

Facility Name & ID Number Saline Care Center

0029462 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	33,205	4,555		37,760	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,205	4,555		37,760	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.65%

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)

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

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 05/15/85

J. Was the facility purchased or leased after January 1, 1978?

YES Date 05/15/85 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 N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Saline Care Center # 0029462 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	143,317	18,788	6,190	168,295		168,295		168,295	1	
2	Food Purchase		158,150		158,150		158,150		158,150	2	
3	Housekeeping	161,784	21,581		183,365		183,365	187	183,552	3	
4	Laundry	63,155	16,976	10,941	91,072		91,072	135	91,207	4	
5	Heat and Other Utilities			150,177	150,177		150,177	1,262	151,439	5	
6	Maintenance	74,020	35,345	10,093	119,458		119,458	696	120,154	6	
7	Other (specify):*									7	
8	TOTAL General Services	442,276	250,840	177,401	870,517		870,517	2,280	872,797	8	
	B. Health Care and Programs										
9	Medical Director									9	
10	Nursing and Medical Records	1,025,807	54,506	5,925	1,086,238		1,086,238	1,530	1,087,768	10	
10a	Therapy			4,488	4,488		4,488		4,488	10a	
11	Activities	45,633	3,488		49,121		49,121	2,928	52,049	11	
12	Social Services	47,402		2,534	49,936		49,936		49,936	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,118,842	57,994	12,947	1,189,783		1,189,783	4,458	1,194,241	16	
	C. General Administration										
17	Administrative	68,645		169,638	238,283		238,283	(35,410)	202,873	17	
18	Directors Fees									18	
19	Professional Services			16,080	16,080		16,080	21,490	37,570	19	
20	Dues, Fees, Subscriptions & Promotions			17,325	17,325		17,325	(3,771)	13,554	20	
21	Clerical & General Office Expenses	61,924	19,487	34,968	116,379		116,379	36,661	153,040	21	
22	Employee Benefits & Payroll Taxes			293,619	293,619		293,619		293,619	22	
23	Inservice Training & Education			901	901		901		901	23	
24	Travel and Seminar			217	217		217	1,218	1,435	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			80,125	80,125		80,125	15,554	95,679	26	
27	Other (specify):* Home office benefits							4,607	4,607	27	
28	TOTAL General Administration	130,569	19,487	612,873	762,929		762,929	40,349	803,278	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,691,687	328,321	803,221	2,823,229		2,823,229	47,087	2,870,316	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Saline Care Center

#0029462

Report Period Beginning:

01/01/08

Ending:

12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,833	36,833		36,833	60,037	96,870			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,798	23,798		23,798	(100)	23,698			32
33	Real Estate Taxes			21,000	21,000		21,000	936	21,936			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,622	7,622		7,622		7,622			35
36	Other (specify):*											36
37	TOTAL Ownership			89,253	89,253		89,253	60,873	150,126			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			77,958	77,958		77,958		77,958			42
43	Other (specify):* Non-allowable cost			1,198	1,198		1,198	(1,198)				43
44	TOTAL Special Cost Centers			79,156	79,156		79,156	(1,198)	77,958			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,691,687	328,321	971,630	2,991,638		2,991,638	106,762	3,098,400			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	57,881	30		9
10	Interest and Other Investment Income	(100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(428)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(120)	43		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	(6,897)	20		28
29	Other-Attach Schedule <u>See Pg 5A</u>	(650)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 49,686		\$	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)	57,076		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 57,076		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 106,762		37

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

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

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

BHF USE ONLY							
48		49		50		51	
						52	

Saline Care Center

ID# 0029462

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Political contributions	\$ (650)	43	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	Total	(650)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Saline Care Center# 0029462

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	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	187	0	0	0	0	0	0	0	0	0	187	3
4	Laundry	0	135	0	0	0	0	0	0	0	0	0	135	4
5	Heat and Other Utilities	0	1,262	0	0	0	0	0	0	0	0	0	1,262	5
6	Maintenance	0	696	0	0	0	0	0	0	0	0	0	696	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	2,280	0	0	0	0	0	0	0	0	0	2,280	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,530	0	0	0	0	0	0	0	0	0	1,530	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,928	0	0	0	0	0	0	0	0	0	2,928	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	TOTAL Health Care and Programs	0	4,458	0	0	0	0	0	0	0	0	0	4,458	16
	C. General Administration													
17	Administrative	0	134,228	(169,638)	0	0	0	0	0	0	0	0	(35,410)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,490	0	0	0	0	0	0	0	0	0	21,490	19
20	Fees, Subscriptions & Promotions	(6,897)	3,126	0	0	0	0	0	0	0	0	0	(3,771)	20
21	Clerical & General Office Expenses	0	36,661	0	0	0	0	0	0	0	0	0	36,661	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,218	0	0	0	0	0	0	0	0	0	1,218	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	15,554	0	0	0	0	0	0	0	0	0	15,554	26
27	Other (specify):*	0	4,607	0	0	0	0	0	0	0	0	0	4,607	27
28	TOTAL General Administration	(6,897)	216,884	(169,638)	0	40,349	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,897)	223,622	(169,638)	0	47,087	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Saline Care Center

0029462

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	57,881	0	2,156	0	0	0	0	0	0	0	0	60,037	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(100)	0	0	0	0	0	0	0	0	0	0	(100)	32
33	Real Estate Taxes	0	0	936	0	0	0	0	0	0	0	0	936	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	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	57,781	0	3,092	0	60,873	37							
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(1,198)	0	0	0	0	0	0	0	0	0	0	(1,198)	43
44	TOTAL Special Cost Centers	(1,198)	0	0	0	0	0	0	0	0	0	0	(1,198)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	49,686	223,622	(166,546)	0	106,762	45							

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 Herrin	50	Carrier Mills Nursing Home	Carrier Mills, IL	RDK Management	Harrisburg, IL	Management Co
Larry Jones	50	Stone Bridge Care Center	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:		
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	3 Cleaning	\$	RDK Management Inc.		\$ 187	\$	187	1
2	V	4 Laundry		RDK Management Inc.		135		135	2
3	V	5 Utilities		RDK Management Inc.		1,262		1,262	3
4	V	6 Repairs & Maintence		RDK Management Inc.		696		696	4
5	V	10 Drugs & Operating Supplies		RDK Management Inc.		1,530		1,530	5
6	V	11 Christmas Party		RDK Management Inc.		2,928		2,928	6
7	V	17 Officer Salaries		RDK Management Inc.		134,228		134,228	7
8	V	19 Legal & Professional		RDK Management Inc.		21,490		21,490	8
9	V	20 Dues, Subscriptions & Licenses		RDK Management Inc.		3,126		3,126	9
10	V	21 Office, Clerical		RDK Management Inc.		36,661		36,661	10
11	V	27 Employee Benefits		RDK Management Inc.		4,607		4,607	11
12	V	24 Travel Expenses		RDK Management Inc.		1,218		1,218	12
13	V	26 Auto Expense		RDK Management Inc.		15,554		15,554	13
14	Total		\$			\$ 223,622	\$ *	223,622	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. 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	30 Depreciation	\$	RDK Management Inc.		\$ 2,156	\$ 2,156	15
16	V	33 Real Estate Taxes		RDK Management Inc.		936	936	16
17	V	17 Management Fees	169,638	RDK Management Inc.			(169,638)	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		\$ 169,638			\$ 3,092	\$ * (166,546)	39

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

Facility Name & ID Number

Saline Care Center

0029462

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	185,272	20	29.00	Mgmt. Fees	\$ 134,228	17(3)	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 134,228		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

Saline Care Center

ID # 0029462

Compensation Received From Other Related Nursing Home

FYE: 12/31/2008

Other Related Nursing Homes:	Roger Herrin
Stonebridge Senior Living Center (ID # 0033258)	91,691
Carrier Mills Nursing Home (ID # 0033258)	93,581
Total	<u>185,272</u>

Above Salaries received through RDK Management, Inc.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center

0029462

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 RDK Management Inc.
 Street Address 607 S. Commercial
 City / State / Zip Code Harrisburg, IL 62946
 Phone Number (618) 926-3007
 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	3	Cleaning	Bed Days Available	123,708	3	\$ 446	\$ 51,972	\$ 187	1
2	4	Laundry	Bed Days Available	123,708	3	321	51,972	135	2
3	5	Utilities	Bed Days Available	123,708	3	3,003	51,972	1,262	3
4	6	Repairs & Maintenance	Bed Days Available	123,708	3	1,657	51,972	696	4
5	10	Drugs & Operating Supplies	Bed Days Available	123,708	3	3,642	51,972	1,530	5
6	11	Christmas Party	Bed Days Available	123,708	3	6,970	51,972	2,928	6
7	17	Officer Salaries	Bed Days Available	123,708	3	319,500	319,500	134,228	7
8	19	Legal & Professional	Bed Days Available	123,708	3	51,153	51,972	21,490	8
9	20	Dues, Subscriptions & Licenses	Bed Days Available	123,708	3	7,442	51,972	3,127	9
10	21	Office, Clerical	Bed Days Available	123,708	3	87,265	60,141	36,660	10
11	22	Employee Benefits	Bed Days Available	123,708	3	10,965	51,972	4,607	11
12	24	Travel Expenses	Bed Days Available	123,708	3	2,900	51,972	1,218	12
13	26	Auto Expense	Bed Days Available	123,708	3	37,022	51,972	15,554	13
14	30	Depreciation	Bed Days Available	123,708	3	5,131	51,972	2,156	14
15	33	Real Estate Taxes	Bed Days Available	123,708	3	2,228	51,972	936	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 539,645	\$ 379,641	\$ 226,714	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Saline Care Center

0029462

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Regions Bank		X	Loan Consol. & Renovation	\$20,000.00	5/25/1997	\$ 2,200,000	\$ 1,097,336	03/25/2010	0.0650	\$ 2,773	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Farmers Bank		X	Line of Credit	Varies	7/3/08	926,161	180,000	7/3/2009	Varies	21,025	6						
7												7						
8												8						
9	TOTAL Facility Related				\$20,000.00		\$ 3,126,161	\$ 1,277,336			\$ 23,798	9						
B. Non-Facility Related*																		
10											(100)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (100)	14						
15	TOTALS (line 9+line14)						\$ 3,126,161	\$ 1,277,336			\$ 23,698	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ No Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' 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

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

1. Real Estate Tax accrual used on 2007 report.		\$	41,940	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.)	2007	\$	43,053	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,113	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	19,887	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
	Allocated Mgmt. Co.		936	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	21,936	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	37,130	8
	2004	38,900	9
	2005	40,142	10
	2006	41,941	11
	2007	43,053	12

Accrual is based on 2007 real estate tax expense.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 & Building</u>	\$ <u>16,641.50</u>	\$ <u>16,641.50</u>
2. <u>06-1-098-01</u>	<u>Land & Building</u>	\$ <u>26,411.88</u>	\$ <u>26,411.88</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>43,053.38</u>	\$ <u>43,053.38</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center

0029462

Report Period Beginning:

01/01/08

Ending:

12/31/08

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).

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	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility Use	514,920	1985	\$ 50,000	1
2	Allocated from Home Office	4,465	1993	7,982	2
3	TOTALS	519,385		\$ 57,982	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center

0029462

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	124	1985	1969	\$ 1,230,310	\$	30	\$ 41,010	\$ 41,010	\$ 968,861	4
5	18	1992	1992	700,233	21,738	30	23,341	1,603	377,595	5
6										6
7										7
8										8
	Improvement Type**									
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		10			2,209	14
15	IMPROVEMENTS-A/C & HEATER	1987		3,348		8			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		15			10,381	18
19	IMPROVEMENTS-ALLOCATION	1993		45,764	1,187	30	1,525	338	20,642	19
20	IMPROVEMENTS-CARPORT	1994		1,859	48	30	62	14	930	20
21	IMPROVEMENTS-ALLOCATION	1994		1,978	69	30	66	(3)	841	21
22	IMPROVEMENTS-ALLOCATION	1996		73	5	30	2	(3)	29	22
23	IMPROVEMENTS-ROOF	1997		14,650	376	39	488	112	5,856	23
24	IMPROVEMENTS-STORAGE BUILDING	1998		4,244	109	39	109		1,199	24
25	IMPROVEMENTS-GARAGE DOOR	1998		313	8	39	8		88	25
26	IMPROVEMENTS-ALLOCATION	1998		333	8	30	11	3	109	26
27	IMPROVEMENTS-ROOF	2000		55,245	1,417	39	1,417		12,753	27
28	IMPROVEMENTS-CARPET & ACCOU WALL	2000		17,037	760	7		(760)	17,037	28
29	IMPROVEMENTS-ALLOCATION	2000		7,352	326	30	246	(80)	1,959	29
30	IMPROVEMENTS-A & HEAT PUMP/C	2001		7,245	647	7	1,035	388	8,280	30
31	IMPROVEMENTS-SECURITY ALARM	2004		2,313		7	330	330	1,532	31
32	IMPROVEMENTS-VINYL FLOORING NURSE STATION	2004		2,020		7	289	289	1,324	32
33	IMPROVEMENTS	2006		708	18	39	18		54	33
34	IMPROVEMENTS	2006		815	21	39	21		63	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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)	\$	2,337,841	\$	26,737	\$	69,978	\$	43,241	\$	1,664,501	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:

01/01/08

Ending:

12/31/08

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	\$ 235,849	\$ 6,828	\$ 23,451	\$ 16,623	10	\$ 213,589	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	431,220				10	431,220	73
74								74
75	TOTALS	\$ 667,069	\$ 6,828	\$ 23,451	\$ 16,623		\$ 644,809	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	\$ 35,222	\$ 746		\$ (746)		\$ 35,222	76
77	TRANSPORT PATIENTS	1998 FORD SUPERWAGON	1998	26,502					26,502	77
78	TRANSPORT PATIENTS	1993 FORD AEROSTAR	1994	18,218					18,218	78
79	HAULING MAINTENANCE	2005 FORD RANGER TRUCK	2005	13,770	2,522	3,441	919		13,770	79
80	TOTALS			\$ 93,712	\$ 3,268	\$ 3,441	\$ 173		\$ 93,712	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)	\$ 3,156,604	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,833	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,870	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 60,037	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,403,022	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

(1) Includes allocation of home office-see schedule

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		<u>N/A</u>						5
6								6
7	TOTAL				\$			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: \$ 7,622 Description: Postage Meter-\$966; Medical Equipment-\$6,656

(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	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	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

0029462

Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 45,668	\$ 45,668	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	886,521	886,521	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	23,303	23,303	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	181,702	181,702	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See attached sch 17A</u>	280	280	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,137,474	\$ 1,137,474	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	57,982	13
14	Buildings, at Historical Cost	2,036,877	1,930,543	14
15	Leasehold Improvements, at Historical Cost	75,074	407,298	15
16	Equipment, at Historical Cost	961,361	760,781	16
17	Accumulated Depreciation (book methods)	(2,565,203)	(2,403,022)	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 sch 17A</u>	397	397	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 528,506	\$ 753,979	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,665,980	\$ 1,891,453	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,419	\$ 41,419	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	180,000	180,000	29
30	Accrued Salaries Payable	33,563	33,563	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,887	19,887	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached schedule 17A</u>	7,241	7,241	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 282,110	\$ 282,110	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,097,336	1,097,336	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>See attached schedule 17A</u>	23,753	23,753	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,121,089	\$ 1,121,089	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,403,199	\$ 1,403,199	46
47	TOTAL EQUITY(page 18, line 24)	\$ 262,781	\$ 488,254	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,665,980	\$ 1,891,453	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Saline Care Center
 29462
 1/1/08-12/31/08

XV. Balance Sheet

A. Current Assets

Line 9. Other

Description

Garnishment WH
 Federal Wh
 EIC
 State WH

Amount

42 Payroll Advance
 105 FUTA
 106 SUTA
 27 Goodwill
280

C. Other Current Liabilities

Line 36 Other

Description

42 Payroll Advance
 105 FUTA
 106 SUTA
 27 Goodwill

Amount

(5,000)
 (580)
 (1,761)
 100
(7,241)

B. Long Term Assets

Line 23 Other

Description

Closing Cost
 Immediate Use Value
 Accum Amort Loan Cost
 Accum Amort Immed. Use Value

Amount

3,760
 30,000
 (3,363)
 (30,000)
397

C. Other Current Liabilities

Line 44 Other

Description

Accrued Insurance
 Accrued Sales Tax
 Accrued Management Fees

Amount

(7,218)
 (742)
 (15,793)
(23,753)

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 171,936	1
2	Restatements (describe):		2
3	Post closing adjustment	4,267	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 176,203	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	86,578	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 86,578	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)	\$ 262,781	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,078,116	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,078,116	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	100	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 100	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,078,216	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	870,517	31
32	Health Care	1,189,783	32
33	General Administration	762,929	33
	B. Capital Expense		
34	Ownership	89,253	34
	C. Ancillary Expense		
35	Special Cost Centers	1,198	35
36	Provider Participation Fee	77,958	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,991,638	40
41	Income before Income Taxes (line 30 minus line 40)**	86,578	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 86,578	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. Tax Return prepared on tax basis.

*** 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:

01/01/08

Ending:

12/31/08

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	2,088	2,168	\$ 60,683	\$ 27.99	1
2	Assistant Director of Nursing	1,955	2,023	37,445	18.51	2
3	Registered Nurses	576	576	10,745	18.65	3
4	Licensed Practical Nurses	28,320	28,834	361,235	12.53	4
5	CNAs & Orderlies	52,027	53,666	508,047	9.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,172	2,311	18,852	8.16	8
9	Activity Director	1,866	1,956	16,843	8.61	9
10	Activity Assistants	3,605	3,819	28,790	7.54	10
11	Social Service Workers	3,972	4,094	47,402	11.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,168	18,710	143,317	7.66	15
16	Dishwashers					16
17	Maintenance Workers	6,592	6,853	74,020	10.80	17
18	Housekeepers	19,809	20,694	161,784	7.82	18
19	Laundry	7,744	8,175	63,155	7.73	19
20	Administrator	2,544	2,832	68,645	24.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,914	1,970	24,874	12.63	23
24	Clerical	2,520	2,552	37,050	14.52	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) <u>MDS Coordinator</u>	1,851	1,851	28,800	15.56	33
34	TOTAL (lines 1 - 33)	157,723	163,084	\$ 1,691,687 *	\$ 10.37	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	Bi-Monthly	\$ 6,190	L1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	150	L10(3)	39
40	Physical Therapy Consultant	Varies	2,313	L10A(3)	40
41	Occupational Therapy Consultant	Varies	2,175	L10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	2,534	L12(3)	45
46	Other(specify) <u>Psychiatric</u>	Monthly	5,775	L10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,137		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		N/A	52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center

0029462

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	
Scott Stout	Administrator	0%	\$ 23,630	Workers' Compensation Insurance	\$ 95,249	IDPH License Fee	\$ 1,990	
Roxanne Keasler	Administrator	0%	42,942	Unemployment Compensation Insurance	15,176	Advertising: Employee Recruitment	7,378	
Alice Stallings	Executive Director	0%	2,073	FICA Taxes	135,458	Health Care Worker Background Check	1,204	
				Employee Health Insurance	20,778	(Indicate # of checks performed <u>76</u>)		
				Employee Meals		Patient Background Checks	624	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	710	
				Other employee benefits	26,958	Miscellaneous Dues & Subscriptions	5,419	
						Allocated home office	3,126	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 68,645					
B. Administrative - Other								
Description			Amount					
Management Fees			\$ 169,638					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 169,638					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Gray Hunter Stenn	Accounting		\$ 11,696	N/A			Out-of-State Travel	\$
Thomas Wolf	Legal		804					
Elvidge Kelly	Legal		125					
Beverly Spivey	Accounting		3,455				In-State Travel	
							Seminar Expense	217
							Allocated home office	1,218
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 16,080				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,435

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Saline Care Center

0029462

1/1/08-12/31/08

Schedule 21.C

Professional Fees from page 21

16,080

Home office allocation

21,490

Page 3, Line 19, Col. 8

37,570

See Accountants' Compilation Report

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Saline Care Center# 0029462

Report Period Beginning:

01/01/08

Ending:

12/31/08**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? No
If YES, give association name and amount. N/A
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 419 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. \$ 77,958
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? 0 Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- 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