

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0054577</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Pinckneyville Nursing Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>708 Virginia Court</u> <u>Pinckneyville</u> <u>62274</u>																									
Number City Zip Code																									
County: <u>Perry</u>																									
Telephone Number: <u>(618) 357-2493</u> Fax # <u>(618) 357-3120</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u>	(Telephone) <u>(630) 361-2868</u> 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												
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	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																								
Date of Initial License for Current Owners: <u>3/1/2017</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Pinckneyville Nursing Rehab

0054577 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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>2,312</u>	<u>2,312</u>	8
9	SNF/PED					9
10	ICF	<u>8,470</u>	<u>4,452</u>	<u>1,227</u>	<u>14,149</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,470</u>	<u>4,452</u>	<u>3,539</u>	<u>16,461</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.96%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 3/1/17

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 3/1/17 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 2,095

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nursing Rehab # 0054577 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	139,996	7,417	3,368	150,781		150,781		150,781			1
2	Food Purchase		95,267		95,267		95,267		95,267			2
3	Housekeeping	118,410	5,892		124,302		124,302	438	124,740			3
4	Laundry	62,558	5,335		67,893		67,893		67,893			4
5	Heat and Other Utilities			47,271	47,271		47,271	469	47,740			5
6	Maintenance	26,143	4,748	22,799	53,690		53,690	(5,960)	47,730			6
7	Other (specify):* Waste Removal			7,589	7,589		7,589	50	7,639			7
8	TOTAL General Services	347,107	118,659	81,027	546,793		546,793	(5,003)	541,790			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,115,651	66,116	2,400	1,184,167		1,184,167	995	1,185,162			10
10a	Therapy			1,365	1,365		1,365		1,365			10a
11	Activities	19,870	967	2,056	22,893		22,893		22,893			11
12	Social Services	26,136		2,196	28,332		28,332		28,332			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* WLC Benefits Alloc							113	113			15
16	TOTAL Health Care and Programs	1,161,657	67,083	12,817	1,241,557		1,241,557	1,108	1,242,665			16
	C. General Administration											
17	Administrative	96,960		183,327	280,287		280,287	(166,198)	114,089			17
18	Directors Fees											18
19	Professional Services			28,030	28,030		28,030	331	28,361			19
20	Dues, Fees, Subscriptions & Promotions			7,954	7,954		7,954	(431)	7,523			20
21	Clerical & General Office Expenses	58,203	11,691	7,496	77,390		77,390	33,767	111,157			21
22	Employee Benefits & Payroll Taxes			212,632	212,632		212,632		212,632			22
23	Inservice Training & Education											23
24	Travel and Seminar			673	673		673	12	685			24
25	Other Admin. Staff Transportation			5,711	5,711		5,711	651	6,362			25
26	Insurance-Prop.Liab.Malpractice			57,777	57,777		57,777	611	58,388			26
27	Other (specify):* WLC Benefits Alloc							5,797	5,797			27
28	TOTAL General Administration	155,163	11,691	503,600	670,454		670,454	(125,460)	544,994			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,663,927	197,433	597,444	2,458,804		2,458,804	(129,355)	2,329,449			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			40,152	40,152		40,152	(25,311)	14,841			30
31	Amortization of Pre-Op. & Org.							212	212			31
32	Interest											32
33	Real Estate Taxes			17,463	17,463		17,463	342	17,805			33
34	Rent-Facility & Grounds			416,870	416,870		416,870		416,870			34
35	Rent-Equipment & Vehicles			4,630	4,630		4,630	45	4,675			35
36	Other (specify):*											36
37	TOTAL Ownership			479,115	479,115		479,115	(24,712)	454,403			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			207	207		207		207			38
39	Ancillary Service Centers		57,933	300,976	358,909		358,909		358,909			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,490	129,490		129,490		129,490			42
43	Other (specify):* Disallowed Costs			70,379	70,379		70,379	(70,379)				43
44	TOTAL Special Cost Centers		57,933	501,052	558,985		558,985	(70,379)	488,606			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,663,927	255,366	1,577,611	3,496,904		3,496,904	(224,446)	3,272,458			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.)

		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	(4,102)	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	(36,735)	30		9
10	Interest and Other Investment Income	(46)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(138)	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	(682)	20		17
18	Fines and Penalties	(1,100)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,616)	43		24
25	Fund Raising, Advertising and Promotional	(21,442)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(613)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(7,926)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (115,400)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1	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)	(109,046)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (109,046)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (224,446)		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gifts	\$	43	1
2	Miscellaneous income offset	(368)	21	2
3	Capitalized Improvements over \$2,500	(7,051)	6	3
4				4
5				5
6				6
7				7
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44				44
45				45
46				46
47				47
48				48
49	Total	(7,926)		49

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
Scott Stout	100	See Page 6 Supp		WLC Management Fir	Harrisburg	Management Co.

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	Housekeeping	\$	WLC Management Firm, LLC	100.00%	\$ 438	\$ 438	1
2	V	5	Utilities		WLC Management Firm, LLC	100.00%	469	469	2
3	V	6	Maintenance		WLC Management Firm, LLC	100.00%	1,091	1,091	3
4	V	7	Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	50	50	4
5	V	10	Nursing and Medical Records		WLC Management Firm, LLC	100.00%	995	995	5
6	V	15	Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	113	113	6
7	V	17	Administrative	183,327	WLC Management Firm, LLC	100.00%	17,129	(166,198)	7
8	V	19	Professional Services		WLC Management Firm, LLC	100.00%	331	331	8
9	V	20	Dues, Fees, Subs & Prom		WLC Management Firm, LLC	100.00%	251	251	9
10	V	21	Clerical & General Office		WLC Management Firm, LLC	100.00%	34,274	34,274	10
11	V	24	Travel & Seminar		WLC Management Firm, LLC	100.00%	12	12	11
12	V	25	Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	651	651	12
13	V	26	Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	611	611	13
14	Total			\$ 183,327			\$ 56,415	\$ * (126,912)	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.

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Mgmt Allocation of Benefits	\$	WLC Management Firm, LLC	100.00%	\$ 5,797	\$ 5,797	15
16	V	30	Depreciation		WLC Management Firm, LLC	100.00%	11,424	11,424	16
17	V	31	Amortization		WLC Management Firm, LLC	100.00%	212	212	17
18	V	32	Interest		WLC Management Firm, LLC	100.00%	46	46	18
19	V	33	Real Estate Taxes		WLC Management Firm, LLC	100.00%	342	342	19
20	V	35	Equipment Rental		WLC Management Firm, LLC	100.00%	45	45	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 17,866	\$ * 17,866	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Pinckneyville Nursing Rehab

0054577

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Alhambra Rehab and Healthcare	Alhambra	Acorn Estates	Mount Carmel	Supportive Living	1
2			Carrier Mills Nursing & Rehab Center	Carrier Mills				2
3			Duquoin Nursing & Rehabilitation Center	Duquoin				3
4			Eldorado Rehab and Healthcare	Eldorado				4
5			Fairview Rehab and Healthcare	DuQuoin				5
6			Greenville Nursing and Rehab Center	Greenville				6
7			Heartland Nursing and Rehab	Casey				7
8			Oakview Nursing and Rehab	Mt Carmel				8
9			Saline Care Nursing and Rehab Center	Harrisburg				9
10			Stonebridge Nursing and Rehab Center	Benton				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nursing Rehab # 0054577 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Scott Stout	Stockholder	Administrative	100.00	See Att Sch 7A	2.74	6.85	Alloc. Salary	\$ 17,129	L17, C7	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	\$ 17,129		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 Nursing Rehab # 0054577 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 WLC Management Firm, LLC
Street Address 215 East Locust Street
City / State / Zip Code Harrisburg, IL 62946
Phone Number (618) 294-8696
Fax Number (618) 294-8699

	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	Weightd Avg Census	240,729	12	\$ 6,399	\$ 6,399	16,461	\$ 438	1
2	5	Utilities	Weightd Avg Census	240,729	12	6,853		16,461	469	2
3	6	Maintenance	Weightd Avg Census	240,729	12	15,959		16,461	1,091	3
4	7	Mgmt Allocation of Benefits	Weightd Avg Census	240,729	12	734		16,461	50	4
5	10	Nursing and Medical Records	Weightd Avg Census	240,729	12	14,557	14,557	16,461	995	5
6	15	Mgmt Allocation of Benefits	Weightd Avg Census	240,729	12	1,669		16,461	113	6
7	17	Administrative	Weightd Avg Census	240,729	12	250,490	250,490	16,461	17,129	7
8	19	Professional Services	Weightd Avg Census	240,729	12	4,836		16,461	331	8
9	20	Dues, Fees, Subscriptions & Prom	Weightd Avg Census	240,729	12	3,667		16,461	251	9
10	21	Clerical & General Office	Weightd Avg Census	240,729	12	501,243	488,721	16,461	34,274	10
11	24	Travel & Seminar	Weightd Avg Census	240,729	12	179		16,461	12	11
12	25	Other Admin Staff Transport	Weightd Avg Census	240,729	12	9,524		16,461	651	12
13	26	Insurance-Prop/Liab/Malprac	Weightd Avg Census	240,729	12	8,930		16,461	611	13
14	27	Mgmt Allocation of Benefits	Weightd Avg Census	240,729	12	84,770		16,461	5,797	14
15	30	Depreciation	Weightd Avg Census	240,729	12	167,061		16,461	11,424	15
16	31	Amortization	Weightd Avg Census	240,729	12	3,096		16,461	212	16
17	32	Interest	Weightd Avg Census	240,729	12	673		16,461	46	17
18	33	Real Estate Taxes	Weightd Avg Census	240,729	12	5,000		16,461	342	18
19	35	Equipment Rental	Weightd Avg Census	240,729	12	653		16,461	45	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,086,293	\$ 760,167		\$ 74,281	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							\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6														6					
7														7					
8														8					
9	TOTAL Facility Related						\$		\$			\$		9					
	B. Non-Facility Related*																		
10														10					
11										Interest Income Offset		(46)		11					
12										WLC Mgmt Allocation		46		12					
13														13					
14	TOTAL Non-Facility Related						\$		\$			\$		14					
15	TOTALS (line 9+line14)						\$		\$			\$		15					

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	16,835	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.)		2019		\$	17,463	2
3. Under or (over) accrual (line 2 minus line 1).				\$	628	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	16,835	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Allocation from Mgmt Co			342	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	342	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	17,805	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015		8		
		2016	16,005	9		
		2017	16,915	10		
		2018	17,344	11		
		2019	17,463	12		
Accrual based on prior year tax bill.				13	FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 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' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pinckneyville Nursing Rehab COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0054577

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 294-8696 FAX #: (618) 294-8699

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 1-53-0360-180	Long Term Care Property	\$ 17,462.66	\$ 17,462.66
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 17,462.66	\$ 17,462.66

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

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:

Allocation from Mgmt Co

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

3. Current Period Amortization:

212

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					\$	1
2						2
3	TOTALS				\$	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	New 100,000 High Efficiency Furnace & 4 Ton 14 SEER AC Unit			2017	9,575		20	479	479	1,676
10	New Trees/Bushes/Landscape Gravel/Irrigation System/Lighting			2018	30,000		20	1,500	1,500	3,750
11	Kitchen Renovation:			2019	45,510		20	2,276	2,276	3,410
12	New Cabinets/ Countertops/ Wallboard/ Electrical Updates/									12
13	New Molding/ Painting/ Stripping and Waxing Floors									13
14	Sealcoat and Stripe Parking Lot			2020	3,512		20	88	88	88
15	Wallcoverings - Kitchen and Dining Room			2020	3,377		20	84	84	84
16										16
17										17
18										18
19										19
20	Financial Statement Depreciation					40,152			(40,152)	20
21										21
22										22
23	Allocated from WLC Management			2018	25,433		15-39	1,085	1,085	12,007
24	Allocated from WLC Management			2020	8,896		15	296	296	296
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										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' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nursing Rehab

0054577

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		\$ 126,303	\$ 40,152		\$ 5,808	\$ (34,344)	\$ 21,311	70

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	\$ 4,500	\$	\$ 450	\$ 450	10 yrs	\$ 1,575	71
72	Current Year Purchases	11,368		568	568	10 Yrs	568	72
73	Fully Depreciated Assets							73
74	Allocated from WLC Mgmt	306					306	74
75	TOTALS	\$ 16,174	\$	\$ 1,018	\$ 1,018		\$ 2,449	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	Facility	2014 Dodge Grand Caravan	2018	\$ 14,420	\$	\$ 3,605	\$ 3,605	4	\$ 7,931	76
77	Facility	2007 Ford Freestar Van	2020	10,000		1,250	1,250	4	1,250	77
78	Allocated from WLC Mgmt			15,626		3,160	3,160		15,626	78
79										79
80	TOTALS			\$ 40,046	\$	\$ 8,015	\$ 8,015		\$ 24,807	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)	\$ 182,523	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 40,152	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,841	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (25,311)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 48,567	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:CTR Partnership, LP
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:	1971	60	2/17/17	\$416,870			3
4	Additions							4
5								5
6								6
7	TOTAL		60		\$416,870			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

N/A

N/A
9. Option to Buy:

YES

X

NOTerms:*

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:\$4,675Description:Medical Equipment \$4,460; Office Equipment \$170; HO Allocation \$45
(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

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)

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

		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)	\$			

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3), 39(3)	hrs	\$	5,286	\$ 97,218	\$	5,286	\$ 97,218	1
2	Licensed Speech and Language Development Therapist	10A(3), 39(3)	hrs		1,967	45,602		1,967	45,602	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3), 39(3)	hrs		6,194	148,716		6,194	148,716	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				57,933		57,933	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	13,447	\$ 291,536	\$ 57,933	13,447	\$ 349,469	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

XV. BALANCE SHEET - Unrestricted Operating Fund.				
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	\$ 595,155	\$ 595,155	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,184)	1,155,190	1,155,190	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,778	5,778	6
7	Other Prepaid Expenses	89,637	89,637	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,845,760	\$ 1,845,760	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	70,319	126,303	15
16	Equipment, at Historical Cost	28,920	56,220	16
17	Accumulated Depreciation (book methods)	(89,969)	(48,567)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,270	\$ 133,956	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,855,030	\$ 1,979,716	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,563	\$ 23,563	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,535	37,535	30
31	Accrued Taxes Payable (excluding real estate taxes)	967	967	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,835	16,835	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	3,144	3,144	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 82,044	\$ 82,044	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	533,109	533,109	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 533,109	\$ 533,109	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 615,153	\$ 615,153	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,239,877	\$ 1,364,563	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,855,030	\$ 1,979,716	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,065,893	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,065,893	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	392,924	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	(218,940)	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)	\$ 173,984	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)	\$ 1,239,877	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nursing Rehab

0054577

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 2,814,078	1
2	Discounts and Allowances for all Levels	743,584	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,557,662	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,618	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 126,618	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	198,676	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	5,226	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	58	19
20	Radiology and X-Ray	1,287	20
21	Other Medical Services	(486)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 204,761	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	280	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 280	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	507	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 507	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,889,828	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	546,793	31
32	Health Care	1,241,557	32
33	General Administration	670,454	33
	B. Capital Expense		
34	Ownership	479,115	34
	C. Ancillary Expense		
35	Special Cost Centers	429,495	35
36	Provider Participation Fee	129,490	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,496,904	40
41	Income before Income Taxes (line 30 minus line 40)**	392,924	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 392,924	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,511,673	44
45	Private Pay - Net Inpatient Revenue	531,590	45
46	Medicare - Net Inpatient Revenue	1,206,684	46
47	Other-(specify) <u>Insurance</u>	56,180	47
48	Other-(specify) <u>VA</u>	251,535	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,557,662	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	1,772	1,928	\$ 65,299	\$ 33.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,878	9,506	297,373	31.28	3
4	Licensed Practical Nurses	10,772	11,146	229,176	20.56	4
5	CNAs & Orderlies	34,287	35,923	523,803	14.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,695	1,711	19,870	11.61	9
10	Activity Assistants					10
11	Social Service Workers	1,800	1,826	26,136	14.31	11
12	Dietician					12
13	Food Service Supervisor	2,277	2,381	34,131	14.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,612	9,873	105,865	10.72	15
16	Dishwashers					16
17	Maintenance Workers	1,650	1,803	26,143	14.50	17
18	Housekeepers	10,041	10,694	118,410	11.07	18
19	Laundry	5,238	5,809	62,558	10.77	19
20	Administrator	2,535	2,613	96,960	37.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,766	4,004	58,203	14.54	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)	94,323	99,217	\$ 1,663,927 *	\$ 16.77	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	69	\$ 3,368	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	2,400	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	29	1,430	L11, C3	44
45	Social Service Consultant	40	2,196	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	138	\$ 14,194		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Julie Wilder	Administrator	0	\$ 78,851
Merle Taylor	Admin Reg Exec	0	17,209
Lon Linder	VP Operations	0	900
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,960
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7		\$	183,327
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 183,327
C. Professional Services			
Vendor/Payee	Type		Amount
E-Solutions, Inc.	Health Info Management	\$	1,453
American Healthtech	LTC Software		11,845
Information Controls	Payroll Service		4,734
Prime Care Technologies	Computer Services		3,790
Templin Healthcare Accounting	Accounting Services		4,468
Kemper CPA Group	Accounting Services		1,740
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 28,030
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	35,122
Unemployment Compensation Insurance			11,385
FICA Taxes			126,912
Employee Health Insurance			31,578
Employee Meals			755
Illinois Municipal Retirement Fund (IMRF)*			
Employee Physicals/Drug Tests			1,566
Life/Disability Insurance			4,795
Other Employee Benefits			519
TOTAL (agree to Schedule V, line 22, col.8)			\$ 212,632
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			860
Health Care Worker Background Check (Indicate # of checks performed 78)			2,085
Patient Background Checks 151			2,888
License & Permits			1,439
Dues & Subcriptions			682
Allocated From WLC Mgmt Firm			251
Less: Public Relations Expense			(682)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,523
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			673
Allocated From WLC Mgmt Firm			12
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	685

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name & ID Number Pinckneyville Nursing Rehab	STATE OF ILLINOIS # 0054577	Report Period Beginning: 1/1/2020	Ending: 12/31/2020
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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? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 10 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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? Yes
 If YES, give effective date of lease. 2/17/17

(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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Pinckneyville Nursing & Rehab, ID #0052704, 2/17/17

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 129,490
 This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 755 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: _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. N/A
 Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' PREPARATION REPORT