20	298	298	298	11
12	4 Heating/Cooling Units	2016	2,773		20	324	324	324	12
13	Elevators Electrical Upgrades	2016	7,725		20	386	386	386	13
14	New Compressor For Dining Room A/C Unit	2016	5,578		20	465	465	465	14
15	Compressor For Lobby A/C Unit	2016	3,128		20	261	261	261	15
16	12.5 Ton Air Unit	2016	18,400		20	613	613	613	16
17	5 Ptech A/C Wall Units	2016	3,426		20	171	171	171	17
18	Aluminium Retainer And Caps	2016	4,156		20	104	104	104	18
19	Installation Of 9" Pit Ladder To Elevators	2016	12,471		20	104	104	104	19
20	Water Heater Replacement	2016	6,804		20	57	57	57	20
21	12 Ptech Units With Heat Pumps	2016	7,769		20	129	129	129	21
22	New Windows	2016	5,075		20	338	338	338	22
23	Under Lav Protectors	2016	4,802		20	240	240	240	23
24	Install Soft Start Model Line Starter	2016	2,950		20	148	148	148	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,112,944	\$ 618,703		\$ 606,922	\$ (11,781)	\$ 9,355,858	34

**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	Totals from Page 12D, Carried Forward		\$ 11,112,944	\$ 618,703		\$ 606,922	\$ (11,781)	\$ 9,355,858	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,112,944	\$ 618,703		\$ 606,922	\$ (11,781)	\$ 9,355,858	34

**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		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,194,693	\$173	\$185,213	\$185,040	10	\$857,532	71
72	Current Year Purchases	89,991		10,515	10,515	10	10,515	72
73	Fully Depreciated Assets	1,712,214		19	19	10	1,712,213	73
74								74
75	TOTALS	\$2,996,898	\$173	\$195,747	\$195,574		\$2,580,260	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	\$	\$4,306	\$4,306	5	\$30,000	76
77										77
78										78
79										79
80	TOTALS			\$30,000	\$	\$4,306	\$4,306		\$30,000	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)	\$14,547,842	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$618,876	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$806,975	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$188,099	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$11,966,118	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	\$	\$39,141	86
87					87
88					88
89					89
90					90
91	TOTALS	\$39,141	\$	\$39,141	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES

☐ NO
- If NO, see instructions.

		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				40,751			5
6	Allocated from MS Healthcare Accounting				17,000			6
7	TOTAL				\$57,751			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: \$26,775Description: 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	2016 GMC Savana	\$	5,969	17
18		Passenger Van			18
19	Allocated from H.A.S			4,876	19
20					20
21	TOTAL		\$-	\$10,845	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. /2017	\$
13. /2018	\$
14. /2019	\$

* 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

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)	\$			

(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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 633,295	\$		\$ 633,295	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			331,528			331,528	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			643,052			643,052	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				421,038		421,038	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			612,753		33,433	588,033		1,234,219	13
14	TOTAL			\$ 612,753		\$ 1,641,308	\$ 1,009,071		\$ 3,263,132	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.

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	\$ 1,871,989	\$ 1,872,739	1
2	Cash-Patient Deposits	59,370	59,370	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,765,508	5,765,508	3
4	Supply Inventory (priced at)	73,354	73,354	4
5	Short-Term Investments			5
6	Prepaid Insurance	40,334	40,334	6
7	Other Prepaid Expenses	17,275	152,315	7
8	Accounts Receivable (owners or related parties)	132,811	2,213,652	8
9	Other(specify): <u>See Attached Schedule</u>	1,047	1,047	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,961,688	\$ 10,178,319	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	3,067,720	3,067,720	15
16	Equipment, at Historical Cost	2,545,381	3,361,381	16
17	Accumulated Depreciation (book methods)	(4,074,506)	(8,661,194)	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): <u>See Attached Schedule</u>	240,000	288,437	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,778,595	\$ 6,485,624	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,740,283	\$ 16,663,943	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,075,796	\$ 1,187,683	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,870	57,870	28
29	Short-Term Notes Payable	1,000,000	1,000,000	29
30	Accrued Salaries Payable	889,264	889,264	30
31	Accrued Taxes Payable (excluding real estate taxes)	52,192	52,192	31
32	Accrued Real Estate Taxes(Sch.IX-B)	180,031	180,031	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,250	7,250	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	557,533	597,533	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,819,936	\$ 3,971,823	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	140,000	13,826,245	39
40	Mortgage Payable		6,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 140,000	\$ 19,826,245	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,959,936	\$ 23,798,068	46
47	TOTAL EQUITY(page 18, line 24)	\$ (219,653)	\$ (7,134,125)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,740,283	\$ 16,663,943	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,488,232	1
2	Restatements (describe):		2
3	Bad Debts, Sequestration, other misc.	191,002	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,679,234	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,066,737)	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	(832,150)	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)	\$ (2,898,887)	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)	\$ (219,653)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Salem Village Nrsing & Rehab

0044057

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	\$ 23,888,646	1
2	Discounts and Allowances for all Levels	(7,019,693)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,868,953	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,080,632	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,080,632	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	150	13
14	Non-Patient Meals	2,231	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	375	16
17	Sale of Drugs	500,894	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	95,097	19
20	Radiology and X-Ray	33,180	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 631,927	23
	D. Non-Operating Revenue		
24	Contributions	75	24
25	Interest and Other Investment Income***	6,518	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,593	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	41,222	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 41,222	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,629,327	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,732,985	31
32	Health Care	7,763,896	32
33	General Administration	5,877,609	33
	B. Capital Expense		
34	Ownership	2,202,975	34
	C. Ancillary Expense		
35	Special Cost Centers	3,528,530	35
36	Provider Participation Fee	590,069	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,696,064	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,066,737)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,066,737)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,099,684	44
45	Private Pay - Net Inpatient Revenue	1,532,873	45
46	Medicare - Net Inpatient Revenue	2,926,336	46
47	Other-(specify) <u>Hospice</u>	629,634	47
48	Other-(specify) <u>Insurance</u>	3,680,426	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,868,953	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	2,040	2,120	\$ 114,803	\$ 54.15	1
2	Assistant Director of Nursing	4,169	4,329	196,494	45.39	2
3	Registered Nurses	58,912	61,128	1,871,722	30.62	3
4	Licensed Practical Nurses	54,496	56,648	1,690,048	29.83	4
5	CNAs & Orderlies	176,459	182,308	1,880,524	10.32	5
6	CNA Trainees					6
7	Licensed Therapist	21,258	22,124	612,753	27.70	7
8	Rehab/Therapy Aides	17,331	17,851	209,798	11.75	8
9	Activity Director					9
10	Activity Assistants	21,065	21,786	236,706	10.87	10
11	Social Service Workers	9,946	10,268	156,676	15.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,367	42,152	551,202	13.08	15
16	Dishwashers					16
17	Maintenance Workers	9,791	10,054	165,707	16.48	17
18	Housekeepers	40,692	42,461	456,783	10.76	18
19	Laundry	15,988	16,660	180,940	10.86	19
20	Administrator	2,060	2,140	175,870	82.18	20
21	Assistant Administrator					21
22	Other Administrative	2,011	2,091	67,481	32.27	22
23	Office Manager					23
24	Clerical	26,668	27,706	588,040	21.22	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	5,263	5,472	72,876	13.32	31
32	Other Health Care(specify)					32
33	Other(specify)	5,995	6,321	197,371	31.22	33
34	TOTAL (lines 1 - 33)	514,511	533,619	\$ 9,425,794 *	\$ 17.66	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	605	\$ 28,412	01-03	35
36	Medical Director	Monthly	84,000	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	466	18,440	10-03	38
39	Pharmacist Consultant	\$5 Per Chart	13,175	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	216	14,663	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,287	\$ 163,490		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	34,667	939,896	10-03	52
53	TOTAL (lines 50 - 52)	34,667	\$ 939,896		53

STATE OF ILLINOIS

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Facility Name & ID Number

Salem Village Nrsing & Rehab

0044057

Report Period Beginning:

01/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Kelly Covarrubias		Administrator	0	\$ 175,870	Workers' Compensation Insurance		\$ 348,780	IDPH License Fee		\$	
Lorraine Suissa		Administrative	0	67,481	Unemployment Compensation Insurance		111,222	Advertising: Employee Recruitment		24,181	
					FICA Taxes		683,961	Health Care Worker Background Check			
					Employee Health Insurance		512,776	(Indicate # of checks performed 115)		8,229	
					Employee Meals			Patient Background Checks		304 3,039	
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		37,839	
					401K Match/Pension		160,694	License & Fees		5,600	
					Holiday Expense		18,892	Allocated from Healthcare Accounting		2,004	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 243,350							
B. Administrative - Other											
Description			Amount								
Management Fees - Mark Suissa			\$ 120,000								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 120,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,836,325	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 80,892
(Attach a copy of any management service agreement)					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
C. Professional Services		Type	Amount	Description		Line #	Amount	Description		Amount	
Vendor/Payee								Out-of-State Travel		\$	
Marcum LLP		Accounting	\$ 60,130								
Healthcare Accounting Svcs.		Bookkeeping/Accounting	454,542								
See Attached		Legal Fees	342,191								
Paychex		Payroll Processing	69,688					In-State Travel			
Personnel Planners		Unemployment Tax Cons.	2,847								
National Datacare		Data Processing	4,983								
Achieve Accreditation		Joint Commision Consult	13,475								
Legat Architects		Architectural Services	2,189					Seminar Expense		15,071	
BH Suhr & Company		Land Survey	1,900					Allocated from Healthcare Accounting		1,215	
Murphy Consult		Technology & Business Conslt	500								
The Joint Commission		Accreditation	3,500								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Entertainment Expense		()	
(For legal fee disclosure, see page 39 of instructions)			\$ 955,944					(agree to Sch. V, line 24, col. 8)			
								TOTAL		\$ 16,286	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Salem Village Nrsing & Rehab	STATE OF ILLINOIS # 0044057	Report Period Beginning: 01/01/16	Ending: 12/31/16
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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 \$53,092

(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 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,448 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. \$ 590,069
 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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,231

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