FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 0052704

Facility Name: Pinckneyville Nrsing & Rehab

Address: 708 Virginia Court (Number) Pinckneyville (City) 62274 (Zip Code)

County: Perry

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

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2014

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 2/1/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
(Print Name and Title) 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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	20,040	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	20,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	7,868	1,666		9,534	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,868	1,666		9,534	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.57%

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 [X] 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 [X]

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 [X] Date 2/1/2014 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	85,340	7,050	2,969	95,359		95,359		95,359			1
2	Food Purchase		74,541		74,541		74,541		74,541			2
3	Housekeeping	94,849	8,973		103,822		103,822	(15,197)	88,625			3
4	Laundry		4,445		4,445		4,445	27	4,472			4
5	Heat and Other Utilities			34,162	34,162		34,162	669	34,831			5
6	Maintenance	17,645	5,601	44,094	67,340		67,340	(48,978)	18,362			6
7	Other (specify):* Waste Removal			4,124	4,124		4,124		4,124			7
8	TOTAL General Services	197,834	100,610	85,349	383,793		383,793	(63,479)	320,314			8
	B. Health Care and Programs											
9	Medical Director			4,090	4,090		4,090		4,090			9
10	Nursing and Medical Records	383,525	43,250	1,000	427,775		427,775		427,775			10
10a	Therapy			100	100		100		100			10a
11	Activities	2,939			2,939		2,939		2,939			11
12	Social Services	19,800	935	4,388	25,123		25,123		25,123			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	406,264	44,185	9,578	460,027		460,027		460,027			16
	C. General Administration											
17	Administrative	39,309		89,546	128,855		128,855	(44,500)	84,355			17
18	Directors Fees											18
19	Professional Services			25,265	25,265		25,265	995	26,260			19
20	Dues, Fees, Subscriptions & Promotions			7,426	7,426		7,426	33	7,459			20
21	Clerical & General Office Expenses	9,639	9,486	5,932	25,057		25,057	18,151	43,208			21
22	Employee Benefits & Payroll Taxes			108,375	108,375		108,375		108,375			22
23	Inservice Training & Education											23
24	Travel and Seminar			573	573		573	150	723			24
25	Other Admin. Staff Transportation			749	749		749	8,039	8,788			25
26	Insurance-Prop.Liab.Malpractice			18,789	18,789		18,789	717	19,506			26
27	Other (specify):* RDK/SI Benefits Alloc							4,705	4,705			27
28	TOTAL General Administration	48,948	9,486	256,655	315,089		315,089	(11,710)	303,379			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	653,046	154,281	351,582	1,158,909		1,158,909	(75,189)	1,083,720			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Pinckneyville Nrsing & Rehab #0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,558	30,558		30,558	1,083	31,641			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,281	17,281		17,281	(10)	17,271			32
33	Real Estate Taxes			22,486	22,486		22,486	78	22,564			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			321	321		321		321			35
36	Other (specify):* **Loan Costs**			5,235	5,235		5,235		5,235			36
37	**TOTAL Ownership**			75,881	75,881		75,881	1,151	77,032			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,195	79,195		79,195		79,195			42
43	Other (specify):* **Non-allowable Costs**			5,570	5,570		5,570	(5,570)				43
44	**TOTAL Special Cost Centers**			84,765	84,765		84,765	(5,570)	79,195			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	653,046	154,281	512,228	1,319,555		1,319,555	(79,608)	1,239,947			45

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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	(1,528)	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				9
10	Interest and Other Investment Income	(10)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5)	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	(136)	20		17
18	Fines and Penalties	(1)	43		18
19	Entertainment	(575)	43		19
20	Contributions	(450)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,317)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(65,093)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,115)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(9,493)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (9,493)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (79,608)		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

Pinckneyville Nrsing & Rehab

ID# 0052704

Report Period Beginning: 2/1/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Birthday Expense	$ (322)	43	1
2	Gifts	(39)	43	2
3	Goodwill Amortization	(333)	43	3
4	Capitalized Construction Labor/Supplies	(49,202)	6	4
5	Capitalized Construction Labor	(15,197)	3	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**	(65,093)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 **Report Period Beginning:** 2/1/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	(15,197)	0	0	0	0	0	0	0	0	0	0	(15,197)	3
4	Laundry	0	27	0	0	0	0	0	0	0	0	0	27	4
5	Heat and Other Utilities	0	669	0	0	0	0	0	0	0	0	0	669	5
6	Maintenance	(49,202)	224	0	0	0	0	0	0	0	0	0	(48,978)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(64,399)	920	0	0	0	0	0	0	0	0	0	(63,479)	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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	3,667	(48,167)	0	0	0	0	0	0	0	0	(44,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	449	546	0	0	0	0	0	0	0	0	995	19
20	Fees, Subscriptions & Promotions	(136)	149	20	0	0	0	0	0	0	0	0	33	20
21	Clerical & General Office Expenses	0	5,567	12,584	0	0	0	0	0	0	0	0	18,151	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	0	150	0	0	0	0	0	0	0	0	150	24
25	Other Admin. Staff Transportation	0	7,810	229	0	0	0	0	0	0	0	0	8,039	25
26	Insurance-Prop.Liab.Malpractice	0	686	31	0	0	0	0	0	0	0	0	717	26
27	Other (specify):*	0	2,100	2,605	0	0	0	0	0	0	0	0	4,705	27
28	**TOTAL General Administration**	(136)	20,428	(32,002)	0	0	0	0	0	0	0	0	(11,710)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(64,535)	21,348	(32,002)	0	0	0	0	0	0	0	0	(75,189)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 **Report Period Beginning:** 2/1/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	1,083	0	0	0	0	0	0	0	0	0	1,083	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10)	0	0	0	0	0	0	0	0	0	0	(10)	32
33	Real Estate Taxes	0	78	0	0	0	0	0	0	0	0	0	78	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**	(10)	1,161	0	0	0	0	0	0	0	0	0	1,151	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):*	(5,570)	0	0	0	0	0	0	0	0	0	0	(5,570)	43
44	**TOTAL Special Cost Centers**	(5,570)	0	0	0	0	0	0	0	0	0	0	(5,570)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(70,115)	22,509	(32,002)	0	0	0	0	0	0	0	0	(79,608)	45

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	4	Laundry	$	RDK Management, Inc.	100.00%	$ 27	$ 27	1
2	V	5	Utilities		RDK Management, Inc.	100.00%	669	669	2
3	V	6	Repairs and Maint.		RDK Management, Inc.	100.00%	224	224	3
4	V	17	Administrative	27,746	RDK Management, Inc.	100.00%	31,413	3,667	4
5	V	19	Professional Fees		RDK Management, Inc.	100.00%	449	449	5
6	V	20	Fees, Subscriptions		RDK Management, Inc.	100.00%	149	149	6
7	V	21	Clerical And General		RDK Management, Inc.	100.00%	5,567	5,567	7
8	V	25	Admin. Staff Trans.		RDK Management, Inc.	100.00%	7,810	7,810	8
9	V	26	Insurance-Prop./Liab./Malprac.		RDK Management, Inc.	100.00%	686	686	9
10	V	27	Gen. Admin. Emp. Ben.		RDK Management, Inc.	100.00%	2,100	2,100	10
11	V	30	Depreciation		RDK Management, Inc.	100.00%	1,083	1,083	11
12	V	33	Real Estate Tax		RDK Management, Inc.	100.00%	78	78	12
13	V								13
14	Total			$ 27,746			$ 50,255	$ * 22,509	14

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	$ 61,800	SI Management Services, LLC	100.00%	$ 13,633	$ (48,167)	15
16	V	19	Professional Fees		SI Management Services, LLC	100.00%	546	546	16
17	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	20	20	17
18	V	21	Clerical And General		SI Management Services, LLC	100.00%	12,584	12,584	18
19	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	150	150	19
20	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	229	229	20
21	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	31	31	21
22	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	2,605	2,605	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			$ 61,800			$ 29,798	$ * (32,002)	39

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Dr. Roger Herrin	Owner	Administrative	33.33%	See Att Sch 7A	2.02	5.05	Alloc. Salary	$ 27,774	L17, C7	1
2	Steven Herrin	Owner	Administrative	33.33%	105,531	0	0.00				2
3	Scott Stout	Owner	Administrative	33.33%	See Att Sch 7A	2.00	5.00	Alloc. Salary	5,770	L17, C7	3
4											4
5											5
6											6
7	Steven Herrin received wages from Stonebridge Senior Living Center										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 33,544		13

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

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 2/31/2014

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry	Census	118,000	5	339		9,534	$ 27	1
2	5	Utilities	Census	118,000	5	8,278		9,534	669	2
3	6	Repairs and Maint.	Census	118,000	5	2,777		9,534	224	3
4	17	Administrative	Census	118,000	5	388,792	388,792	9,534	31,413	4
5	19	Professional Fees	Census	118,000	5	5,552		9,534	449	5
6	20	Fees, Subscriptions	Census	118,000	5	1,842		9,534	149	6
7	21	Clerical And General	Census	118,000	5	68,903	44,301	9,534	5,567	7
8	25	Admin. Staff Trans.	Census	118,000	5	96,661		9,534	7,810	8
9	26	Insurance-Prop./Liab./Malprac.	Census	118,000	5	8,492		9,534	686	9
10	27	Gen. Admin. Emp. Ben.	Census	118,000	5	25,990		9,534	2,100	10
11	30	Depreciation	Census	118,000	5	13,405		9,534	1,083	11
12	33	Real Estate Tax	Census	118,000	5	970		9,534	78	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					$ 622,001	$ 433,093		$ 50,255	25

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 2/31/2014

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Census	118,000	5	168,736	168,736	9,534	$ 13,633	1
2	19	Professional Fees	Census	118,000	5	6,755		9,534	546	2
3	20	Fees, Subscriptions	Census	118,000	5	250		9,534	20	3
4	21	Clerical And General	Census	118,000	5	155,745	154,984	9,534	12,584	4
5	24	Travel and Seminar	Census	118,000	5	1,851		9,534	150	5
6	25	Admin. Staff Trans.	Census	118,000	5	2,835		9,534	229	6
7	26	Insurance-Prop./Liab./Malprac.	Census	118,000	5	388		9,534	31	7
8	27	Gen. Admin. Emp. Ben.	Census	118,000	5	32,236		9,534	2,605	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 368,796	$ 323,720		$ 29,798	25

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1											$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Farmers State Bank		X	Line of Credit/Construction	Interest Only	12/19/14	$ 1,125,000	$ 1,124,977	12/19/15	0.0475	148	6
7	Farmers State Bank		X	Line of Credit/Construction	Interest Only	3/20/14	500,000	246,357	3/20/15	0.0475	17,133	7
8												8
9	TOTAL Facility Related						$ 1,625,000	$ 1,371,334			$ 17,281	9
	B. Non-Facility Related*											
10												10
11								Offset Interest Income			(10)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10)	14
15	TOTALS (line 9+line14)						$ 1,625,000	$ 1,371,334			$ 17,271	15

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

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 23,652	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.)	2013	$ 23,920	2
3. Under or (over) accrual (line 2 minus line 1).		$ 268	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 22,218	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.	Allocated from RDK 78		
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ 78	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 22,564	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012		11
2013	23,920	12

2014 Tax Accrual = 2011 taxes $21,996 x 1.01 = $22,218

Note: Beginning accrual is credit received at closing for 2013 taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pinckneyville Nrsing & Rehab COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0052704

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #:

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1-53-0360-150	Long Term Care Property	$ 23,919.82	$ 23,919.82
2.	06-2-275-02	Home Office Allocation	$ 969.58	$ 78.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,889.40	$ 23,997.82

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	108,900	2014	$ 10,000	1
2					2
3	TOTALS	108,900		$ 10,000	3

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		2014	1971	$ 20,245	$ 519	39	$ 519	$	$ 519	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pole Barn			2014	35,343	453	39	453		453	9
10	New Windows			2014	22,000	282	39	282		282	10
11	All Bathroom/Shower Rooms - cabinets, countertops, drywall,			2014	46,695	1,038	15	1,038		1,038	11
12	plumbing, electric, mirrors, paint										12
13	Replace/Repair walls & drywall, relocate plumbing & electric,			2014	146,393	313	39	313		313	13
14	New Doors, Paint & Molding for entire facility										14
15	Generator			2014	48,621	4,052	7	4,052		4,052	15
16	New Roof			2014	41,660	926	15	926		926	16
17	Parking Lot Paving			2014	25,411	847	15	847		847	17
18	Landscaping			2014	12,540	139	15	139		139	18
19	New Entry Doors			2014	16,610	92	15	92		92	19
20	Sprinkler System			2014	35,929	428	7	428		428	20
21	Installed new Air Maint System, 9 AC Units with Sleeves,			2014	9,793	383	7	383		383	21
22	Phone wiring in offices, Side Entry Awning										22
23	Facility Camera Detector System			2014	5,895	140	7	140		140	23
24	Install Therapure Side Entry Bath			2014	9,530	227	7	227		227	24
25	Wall Vinyl - Res Rms, Hallways, Nurses Station, Dining Rm			2014	22,626	775	7	775		775	25
26	Privacy Tracks/Draperies - Resident Rms, Shower/Tub Room			2014	3,023	104	7	104		104	26
27	Handrails/bumper guards-Halls A, B, C, Service and Dining			2014	8,813	302	7	302		302	27
28	Flooring/cove base-Res Rms, Halls A, B, C and Service, Toilet			2014	64,122	2,195	7	2,195		2,195	28
29	& Shower Rms, Nurses Station, Beauty Shop, Fitness Rm										29
30	Blinds/windowcoverings - Resident Rms, Corridors A, B & C,			2014	8,766	300	7	300		300	30
31	Kitchen, Dining Rm, Laundry, Offices, Fitness Center										31
32	Light fixtures/sconces- Res Rms, Halls A, B & C, Shower			2014	9,771	335	7	335		335	32
33	& Toilet Rms, Beauty Shop, Fitness Center, Nurses Station										33
34	Interior Design Development Fee			2014	10,000	536	7	536		536	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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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	Room/Hall and Outdoor signs, Paint & Constr Supplies, Tile	2014	6,510	$	10	$	$	$	37
38	Labor - Drywall Finishing/Painting/Wallpapering/Staining	2014	57,889		10				38
39	throughout facility								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)		$ 668,185	$ 14,386		$ 14,386	$	$ 14,386	70

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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	$	$	$	$		$	71
72	Current Year Purchases	221,389	15,520	15,520		3-7 yrs	15,520	72
73	Fully Depreciated Assets							73
74	Allocated from RDK Mgmt			1,083	1,083			74
75	TOTALS	$ 221,389	$ 15,520	$ 16,603	$ 1,083		$ 15,520	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	$ 577	$ 577	$	5	$ 577	76
77	Administrative	2001 Mustang	2014	640	75	75		5	75	77
78										78
79										79
80	TOTALS			$ 4,971	$ 652	$ 652	$		$ 652	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)	$	904,545	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	30,558	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	31,641	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	1,083	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	30,558	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 321 Description: Medical Equipment $90; Office Equipment $231
    (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.

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			100			100	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			$		$ 100	$		$ 100	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.

STATE OF ILLINOIS

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (last day of reporting year)

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	$ 342,218	$ 342,218	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	234,026	234,026	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,256	15,256	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 591,500	$ 591,500	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	20,245	20,245	14
15	Leasehold Improvements, at Historical Cost	567,575	647,940	15
16	Equipment, at Historical Cost	242,326	226,360	16
17	Accumulated Depreciation (book methods)	(30,558)	(30,558)	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): Goodwill	4,667	4,667	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 814,255	$ 878,654	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,405,755	$ 1,470,154	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 16,824	$ 16,824	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,371,334	1,371,334	29
30	Accrued Salaries Payable	16,921	16,921	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,141	5,141	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,218	22,218	32
33	Accrued Interest Payable	704	704	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)**	$ 1,433,142	$ 1,433,142	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,433,142	$ 1,433,142	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (27,387)	$ 37,012	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,405,755	$ 1,470,154	48

***(See instructions.)**

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(146,559)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants		120,000	11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners		(828)	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)**	$	(27,387)	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)**	$	(27,387)	24 *

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,172,986	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,172,986	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,172,996	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	383,793	31
32	Health Care	460,027	32
33	General Administration	315,089	33
	B. Capital Expense		
34	Ownership	75,881	34
	C. Ancillary Expense		
35	Special Cost Centers	5,570	35
36	Provider Participation Fee	79,195	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,319,555	40
41	**Income before Income Taxes (line 30 minus line 40)****	(146,559)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (146,559)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 872,616	44
45	Private Pay - Net Inpatient Revenue	259,450	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Insurance	40,920	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,172,986	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.**

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,870	1,886	$ 42,903	$ 22.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,988	3,020	60,318	19.97	3
4	Licensed Practical Nurses	4,887	4,903	72,949	14.88	4
5	CNAs & Orderlies	22,524	22,653	207,355	9.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	287	312	2,939	9.42	10
11	Social Service Workers	1,626	1,650	19,800	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,947	9,005	85,340	9.48	15
16	Dishwashers					16
17	Maintenance Workers	1,441	1,466	17,645	12.04	17
18	Housekeepers	10,501	10,570	94,849	8.97	18
19	Laundry					19
20	Administrator	1,600	1,600	39,309	24.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	560	584	9,639	16.51	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)	57,231	57,649	$ 653,046 *	$ 11.33	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	50	$ 2,969	L1, C3	35
36	Medical Director	Monthly	4,090	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,000	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	62	4,388	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	112	$ 12,447		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeffrey McDaniel	Administrator	0	$ 39,309
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 39,309

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 89,546
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 89,546

C. Professional Services

Vendor/Payee	Type	Amount
Thomas J. Wolf Jr. P.C.	Legal	$ 986
Daniel Maher Law Offices	Legal	14,267
Frost Ruttenberg & Rothblatt	Accounting	1,500
James Henson PC	Accounting	863
Payroll Services by Extra Help	Payroll Service	1,154
Lintech	LTC Software	5,188
Ability Network	Health Info Management	1,132
MES of Illinois	Professional Network	175
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 25,265

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,782
Unemployment Compensation Insurance	22,974
FICA Taxes	49,516
Employee Health Insurance	484
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Incentive Expense	1,040
Life Ins / Disability	295
Other Employee Benefits	284
TOTAL (agree to Schedule V, line 22, col.8)	$ 108,375

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,640
Advertising: Employee Recruitment	1,409
Health Care Worker Background Check	
(Indicate # of checks performed 5)	270
Patient Background Checks 14	361
License & Permits	610
Allocated From RDK/SI Management	169
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,459

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	44
Seminar Expense	529
Allocated From SI Management	150
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 723

**See instructions.

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 2/1/2014 Ending: 12/31/2014

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Pinckneyville Nrsing & Rehab **#** 0052704 **Report Period Beginning:** 2/1/2014 **Ending:** 12/31/2014

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? **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? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,405** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **79,195**
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. $ **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.