

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0029462

**Facility Name:** SALINE CARE CENTER

**Address:** 120 SOUTH LAND STREET HARRISBURG 62946  
 Number City Zip Code

**County:** SALINE

**Telephone Number:** (618) 252-7405 **Fax #** (618) 253-3418

**HFS ID Number:** 37-1176175001

**Date of Initial License for Current Owners:** 5/15/1985

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** WILLIAM H. MOORMAN **Telephone Number:** (618) 993-2647

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Type or Print Name) \_\_\_\_\_

(Title) \_\_\_\_\_

**Paid Preparer**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Print Name and Title) WILLIAM H. MOORMAN, CPA  
PARTNER

(Firm Name & Address) GRAY HUNTER STENN LLP  
P.O. BOX 1728, MARION, IL 62959

(Telephone) (618) 993-2647 Fax # (618) 993-3981

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALINE CARE CENTER

# 0029462 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	142	Intermediate (ICF)	142	51,830	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	142	TOTALS	142	51,830	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	38,763	6,056		44,819
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	38,763	6,056		44,819

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.47%

D. How many bed-hold days during this year were paid by the Department? 0 (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)  
N/A

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 05/15/1985

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/15/1985 NO

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number SALINE CARE CENTER # 0029462 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	144,636	19,196	6,825	170,657		170,657		170,657		1
2	Food Purchase		189,169		189,169		189,169		189,169		2
3	Housekeeping	146,781	26,152		172,933		172,933		172,933		3
4	Laundry	59,026	20,843		79,869		79,869	407	80,276		4
5	Heat and Other Utilities			100,875	100,875		100,875	3,355	104,230		5
6	Maintenance	59,536	23,154	34,635	117,325		117,325	3,926	121,251		6
7	Other (specify):* SALES TAX			1,710	1,710		1,710	(1,710)			7
8	<b>TOTAL General Services</b>	<b>409,979</b>	<b>278,514</b>	<b>144,045</b>	<b>832,538</b>		<b>832,538</b>	<b>5,978</b>	<b>838,516</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	909,649	51,838	5,950	967,437		967,437		967,437		10
10a	Therapy	26,841		6,400	33,241		33,241		33,241		10a
11	Activities	37,749	5,120		42,869		42,869		42,869		11
12	Social Services	40,899		2,160	43,059		43,059		43,059		12
13	CNA Training										13
14	Program Transportation			5,123	5,123		5,123		5,123		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,015,138</b>	<b>56,958</b>	<b>19,633</b>	<b>1,091,729</b>		<b>1,091,729</b>		<b>1,091,729</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	63,750			63,750		63,750	140,646	204,396		17
18	Directors Fees										18
19	Professional Services			212,902	212,902		212,902	(188,757)	24,145		19
20	Dues, Fees, Subscriptions & Promotions			16,447	16,447		16,447	(2,728)	13,719		20
21	Clerical & General Office Expenses	48,468	11,137	11,960	71,565		71,565	26,856	98,421		21
22	Employee Benefits & Payroll Taxes			234,317	234,317		234,317	6,681	240,998		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,860	1,860		1,860		1,860		24
25	Other Admin. Staff Transportation			270	270		270	4,985	5,255		25
26	Insurance-Prop.Liab.Malpractice			114,956	114,956		114,956	1,170	116,126		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>112,218</b>	<b>11,137</b>	<b>592,712</b>	<b>716,067</b>		<b>716,067</b>	<b>(11,147)</b>	<b>704,920</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,537,335</b>	<b>346,609</b>	<b>756,390</b>	<b>2,640,334</b>		<b>2,640,334</b>	<b>(5,169)</b>	<b>2,635,165</b>		<b>29</b>

\*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.

Facility Name & ID Number SALINE CARE CENTER

#0029462

Report Period Beginning:

01/01/06

Ending:

12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			33,764	33,764	33,764	65,653	99,417				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,517	57,517	57,517	(191)	57,326				32
33	Real Estate Taxes			38,589	38,589	38,589	943	39,532				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,502	7,502	7,502		7,502				35
36	Other (specify):* <b>PENALTY</b>			6,435	6,435	6,435	(6,435)					36
37	<b>TOTAL Ownership</b>			143,807	143,807	143,807	59,970	203,777				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			77,745	77,745	77,745		77,745				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			77,745	77,745	77,745		77,745				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,537,335	346,609	977,942	2,861,886	2,861,886	54,801	2,916,687				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

Facility Name & ID Number SALINE CARE CENTER

# 0029462

Report Period Beginning: 01/01/06

Ending: 12/31/06

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	63,046	V-30		9
10	Interest and Other Investment Income	(256)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,710)	V-7		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	(6,435)	V-36		18
19	Entertainment				19
20	Contributions	(2,130)	V-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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,313)	V-20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 51,202		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	3,599		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 3,599		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 54,801		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

SALINE CARE CENTER

ID# 0029462

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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
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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SALINE CARE CENTER

# 0029462

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	407	0	0	0	0	0	0	0	0	0	0	407	4
5	Heat and Other Utilities	3,355	0	0	0	0	0	0	0	0	0	0	3,355	5
6	Maintenance	3,926	0	0	0	0	0	0	0	0	0	0	3,926	6
7	Other (specify):*	0	(1,710)	0	0	0	0	0	0	0	0	0	(1,710)	7
8	<b>TOTAL General Services</b>	<b>7,688</b>	<b>(1,710)</b>	<b>0</b>	<b>5,978</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	140,646	0	0	0	0	0	0	0	0	0	0	140,646	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	9,859	(198,616)	0	0	0	0	0	0	0	0	0	(188,757)	19
20	Fees, Subscriptions & Promotions	715	(3,443)	0	0	0	0	0	0	0	0	0	(2,728)	20
21	Clerical & General Office Expenses	26,856	0	0	0	0	0	0	0	0	0	0	26,856	21
22	Employee Benefits & Payroll Taxes	6,681	0	0	0	0	0	0	0	0	0	0	6,681	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	4,985	0	0	0	0	0	0	0	0	0	0	4,985	25
26	Insurance-Prop.Liab.Malpractice	1,170	0	0	0	0	0	0	0	0	0	0	1,170	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>190,912</b>	<b>(202,059)</b>	<b>0</b>	<b>(11,147)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>198,600</b>	<b>(203,769)</b>	<b>0</b>	<b>(5,169)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SALINE CARE CENTER# 0029462 Report Period Beginning:01/01/06 Ending: 12/31/06

## 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	2,607	63,046	0	0	0	0	0	0	0	0	0	65,653	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	65	(256)	0	0	0	0	0	0	0	0	0	(191)	32
33	Real Estate Taxes	943	0	0	0	0	0	0	0	0	0	0	943	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	(6,435)	0	0	0	0	0	0	0	0	0	(6,435)	36
37	<b>TOTAL Ownership</b>	<b>3,615</b>	<b>56,355</b>	<b>0</b>	<b>59,970</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>202,215</b>	<b>(147,414)</b>	<b>0</b>	<b>54,801</b>	<b>45</b>								

Facility Name & ID Number SALINE CARE CENTER

# 0029462

Report Period Beginning:

01/01/06

Ending:

12/31/06

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROGER D. HERRIN	50.00%	CARRIER MILLS NURSING HOME	CARRIER MILLS, IL	RDK MGMT., INC.	HARRISBURG, IL	MANAGEMENT
LARRY JONES	50.00%	SEVERIN INTERMEDIATE CARE HOME	BENTON, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 PROFESSIONAL SERVICES	\$ 198,616	RDK MANAGEMENT, INC. (SEE ATTACHED SCHEDULE)		\$ 202,215	\$ 3,599	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 198,616			\$ 202,215	\$ * 3,599	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALINE CARE CENTER # 0029462 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	DR. ROGER HERRIN	PARTNER	MANAGER	50.00	169,354	20	29.00	MGMT. FEES	\$ 140,646	17-7	1
2	DR. LARRY JONES	PARTNER	CONSULTANT	50.00	3,600	VARIOUS	VARIOUS	PHYS. FEES	912	19-3	2
3											3
4	(1) SEE ATTACHED SCHEDULE										4
5											5
6	(2) FROM MANAGEMENT EXPENSES ALLOCATION SCHEDULE										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 141,558		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALINE CARE CENTER

# 0029462 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	REGIONS BANK		X	LOAN CONSOL & RENOVAT	\$20,000.00	5/25/1997	\$ 2,200,000	\$ 491,908	6/25/2010	0.0725	\$ 40,640	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	MIDCOUNTRY BANK		X	WORKING CAPITAL	SINGLE PAY	5/20/2005	150,000		5/20/2006	0.0600	4,500	6								
7	FARMERS BANK		X	WORKING CAPITAL	SINGLE PAY	12/21/2006	400,000	400,000	12/21/2007	0.0600	12,377	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$20,000.00		\$ 2,750,000	\$ 891,908			\$ 57,517	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,750,000	\$ 891,908			\$ 57,517	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number SALINE CARE CENTER

# 0029462 Report Period Beginning: 01/01/06

Ending: 12/31/06

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 41,694	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.)		\$ 40,142	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (1,552)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 41,084	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 39,532	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	34,850	8
	2002	35,926	9
	2003	37,130	10
	2004	38,900	11
	2005	40,142	12
<b>(1) INCLUDES \$943 FROM ALLOCATION OF MGMT EXPENSES - ADJUSTED IN COLUMN 7. THE ACCRUAL IS BASED UPON 2005 TAXES ACTUALLY PAID.</b>			

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SALINE CARE CENTER COUNTY SALINE

FACILITY IDPH LICENSE NUMBER 0029462

CONTACT PERSON REGARDING THIS REPORT WILLIAM H. MOORMAN

TELEPHONE (618) 993-2647 FAX #: (618) 993-3981

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-1-098-06</u>	<u>LAND &amp; BUILDING</u>	\$ <u>15,516.26</u>	\$ <u>15,516.26</u>
2. <u>06-1-098-01</u>	<u>LAND &amp; BUILDING</u>	\$ <u>24,626.14</u>	\$ <u>24,626.14</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>40,142.40</u>	\$ <u>40,142.40</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number SALINE CARE CENTER

# 0029462 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

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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 USE	514,920	1985	\$ 50,000	1
2	NURSING HOME ADMIN (1)	4,822	1993	8,621	2
3	TOTALS	519,742		\$ 58,621	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number SALINE CARE CENTER

# 0029462

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	124		1985	1969	\$ 1,230,310	\$	30	\$ 41,010	\$ 41,010	\$ 886,841	4
5	18		1992	1992	700,233	21,745	30	23,341	1,596	330,913	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		IMPROVEMENTS	1985		131,167		10			131,167	9
10		IMPROVEMENTS-ROOF/FLOOR REPAIR	1986		69,020		10			69,020	10
11		IMPROVEMENTS-GARAGE	1986		10,992		15			10,992	11
12		IMPROVEMENTS-FENCE	1986		801		8			801	12
13		IMPROVEMENTS-CARPET & TILE	1987		1,392		5			1,392	13
14		IMPROVEMENTS-FLOORING	1987		2,209	71	10		(71)	2,209	14
15		IMPROVEMENTS-A/C & HEATER	1987		3,348	84	8		(84)	3,348	15
16		IMPROVEMENTS-AIR FILTER/FAN	1987		101		15			101	16
17		IMPROVEMENTS-ASPHALT	1988		15,938		10			15,938	17
18		IMPROVEMENTS-LANDSCAPING	1992		10,381	459	15	692	233	9,746	18
19		IMPROVEMENTS-ALLOCATION (1)	1993		49,424	1,282	30	1,647	365	20,646	19
20		IMPROVEMENTS-CARPORT	1994		1,859	48	30	62	14	806	20
21		IMPROVEMENTS-ALLOCATION (1)	1994		2,136	74	30	71	(3)	838	21
22		IMPROVEMENTS-ALLOCATION (1)	1996		78	6	30	3	(3)	29	22
23		IMPROVEMENTS-ROOF	1997		14,650	376	39	488	112	4,880	23
24		IMPROVEMENTS-STORAGE BUILDING	1998		4,244	109	39	109		981	24
25		IMPROVEMENTS-GARAGE DOOR	1998		313	8	39	8		72	25
26		IMPROVEMENTS-ALLOCATION (1)	1998		360	9	30	12	3	106	26
27		IMPROVEMENTS-ROOF	2000		55,245	1,417	39	1,417		9,919	27
28		IMPROVEMENTS-CARPET & ACCOU WALL	2000		17,037	1,521	7	2,434	913	17,038	28
29		IMPROVEMENTS-ALLOCATION (1)	2000		7,940	352	30	266	(86)	1,852	29
30		IMPROVEMENTS-A/C & HEAT PUMP	2001		7,245	646	7	1,035	389	6,210	30
31		IMPROVEMENTS-SECURITY ALARM	2004		2,313		7	330	330	872	31
32		IMPROVEMENTS-VINYL FLOORING NURSE STATION	2004		2,020		7	289	289	746	32
33		IMPROVEMENTS	2006		708	6	39	18	12	18	33
34		IMPROVEMENTS	2006		815	1	39	21	20	21	34
35											35
36		(1) FROM ALLOCATION OF HOME OFFICE ASSETS - SEE ATTACHED LIST									36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,342,279	\$ 28,214		\$ 73,253	\$ 45,039	\$ 1,527,502	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number SALINE CARE CENTER # 0029462 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 220,716	\$ 6,471	\$ 22,072	\$ 15,601	10	\$ 167,875	71
72	Current Year Purchases	11,483	337	649	312	10	649	72
73	Fully Depreciated Assets	431,220				10	431,220	73
74								74
75	TOTALS	\$ 663,419	\$ 6,808	\$ 22,721	\$ 15,913		\$ 599,744	75

D. Vehicle Depreciation (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	TRAVEL	1995 MERCEDES BENZ	1995	\$ 38,041	\$ 805	\$	\$ (805)	4	\$ 38,041	76
77	TRANSPORT PATIENTS	1998 FORD SUPERWAGON	1998	26,502				4	26,502	77
78	TRANSPORT PATIENTS	1993 FORD AEROSTAR	1994	18,218				4	18,218	78
79	HAULING MAINTENANCE	2005 FORD RANGER TRUCK	2005	13,770	1,377	3,443	2,066	4		79
80	TOTALS			\$ 96,531	\$ 2,182	\$ 3,443	\$ 1,261		\$ 82,761	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 3,160,850	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 37,204	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 99,417	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 62,213	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,210,007	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALINE CARE CENTER

# 0029462

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 7,502      Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)**

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist		hrs	\$			\$	\$		\$						1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Exceptional Care Program															12
13	Other (specify):															13
14	<b>TOTAL</b>			\$			\$	\$		\$			\$			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

Facility Name & ID Number SALINE CARE CENTER# 0029462Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (71,123)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	726,822		3
4	Supply Inventory (priced at <u>COST</u> )	3,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	130,609		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 789,808	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	2,055,189		14
15	Leasehold Improvements, at Historical Cost	44,084		15
16	Equipment, at Historical Cost	885,454		16
17	Accumulated Depreciation (book methods)	(2,463,988)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	30,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(30,000)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>GOODWILL</u> )	100		22
23	Other(specify): <u>LOAN FEE NET OF AMORT</u>	776		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 541,615	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,331,423	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 32,898	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	406,174		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	3,259		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,347		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>ACCRUED MGMT. FEES</u>	68,834		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 548,512	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	485,733		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 485,733	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,034,245	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 297,178	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,331,423	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 143,511	1
2	Restatements (describe):		2
3	<b>ADJUSTMENT TO BOOK DEPRECIATION - NO</b>		3
4	<b>EFFECT ON COST REPORT</b>	(10,789)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 132,722	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	414,456	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	(250,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 164,456	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 297,178	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALINE CARE CENTER# 0029462Report Period Beginning: 01/01/06Ending: 12/31/06**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,284,904	1
2	Discounts and Allowances for all Levels	(8,818)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,276,086	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	256	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 256	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,276,342	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	832,538	31
32	Health Care	1,091,729	32
33	General Administration	716,067	33
<b>B. Capital Expense</b>			
34	Ownership	143,807	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	77,745	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,861,886	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	414,456	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 414,456	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number SALINE CARE CENTER

# 0029462

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	1,928	2,008	\$ 38,967	\$ 19.41	1
2	Assistant Director of Nursing	2,000	2,080	39,585	19.03	2
3	Registered Nurses	3,954	4,100	69,492	16.95	3
4	Licensed Practical Nurses	23,726	26,014	318,928	12.26	4
5	CNAs & Orderlies	54,976	58,633	442,677	7.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,966	3,253	26,841	8.25	8
9	Activity Director	1,852	1,981	15,460	7.80	9
10	Activity Assistants	3,052	3,278	22,289	6.80	10
11	Social Service Workers	4,634	4,806	40,899	8.51	11
12	Dietician					12
13	Food Service Supervisor	1,834	1,955	14,822	7.58	13
14	Head Cook	1,584	1,724	16,022	9.29	14
15	Cook Helpers/Assistants	15,922	16,612	113,792	6.85	15
16	Dishwashers					16
17	Maintenance Workers	5,256	5,383	59,536	11.06	17
18	Housekeepers	20,428	21,242	146,781	6.91	18
19	Laundry	7,672	8,255	59,026	7.15	19
20	Administrator	2,000	2,080	50,750	24.40	20
21	Assistant Administrator					21
22	Other Administrative	651	651	13,000	19.97	22
23	Office Manager					23
24	Clerical	5,388	5,545	48,468	8.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>159,823</b>	<b>169,600</b>	<b>\$ 1,537,335 *</b>	<b>\$ 9.06</b>	<b>34</b>

\* 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	166	\$ 6,825	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	48	2,550	10a-3	40
41	Occupational Therapy Consultant	77	3,850	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	48	2,160	12-3	45
46	Other(specify)				46
47	<u>CLINICAL PSYCHOLOGIST</u>	75	5,950	10-3	47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>414</b>	<b>\$ 21,335</b>		<b>49</b>

**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	<b>TOTAL (lines 50 - 52)</b>		<b>\$</b>		<b>53</b>

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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IHCA DUES \$3,312
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YRS.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,511 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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 77,745  
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? N/A
- (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. \$ N/A
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 95%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT