

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0054577

Facility Name: Pinckneyville Nrsing & Rehab

Address: 708 Virginia Court Pinckneyville 62274
Number City Zip Code

County: Perry

Telephone Number: (618) 357-2493 Fax # (618) 357-3120

HFS ID Number:

Date of Initial License for Current Owners: 2/1/14

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ()

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' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab

0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>17</u>	Skilled (SNF)	<u>17</u>	<u>6,222</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>43</u>	Intermediate (ICF)	<u>43</u>	<u>15,738</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,960</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,835</u>	<u>1,835</u>	8
9	SNF/PED					9
10	ICF	<u>9,848</u>	<u>4,621</u>		<u>14,469</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,848</u>	<u>4,621</u>	<u>1,835</u>	<u>16,304</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.24%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ 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 2/1/2014

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 2/1/2014 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 17 and days of care provided 1,755

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	113,290	9,311	4,359	126,960		126,960		126,960			1
2	Food Purchase		81,787		81,787		81,787		81,787			2
3	Housekeeping	81,212	8,968		90,180		90,180	2,399	92,579			3
4	Laundry	45,924	4,314		50,238		50,238		50,238			4
5	Heat and Other Utilities			50,836	50,836		50,836	217	51,053			5
6	Maintenance	27,308	3,491	17,143	47,942		47,942	1,755	49,697			6
7	Other (specify):* Waste Rem/RDK/SI Benefits Alloc			2,801	2,801		2,801	1,010	3,811			7
8	TOTAL General Services	267,734	107,871	75,139	450,744		450,744	5,381	456,125			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	697,884	33,058	1,200	732,142		732,142	19,773	751,915			10
10a	Therapy											10a
11	Activities	27,823			27,823		27,823		27,823			11
12	Social Services	24,459	2,390	4,403	31,252		31,252		31,252			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RDK/SI Benefits Alloc							2,637	2,637			15
16	TOTAL Health Care and Programs	750,166	35,448	10,403	796,017		796,017	22,410	818,427			16
	C. General Administration											
17	Administrative	33,807		139,495	173,302		173,302	(60,280)	113,022			17
18	Directors Fees											18
19	Professional Services			33,079	33,079		33,079	(3,981)	29,098			19
20	Dues, Fees, Subscriptions & Promotions			4,849	4,849		4,849	345	5,194			20
21	Clerical & General Office Expenses	35,696	11,511	8,056	55,263		55,263	17,129	72,392			21
22	Employee Benefits & Payroll Taxes			173,753	173,753		173,753		173,753			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,471	2,471		2,471	48	2,519			24
25	Other Admin. Staff Transportation			1,241	1,241		1,241	3,596	4,837			25
26	Insurance-Prop.Liab.Malpractice			31,270	31,270		31,270	833	32,103			26
27	Other (specify):* RDK/SI Benefits Alloc							8,433	8,433			27
28	TOTAL General Administration	69,503	11,511	394,214	475,228		475,228	(33,877)	441,351			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,087,403	154,830	479,756	1,721,989		1,721,989	(6,086)	1,715,903			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			106,459	106,459		106,459	397	106,856			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,166	69,166		69,166	(34)	69,132			32
33	Real Estate Taxes			17,398	17,398		17,398	117	17,515			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,241	5,241		5,241		5,241			35
36	Other (specify):* Loan Cost Amort			5,109	5,109		5,109		5,109			36
37	TOTAL Ownership			203,373	203,373		203,373	480	203,853			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,555	120,351	175,906		175,906		175,906			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,597	101,597		101,597		101,597			42
43	Other (specify):* Disallowed Costs			1,079	1,079		1,079	(1,079)				43
44	TOTAL Special Cost Centers		55,555	223,027	278,582		278,582	(1,079)	277,503			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,087,403	210,385	906,156	2,203,944		2,203,944	(6,685)	2,197,259			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,850)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(45)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	43		13
14	Non-Care Related Interest	(34)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(100)	20		17
18	Fines and Penalties	(54)	43		18
19	Entertainment	(225)	43		19
20	Contributions	(593)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,167)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	15,361	43		24
25	Fund Raising, Advertising and Promotional	(11,168)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax		43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,764)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,698)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (6,685)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Goodwill Amortization	\$ (333)	43	1
2	Birthday Expense	(997)	43	2
3	Gifts	(161)	43	3
4	Miscellaneous Income Offset	(273)	21	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	(1,764)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pinckneyville Nrsing & Rehab# 0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	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	2,399	0	0	0	0	0	0	0	0	2,399	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	217	0	0	0	0	0	0	0	0	217	5
6	Maintenance	0	0	1,755	0	0	0	0	0	0	0	0	1,755	6
7	Other (specify):*	0	0	1,010	0	0	0	0	0	0	0	0	1,010	7
8	TOTAL General Services	0	0	5,381	0	0	0	0	0	0	0	0	5,381	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	19,773	0	0	0	0	0	0	0	0	0	19,773	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	2,637	0	0	0	0	0	0	0	0	0	2,637	15
16	TOTAL Health Care and Programs	0	22,410	0	0	0	0	0	0	0	0	0	22,410	16
	C. General Administration													
17	Administrative	0	(52,429)	(7,851)	0	0	0	0	0	0	0	0	(60,280)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,167)	699	487	0	0	0	0	0	0	0	0	(3,981)	19
20	Fees, Subscriptions & Promotions	(100)	388	57	0	0	0	0	0	0	0	0	345	20
21	Clerical & General Office Expenses	(273)	15,627	1,775	0	0	0	0	0	0	0	0	17,129	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	23	25	0	0	0	0	0	0	0	0	48	24
25	Other Admin. Staff Transportation	0	1,786	1,810	0	0	0	0	0	0	0	0	3,596	25
26	Insurance-Prop.Liab.Malpractice	0	347	486	0	0	0	0	0	0	0	0	833	26
27	Other (specify):*	0	6,511	1,922	0	0	0	0	0	0	0	0	8,433	27
28	TOTAL General Administration	(5,540)	(27,048)	(1,289)	0	0	0	0	0	0	0	0	(33,877)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(5,540)	(4,638)	4,092	0	0	0	0	0	0	0	0	(6,086)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(45)	442	0	0	0	0	0	0	0	0	0	397	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34)	0	0	0	0	0	0	0	0	0	0	(34)	32
33	Real Estate Taxes	0	0	117	0	0	0	0	0	0	0	0	117	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	(79)	442	117	0	0	0	0	0	0	0	0	480	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):*	(1,079)	0	0	0	0	0	0	0	0	0	0	(1,079)	43
44	TOTAL Special Cost Centers	(1,079)	0	0	0	0	0	0	0	0	0	0	(1,079)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(6,698)	(4,196)	4,209	0	0	0	0	0	0	0	0	(6,685)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steven B. Herrin	33.33	Carrier Mills Nursing & Rehab	Carrier Mills	RDK Management, Inc	Harrisburg	Management Co.
Dr. Roger Herrin	33.33	Saline Care Center	Harrisburg	SI Management Svc, LLC	Harrisburg	Management Co.
Scott Stout	33.33	Stonebridge Senior Living Center	Benton			
		DuQuoin Nursing & Rehab	DuQuoin			

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	10	Nursing Wages	\$	SI Management Services, LLC	100.00%	\$ 19,773	\$ 19,773	1
2	V	15	Health Care and Prog Emp. Ben.		SI Management Services, LLC	100.00%	2,637	2,637	2
3	V	17	Administrative	85,930	SI Management Services, LLC	100.00%	33,501	(52,429)	3
4	V	19	Professional Fees		SI Management Services, LLC	100.00%	699	699	4
5	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	388	388	5
6	V	21	Clerical And General		SI Management Services, LLC	100.00%	15,627	15,627	6
7	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	23	23	7
8	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	1,786	1,786	8
9	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	347	347	9
10	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	6,511	6,511	10
11	V	30	Depreciation		SI Management Services, LLC	100.00%	442	442	11
12	V								12
13	V								13
14	Total			\$ 85,930			\$ 81,734	\$ * (4,196)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	\$	RDK Management, Inc.	100.00%	\$ 2,399	\$ 2,399	15
16	V	5	Utilities		RDK Management, Inc.	100.00%	217	217	16
17	V	6	Maintenance		RDK Management, Inc.	100.00%	1,755	1,755	17
18	V	7	General Svcs. Emp. Ben.		RDK Management, Inc.	100.00%	1,010	1,010	18
19	V	17	Administrative	53,565	RDK Management, Inc.	100.00%	45,714	(7,851)	19
20	V	19	Professional Services		RDK Management, Inc.	100.00%	487	487	20
21	V	20	Dues, Fees, Subs & Promotions		RDK Management, Inc.	100.00%	57	57	21
22	V	21	Clerical and General Office		RDK Management, Inc.	100.00%	1,775	1,775	22
23	V	24	Travel and Seminar		RDK Management, Inc.	100.00%	25	25	23
24	V	25	Other Admin. Staff Transport.		RDK Management, Inc.	100.00%	1,810	1,810	24
25	V	26	Insurance-Prop./Liab./Malprac.		RDK Management, Inc.	100.00%	486	486	25
26	V	27	Mgmt. Allocation of Benefits		RDK Management, Inc.	100.00%	1,922	1,922	26
27	V	33	Real Estate Taxes		RDK Management, Inc.	100.00%	117	117	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			\$ 53,565			\$ 57,774	\$ * 4,209	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dr. Roger Herrin	Owner	Administrative	0.33	See Att Sch 7A	7.29	10.72	Alloc. Fee	\$ 38,478	L17, C7	1
2	Steven Herrin	Owner	Administrative	0.33	147,500						2
3	Scott Stout	Owner	Administrative	0.33	See Att Sch 7A	7.29	12.15	Alloc. Salary	15,555	L17, C7	3
4											4
5											5
6											6
7											7
8	Steven Herrin received \$120,000 of wages from Stonebridge Senior Living Center and \$27,500 of guaranteed payments from Duquoin Nursing and Rehab										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 54,033		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization SI Management Services, LLC
Street Address 607 South Commercial
City / State / Zip Code Harrisburg, Illinois
Phone Number (618) 252-7707
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	10	Nursing Wages	Census	134,154	5	162,702	162,702	16,304	\$ 19,773	1
2	15	Health Care and Prog Emp. Ben.	Census	134,154	5	21,694		16,304	2,637	2
3	17	Administrative	Census	134,154	5	275,658	275,657	16,304	33,501	3
4	19	Professional Fees	Census	134,154	5	5,751		16,304	699	4
5	20	Fees, Subscriptions	Census	134,154	5	3,189		16,304	388	5
6	21	Clerical And General	Census	134,154	5	128,583	126,166	16,304	15,627	6
7	24	Travel and Seminar	Census	134,154	5	191		16,304	23	7
8	25	Admin. Staff Trans.	Census	134,154	5	14,698		16,304	1,786	8
9	26	Insurance-Prop./Liab./Malprac.	Census	134,154	5	2,853		16,304	347	9
10	27	Gen. Admin. Emp. Ben.	Census	134,154	5	53,576		16,304	6,511	10
11	30	Depreciation	Census	134,154	5	3,634		16,304	442	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					\$ 672,529	\$ 564,525		\$ 81,734	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization RDK Management, Inc.
Street Address 607 South Commercial
City / State / Zip Code Harrisburg, Illinois
Phone Number (618) 252-7707
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	Housekeeping	Census	134,154	5	19,736	19,736	16,304	\$ 2,399	1
2	5	Utilities	Census	134,154	5	1,783		16,304	217	2
3	6	Maintenance	Census	134,154	5	14,444	11,560	16,304	1,755	3
4	7	General Svcs. Emp. Ben.	Census	134,154	5	8,314		16,304	1,010	4
5	17	Administrative	Census	134,154	5	376,148	59,539	16,304	45,714	5
6	19	Professional Services	Census	134,154	5	4,010		16,304	487	6
7	20	Dues, Fees, Subs & Promotions	Census	134,154	5	471		16,304	57	7
8	21	Clerical and General Office	Census	134,154	5	14,604		16,304	1,775	8
9	24	Travel and Seminar	Census	134,154	5	207		16,304	25	9
10	25	Other Admin. Staff Transport.	Census	134,154	5	14,897		16,304	1,810	10
11	26	Ins.-Prop.Liab.Malpractice	Census	134,154	5	3,999		16,304	486	11
12	27	Mgmt. Allocation of Benefits	Census	134,154	5	15,817		16,304	1,922	12
13	33	Real Estate Taxes	Census	134,154	5	962		16,304	117	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					\$ 475,392	\$ 90,835		\$ 57,774	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Farmers State Bank		X	Martgage - Facility	\$8,976.45	6/29/2016	\$ 1,381,000	\$ 1,359,173	6/29/2036	0.0475	\$ 33,479	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Farmers State Bank		X	Line of Credit/Construction	Interest Only	3/20/15	500,000		5/20/16	0.0475	1,517	6	
7	Farmers State Bank		X	Line of Credit/Construction	Interest Only	11/25/15	1,326,000		11/25/16	0.0475	31,667	7	
8	Farmers State Bank		X	Line of Credit	Interest Only	6/29/2016	300,000	170,000	6/29/17	0.0475	2,503	8	
9	TOTAL Facility Related				\$8,976.45		\$ 3,507,000	\$ 1,529,173			\$ 69,166	9	
	B. Non-Facility Related*												
10												10	
11							Interest Income Offset				(34)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (34)	14	
15	TOTALS (line 9+line14)						\$ 3,507,000	\$ 1,529,173			\$ 69,132	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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' PREPARATION REPORT

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pinckneyville Nrsing & Rehab COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0054577

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 252-7707 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1-53-0360-150</u>	<u>Long Term Care Property</u>	\$ <u>15,781.38</u>	\$ <u>15,781.38</u>
2. <u>06-2-275-02</u>	<u>Home Office Allocation</u>	\$ <u>963.32</u>	\$ <u>117.00</u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u><u>16,744.70</u></u>	\$ <u><u>15,898.38</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:

13,097

B. General Construction Type:

Exterior

Brick

Frame

Masonry

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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	108,900	2014	\$ 10,000	1
2					2
3	TOTALS	108,900		\$ 10,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	60		2014	1971	\$ 20,245	\$	39	\$ 519	\$ 519	\$ 1,557
5	Sprinkler			2013	24,800		7	3,543	3,543	7,131
6										
7										
8										
	Improvement Type**									
9	Pole Barn		2014		35,343		39	906	906	2,265
10	New Windows		2014		22,000		39	564	564	1,410
11	All Bathroom/Shower Rooms - cabinets, countertops, drywall,		2014		46,695		15	3,113	3,113	7,264
12	plumbing, electric, mirrors, paint									
13	Replace/Repair walls & drywall, relocate plumbing & electric,		2014		146,393		39	3,754	3,754	7,821
14	New Doors, Paint & Molding for entire facility									
15	Generator		2014		39,000		7	5,571	5,571	15,194
16	Generator-Additional Wiring and Hookup		2014		9,621		15	641	641	2,208
17	New Roof		2014		41,660		15	2,777	2,777	6,480
18	Parking Lot Paving		2014		25,411		15	1,694	1,694	4,235
19	Landscaping		2014		12,540		15	836	836	1,811
20	New Entry Doors		2014		16,610		15	1,107	1,107	2,306
21	Sprinkler System - Add & Relocate Sprinklers in Soffits		2014		11,129		7	1,590	1,590	3,563
22	Installed new Air Maint System, 9 AC Units with Sleeves,		2014		9,793		7	1,399	1,399	3,181
23	Phone wiring in offices, Side Entry Awning									
24	Facility Camera Detector System		2014		5,895		7	842	842	1,824
25	Install Therapure Side Entry Bath		2014		9,530		7	1,361	1,361	2,949
26	Wall Vinyl - Res Rms, Hallways, Nurses Station, Dining Rm		2014		22,626		7	3,232	3,232	7,239
27	Privacy Tracks/Draperies - Resident Rms, Shower/Tub Room		2014		3,023		7	432	432	968
28	Handrails/bumper guards-Halls A, B, C, Service and Dining		2014		8,813		7	1,259	1,259	2,820
29	Flooring/cove base-Res Rms, Halls A, B, C and Service, Toilet		2014		64,122		7	9,160	9,160	20,515
30	& Shower Rms, Nurses Station, Beauty Shop, Fitness Rm									
31	Blinds/windowcoverings - Resident Rms, Corridors A, B & C,		2014		8,766		7	1,252	1,252	2,804
32	Kitchen, Dining Rm, Laundry, Offices, Fitness Center									
33	Light fixtures/sconces- Res Rms, Halls A, B & C, Shower		2014		9,771		7	1,396	1,396	3,127
34	& Toilet Rms, Beauty Shop, Fitness Center, Nurses Station									
35	Interior Design Development Fee		2014		10,000		7	1,429	1,429	3,394
36										

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab

0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Room/Hall and Outdoor signs, Paint & Constr Supplies, Tile	2014	6,510	\$	20	325	\$ 325	\$ 650	37
38	Labor - Drywall Finishing/Painting/Wallpapering/Staining	2014	57,889		20	2,894	2,894	5,788	38
39	throughout Facility								39
40	Kithchen & Bathroom Fixtures, Repair & Replace Drywall,	2015	136,082		20	6,804	6,804	10,206	40
41	Doors & Jambs, Moldings, Painting, Wallpapering,								41
42	Electrical & Plumbing Facility wide								42
43	New Landscaping shrubs	2015	539		20	27	27	40	43
44	Relocate Sprinklers in Conference Rm & Install Dry	2015	2,677		20	134	134	201	44
45	Sidewall Piping under Awning								45
46	Wiring & Installation of New Phone System in new Offices	2015	2,815		20	141	141	211	46
47	Side Entry Awning & 3 new Air Conditioner units	2015	3,256		20	163	163	244	47
48	Rewire Camera Sys & Repair Motion Detector on Front Door	2015	2,845		20	142	142	213	48
49	Room Signs and Wallboards	2015	2,025		20	101	101	152	49
50	Wall Vinyl - Resident Rooms	2015	1,134		20	57	57	85	50
51	Privacy Tracks/Draperies - Res Rms, Shower Rms, Fitness Ctr	2015	12,806		20	640	640	960	51
52	Handrails/Bumper Guards/Wall Protections - Dining Rm	2015	2,081		20	104	104	156	52
53	& Kitchen, Fitness Ctr, Shower Rms								53
54	Flooring/Cove Base - Dining & Service Hall, Offices, Closet	2015	9,144		20	457	457	686	54
55	Blinds & Windowcoverings - Res Rms, Dining, Offices, Fitness Ctr	2015	2,950		20	148	148	222	55
56	Light Fixtures/Sconces - Resident Bathrooms, Conference Rm	2015	1,696		20	85	85	127	56
57	Shower Tile - Resident Shower Rms	2015	1,684		20	84	84	126	57
58	Interior Design Development Fee	2015	5,000		20	250	250	375	58
59	Room/Hall and Outdoor signs, Paint & Constr Supplies, Tile	2015	4,292		20	215	215	322	59
60	Labor - Drywall Finishing/Painting/Wallpapering/Staining	2015	26,899		20	1,345	1,345	2,017	60
61	throughout Facility								61
62	New Door, Reception Window & Replace Front Door Glass	2015	4,570		20	229	229	343	62
63	Wall light fixtures & Outdoor Sign	2015	3,165		20	158	158	237	63
64	Built in Cabinets-Activity Rm, Door Protectors & Bumper Guards	2015	6,170		20	309	309	463	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 900,015	\$		\$ 63,189	\$ 63,189	\$ 135,890	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 900,015	\$		\$ 63,189	\$ 63,189	\$ 135,890	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 Financial Statement Depreciation			106,459			(106,459)		27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 900,015	\$ 106,459		\$ 63,189	\$ (43,270)	\$ 135,890	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$304,262	\$	\$42,107	\$42,107	3-7 yrs	\$98,354	71
72	Current Year Purchases	1,753		124	124	5-7 yrs	124	72
73	Fully Depreciated Assets							73
74	SI Management Allocation			442	442			74
75	TOTALS	\$306,015	\$	\$42,673	\$42,673		\$98,478	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	2015 Kia Sorrento	2014	\$4,331	\$	\$866	\$866	5	\$2,309	76
77	Administrative	2001 Mustang	2014	640		128	128	5	331	77
78										78
79										79
80	TOTALS			\$4,971	\$	\$994	\$994		\$2,640	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,221,001	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$106,459	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$106,856	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$397	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$237,008	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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								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: \$5,241
- Description: Medical Equipment \$4,927; Office Equipment \$314
- (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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$		\$ 46,211	\$		\$ 46,211	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			20,545			20,545	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			53,595			53,595	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				55,555		55,555	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			\$		\$ 120,351	\$ 55,555		\$ 175,906	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 101,643	\$ 101,643	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	898,622	898,622	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	264	264	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,000,529	\$ 1,000,529	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,017	5,017	12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	20,245	45,045	14
15	Leasehold Improvements, at Historical Cost	762,556	854,970	15
16	Equipment, at Historical Cost	321,979	310,986	16
17	Accumulated Depreciation (book methods)	(235,856)	(237,008)	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>Goodwill</u>	4,000	4,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 887,941	\$ 993,010	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,888,470	\$ 1,993,539	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 34,183	\$ 34,183	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	170,000	170,000	29
30	Accrued Salaries Payable	36,111	36,111	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,773	1,773	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,610	16,610	32
33	Accrued Interest Payable	1,562	1,562	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 260,239	\$ 260,239	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,359,173	1,359,173	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,359,173	\$ 1,359,173	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,619,412	\$ 1,619,412	46
47	TOTAL EQUITY(page 18, line 24)	\$ 269,058	\$ 374,127	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,888,470	\$ 1,993,539	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,303	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,302	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	449,151	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	(195,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Record Invest. SI Management	1,605	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 255,756	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)	\$ 269,058	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab

0054577

Report Period Beginning: 1/1/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,626,401	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,626,401	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	27,042	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 27,042	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***	34	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	273	28
28a	<u>SI Management Income/Loss</u>	(655)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (382)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,653,095	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	450,744	31
32	Health Care	796,017	32
33	General Administration	475,228	33
	B. Capital Expense		
34	Ownership	203,373	34
	C. Ancillary Expense		
35	Special Cost Centers	176,985	35
36	Provider Participation Fee	101,597	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,203,944	40
41	Income before Income Taxes (line 30 minus line 40)**	449,151	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 449,151	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,236,601	44
45	Private Pay - Net Inpatient Revenue	668,297	45
46	Medicare - Net Inpatient Revenue	679,319	46
47	Other-(specify) <u>Insurance</u>	42,184	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,626,401	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	2,103	2,147	\$ 59,758	\$ 27.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,439	4,622	100,223	21.68	3
4	Licensed Practical Nurses	8,690	8,727	170,084	19.49	4
5	CNAs & Orderlies	32,563	33,884	367,819	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,284	2,288	27,823	12.16	10
11	Social Service Workers	2,267	2,275	24,459	10.75	11
12	Dietician					12
13	Food Service Supervisor	2,269	2,400	29,735	12.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,263	9,521	83,555	8.78	15
16	Dishwashers					16
17	Maintenance Workers	1,970	2,120	27,308	12.88	17
18	Housekeepers	8,267	8,464	81,212	9.59	18
19	Laundry	4,708	4,937	45,924	9.30	19
20	Administrator	1,484	1,615	33,807	20.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,217	3,351	35,696	10.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,524	86,351	\$ 1,087,403 *	\$ 12.59	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	82	\$ 4,359	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	69	4,403	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	151	\$ 14,762		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Pinckneyville Nrsing & Rehab

0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Jeffrey McDaniel

Administrator

0

\$ 10,262

Charity Bathon

Administrator

0

23,545

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 33,807

B. Administrative - Other

Description

Amount

Management Fees-See Page 6, Eliminated on P 3, C 7

\$ 139,495

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 139,495

C. Professional Services

Vendor/Payee

Type

Amount

Adam Lawler Law Firm

Legal

\$ 737

Lawler Brown Law Frim

Legal

4,325

Daniel Maher

Legal

27

Thomas Wolf Jr, PC

Legal

105

Templin Healthcare Accounting

Accounting

4,189

James Henson, PC

Accounting

8,067

Payroll Services by Extra Help

Payroll Service

1,076

Passport Software

Accounting Software

384

IT Next Gen

Web Hosting Service

190

Information Controls

LTC Software

1,165

American Health Tech

LTC Software

11,906

ESolutions Network

Health Info Management

908

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 33,079

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 49,680

Unemployment Compensation Insurance

29,666

FICA Taxes

80,851

Employee Health Insurance

8,294

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Incentive Expenses

2,497

Life/Disability Insurance

2,765

Other Employee Benefits

TOTAL (agree to Schedule V, line 22, col.8)

\$ 173,753

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

Description

Line #

Amount

N/A

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

2,240

Health Care Worker Background Check

(Indicate # of checks performed 15)

765

Patient Background Checks

59

896

License & Permits

500

Dues & Subcriptions

348

Allocated From RDK/SI Management

445

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 5,194

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

1,103

Seminar Expense

1,368

Allocated From RDK/SI Management

48

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 2,519

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Pinckneyville Nrsing & Rehab	STATE OF ILLINOIS # 0054577	Report Period Beginning: 1/1/16	Ending: 12/31/16
--	--	---	--------------------------------

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? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-7 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,266 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. \$ 101,597
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

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

SEE ACCOUNTANTS' PREPARATION REPORT

Pinckneyville Nrsing & Rehab

Period Beginning 1/1/16
Period End 12/31/16

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	552
Fuel and miscellaneous supplies	689
Allocated from Mgmt Co	3,596
	4,837