FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 41671

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 1/1/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 2/1/2015

	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)	60	20,040	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	0	1,860	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	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		52	1,366	1,418	8
9	SNF/PED					9
10	ICF	8,597	2,107		10,704	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,597	2,159	1,366	12,122	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.35%

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 [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 1,315

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	84,342	8,409	3,981	96,732		96,732		96,732			1
2	Food Purchase		71,827		71,827		71,827		71,827			2
3	Housekeeping	67,935	8,492		76,427		76,427	(5,041)	71,386			3
4	Laundry	33,834	4,650		38,484		38,484		38,484			4
5	Heat and Other Utilities			41,408	41,408		41,408	167	41,575			5
6	Maintenance	17,977	21,237	42,353	81,567		81,567	(25,855)	55,712			6
7	Other (specify):* Waste Rem/RDK/SI Benefits A			2,437	2,437		2,437	11	2,448			7
8	**TOTAL General Services**	204,088	114,615	90,179	408,882		408,882	(30,718)	378,164			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	502,388	40,197	1,200	543,785		543,785	12,326	556,111			10
10a	Therapy			106,966	106,966		106,966		106,966			10a
11	Activities	18,668			18,668		18,668		18,668			11
12	Social Services	20,544	1,867	4,506	26,917		26,917		26,917			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RDK/SI Benefits Alloc							1,474	1,474			15
16	**TOTAL Health Care and Programs**	541,600	42,064	117,472	701,136		701,136	13,800	714,936			16
	C. General Administration											
17	Administrative	52,962		119,076	172,038		172,038	(38,615)	133,423			17
18	Directors Fees											18
19	Professional Services			26,202	26,202		26,202	(706)	25,496			19
20	Dues, Fees, Subscriptions & Promotions			8,881	8,881		8,881	(4)	8,877			20
21	Clerical & General Office Expenses	8,668	12,408	7,474	28,550		28,550	18,879	47,429			21
22	Employee Benefits & Payroll Taxes			138,039	138,039		138,039		138,039			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,754	1,754		1,754	159	1,913			24
25	Other Admin. Staff Transportation			624	624		624	1,256	1,880			25
26	Insurance-Prop.Liab.Malpractice			20,768	20,768		20,768	204	20,972			26
27	Other (specify):* RDK/SI Benefits Alloc							7,160	7,160			27
28	**TOTAL General Administration**	61,630	12,408	322,818	396,856		396,856	(11,667)	385,189			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	807,318	169,087	530,469	1,506,874		1,506,874	(28,585)	1,478,289			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab #0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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			98,839	98,839		98,839	810	99,649			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,250	66,250		66,250	(55)	66,195			32
33	Real Estate Taxes			7,770	7,770		7,770	92	7,862			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,426	1,426		1,426		1,426			35
36	Other (specify):* Loan Cost Amort			2,328	2,328		2,328		2,328			36
37	TOTAL Ownership			176,613	176,613		176,613	847	177,460			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,899		51,899		51,899		51,899			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,344	96,344		96,344		96,344			42
43	Other (specify):* Disallowed Costs			4,929	4,929		4,929	(4,929)				43
44	TOTAL Special Cost Centers		51,899	101,273	153,172		153,172	(4,929)	148,243			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	807,318	220,986	808,355	1,836,659		1,836,659	(32,667)	1,803,992			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	(1,763)	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	271	30		9
10	Interest and Other Investment Income	(55)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	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	(100)	20		17
18	Fines and Penalties				18
19	Entertainment	(280)	43		19
20	Contributions	(201)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,313)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	10,266	43		24
25	Fund Raising, Advertising and Promotional	(11,625)	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	(32,445)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (37,317)		$	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)	4,650		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 4,650		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (32,667)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Pinckneyville Nrsing & Rehab

ID# 0052704

Report Period Beginning: 1/1/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Birthday Expense	$ (888)	43	1
2	Gifts	(33)	43	2
3	Goodwill Amortization	(333)	43	3
4	Capitalized Construction costs	(20,941)	6	4
5	Capitalized Construction labor	(5,285)	3	5
6	Capitalized Construction labor	(4,965)	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**	(32,445)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(5,285)	0	244	0	0	0	0	0	0	0	0	(5,041)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	167	0	0	0	0	0	0	0	0	167	5
6	Maintenance	(25,906)	0	51	0	0	0	0	0	0	0	0	(25,855)	6
7	Other (specify):*	0	0	11	0	0	0	0	0	0	0	0	11	7
8	**TOTAL General Services**	(31,191)	0	473	0	0	0	0	0	0	0	0	(30,718)	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	12,326	0	0	0	0	0	0	0	0	0	12,326	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	1,474	0	0	0	0	0	0	0	0	0	1,474	15
16	**TOTAL Health Care and Programs**	0	13,800	0	0	0	0	0	0	0	0	0	13,800	16
	C. General Administration													
17	Administrative	0	(58,025)	19,410	0	0	0	0	0	0	0	0	(38,615)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,313)	225	382	0	0	0	0	0	0	0	0	(706)	19
20	Fees, Subscriptions & Promotions	(100)	44	52	0	0	0	0	0	0	0	0	(4)	20
21	Clerical & General Office Expenses	0	17,215	1,664	0	0	0	0	0	0	0	0	18,879	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	6	153	0	0	0	0	0	0	0	0	159	24
25	Other Admin. Staff Transportation	0	561	695	0	0	0	0	0	0	0	0	1,256	25
26	Insurance-Prop.Liab.Malpractice	0	204	0	0	0	0	0	0	0	0	0	204	26
27	Other (specify):*	0	4,955	2,205	0	0	0	0	0	0	0	0	7,160	27
28	**TOTAL General Administration**	(1,413)	(34,815)	24,561	0	0	0	0	0	0	0	0	(11,667)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,604)	(21,015)	25,034	0	0	0	0	0	0	0	0	(28,585)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pinckneyville Nrsing & Rehab **#** 0052704 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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	271	0	539	0	0	0	0	0	0	0	0	810	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(55)	0	0	0	0	0	0	0	0	0	0	(55)	32
33	Real Estate Taxes	0	0	92	0	0	0	0	0	0	0	0	92	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**	216	0	631	0	0	0	0	0	0	0	0	847	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):*	(4,929)	0	0	0	0	0	0	0	0	0	0	(4,929)	43
44	**TOTAL Special Cost Centers**	(4,929)	0	0	0	0	0	0	0	0	0	0	(4,929)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(37,317)	(21,015)	25,665	0	0	0	0	0	0	0	0	(32,667)	45

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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, In	Harrisburg	Management Co.
Dr. Roger Herrin	33.33	Saline Care Center	Harrisburg	SI Management Svc, L	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	10	Nursing Wages	$	SI Management Services, LLC	100.00%	$ 12,326	$ 12,326	1
2	V	15	Health Care and Prog Emp. Ben.		SI Management Services, LLC	100.00%	1,474	1,474	2
3	V	17	Administrative	82,518	SI Management Services, LLC	100.00%	24,493	(58,025)	3
4	V	19	Professional Fees		SI Management Services, LLC	100.00%	225	225	4
5	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	44	44	5
6	V	21	Clerical And General		SI Management Services, LLC	100.00%	17,215	17,215	6
7	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	6	6	7
8	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	561	561	8
9	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	204	204	9
10	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	4,955	4,955	10
11	V								11
12	V								12
13	V								13
14	Total			$ 82,518			$ 61,503	$ * (21,015)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	3	Housekeeping	$	RDK Management, Inc.	100.00%	$ 244	$ 244	15
16	V	5	Utilities		RDK Management, Inc.	100.00%	167	167	16
17	V	6	Maintenance		RDK Management, Inc.	100.00%	51	51	17
18	V	7	General Svcs. Emp. Ben.		RDK Management, Inc.	100.00%	11	11	18
19	V	17	Administrative	36,558	RDK Management, Inc.	100.00%	55,968	19,410	19
20	V	19	Professional Services		RDK Management, Inc.	100.00%	382	382	20
21	V	20	Dues, Fees, Subs & Promotions		RDK Management, Inc.	100.00%	52	52	21
22	V	21	Clerical and General Office		RDK Management, Inc.	100.00%	1,664	1,664	22
23	V	24	Travel and Seminar		RDK Management, Inc.	100.00%	153	153	23
24	V	25	Other Admin. Staff Transport.		RDK Management, Inc.	100.00%	695	695	24
25	V	27	Mgmt. Allocation of Benefits		RDK Management, Inc.	100.00%	2,205	2,205	25
26	V	30	Depreciation		RDK Management, Inc.	100.00%	539	539	26
27	V	33	Real Estate Taxes		RDK Management, Inc.	100.00%	92	92	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			$ 36,558			$ 62,223	$ * 25,665	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	5.74	8.44	Alloc. Salary	$ 50,652	L17, C7	1
2	Steven Herrin	Owner	Administrative	33.33%	120,000						2
3	Scott Stout	Owner	Administrative	33.33%	See Att Sch 7A	5.74	9.57	Alloc. Salary	11,767	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	$ 62,419		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	10	Nursing Wages	Census	126,706	5	128,842	128,842	12,122	$ 12,326	1
2	15	Health Care and Prog Emp. Ben.	Census	126,706	5	15,408		12,122	1,474	2
3	17	Administrative	Census	126,706	5	256,018	256,018	12,122	24,493	3
4	19	Professional Fees	Census	126,706	5	2,350		12,122	225	4
5	20	Fees, Subscriptions	Census	126,706	5	465		12,122	44	5
6	21	Clerical And General	Census	126,706	5	179,937	177,087	12,122	17,215	6
7	24	Travel and Seminar	Census	126,706	5	61		12,122	6	7
8	25	Admin. Staff Trans.	Census	126,706	5	5,866		12,122	561	8
9	26	Insurance-Prop./Liab./Malprac.	Census	126,706	5	2,129		12,122	204	9
10	27	Gen. Admin. Emp. Ben.	Census	126,706	5	51,789		12,122	4,955	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					$ 642,865	$ 561,947		$ 61,503	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	3	Housekeeping	Census	126,706	5	2,554	2,554	12,122	$ 244	1
2	5	Utilities	Census	126,706	5	1,746		12,122	167	2
3	6	Maintenance	Census	126,706	5	535	379	12,122	51	3
4	7	General Svcs. Emp. Ben.	Census	126,706	5	117		12,122	11	4
5	17	Administrative	Census	126,706	5	585,011	585,011	12,122	55,968	5
6	19	Professional Services	Census	126,706	5	3,992		12,122	382	6
7	20	Dues, Fees, Subs & Promotions	Census	126,706	5	540		12,122	52	7
8	21	Clerical and General Office	Census	126,706	5	17,394		12,122	1,664	8
9	24	Travel and Seminar	Census	126,706	5	1,600		12,122	153	9
10	25	Other Admin. Staff Transport.	Census	126,706	5	7,267		12,122	695	10
11	27	Mgmt. Allocation of Benefits	Census	126,706	5	23,048		12,122	2,205	11
12	30	Depreciation	Census	126,706	5	5,630		12,122	539	12
13	33	Real Estate Taxes	Census	126,706	5	957		12,122	92	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					$ 650,391	$ 587,944		$ 62,223	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	Farmers State Bank		X	Line of Credit/Construction	Interest Only	12/19/14	$ 1,125,000	$	12/19/15	0.0475	48,835	6
7	Farmers State Bank		X	Line of Credit/Construction	Interest Only	3/20/14	500,000	54,435	3/20/15	0.0475	11,117	7
8	Farmers State Bank		X	Line of Credit/Construction	Interest Only	11/25/15	1,326,000	1,326,000	11/25/16	0.0475	6,298	8
9	TOTAL Facility Related						$ 2,951,000	$ 1,380,435			$ 66,250	9
	B. Non-Facility Related*											
10												10
11								Offset Interest Income			(55)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (55)	14
15	TOTALS (line 9+line14)						$ 2,951,000	$ 1,380,435			$ 66,195	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 22,218	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.)	2014	$ 14,994	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,224)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 14,994	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**		92	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$ 92	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 7,862	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011		9
2012		10
2013	23,920	11
2014	14,994	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2014 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 2014 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 2014.

	(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	$ 14,993.74	$ 14,993.74
2.	06-2-275-02	Home Office Allocation	$ 958.10	$ 958.10
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 15,951.84	$ 15,951.84

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 1/1/15 Ending: 12/31/15

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:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$	39	$ 519	$ 519	$ 1,038	4
5	Sprinkler			2014	24,800		7	3,543	3,543	3,588	5
6											6
7											7
8											8
	Improvement Type**										
9	Pole Barn			2014	35,343		39	906	906	1,359	9
10	New Windows			2014	22,000		39	564	564	846	10
11	All Bathroom/Shower Rooms - cabinets, countertops, drywall,			2014	46,695		15	3,113	3,113	4,151	11
12	plumbing, electric, mirrors, paint										12
13	Replace/Repair walls & drywall, relocate plumbing & electric,			2014	146,393		39	3,754	3,754	4,067	13
14	New Doors, Paint & Molding for entire facility										14
15	Generator			2014	39,000		7	5,571	5,571	9,623	15
16	Generator-Additional Wiring and Hookup			2014	9,621		15	641	641	1,567	16
17	New Roof			2014	41,660		15	2,777	2,777	3,703	17
18	Parking Lot Paving			2014	25,411		15	1,694	1,694	2,541	18
19	Landscaping			2014	12,540		15	836	836	975	19
20	New Entry Doors			2014	16,610		15	1,107	1,107	1,199	20
21	Sprinkler System - Add & Relocate Sprinklers in Soffits			2014	11,129		7	1,590	1,590	1,973	21
22	Installed new Air Maint System, 9 AC Units with Sleeves,			2014	9,793		7	1,399	1,399	1,782	22
23	Phone wiring in offices, Side Entry Awning										23
24	Facility Camera Detector System			2014	5,895		7	842	842	982	24
25	Install Therapure Side Entry Bath			2014	9,530		7	1,361	1,361	1,588	25
26	Wall Vinyl - Res Rms, Hallways, Nurses Station, Dining Rm			2014	22,626		7	3,232	3,232	4,007	26
27	Privacy Tracks/Draperies - Resident Rms, Shower/Tub Room			2014	3,023		7	432	432	536	27
28	Handrails/bumper guards-Halls A, B, C, Service and Dining			2014	8,813		7	1,259	1,259	1,561	28
29	Flooring/cove base-Res Rms, Halls A, B, C and Service, Toilet			2014	64,122		7	9,160	9,160	11,355	29
30	& Shower Rms, Nurses Station, Beauty Shop, Fitness Rm										30
31	Blinds/windowcoverings - Resident Rms, Corridors A, B & C,			2014	8,766		7	1,252	1,252	1,552	31
32	Kitchen, Dining Rm, Laundry, Offices, Fitness Center										32
33	Light fixtures/sconces- Res Rms, Halls A, B & C, Shower			2014	9,771		7	1,396	1,396	1,731	33
34	& Toilet Rms, Beauty Shop, Fitness Center, Nurses Station										34
35	Interior Design Development Fee			2014	10,000		7	1,429	1,429	1,965	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$	20	325	$ 325	$ 325	37
38	Labor - Drywall Finishing/Painting/Wallpapering/Staining	2014	57,889		20	2,894	2,894	2,894	38
39	throughout Facility								39
40	Kithchen & Bathroom Fixtures, Repair & Replace Drywall,	2015	136,082		20	3,402	3,402	3,402	40
41	Doors & Jambs, Moldings, Painting, Wallpapering,								41
42	Electrical & Plumbing Facility wide								42
43	New Landscaping shrubs	2015	539		20	13	13	13	43
44	Relocate Sprinklers in Conference Rm & Install Dry	2015	2,677		20	67	67	67	44
45	Sidewall Piping under Awning								45
46	Wiring & Installation of New Phone System in new Offices	2015	2,815		20	70	70	70	46
47	Side Entry Awning & 3 new Air Conditioner units	2015	3,256		20	81	81	81	47
48	Rewire Camera Sys & Repair Motion Detector on Front Door	2015	2,845		20	71	71	71	48
49	Room Signs and Wallboards	2015	2,025		20	51	51	51	49
50	Wall Vinyl - Resident Rooms	2015	1,134		20	28	28	28	50
51	Privacy Tracks/Draperies - Res Rms, Shower Rms, Fitness Ctr	2015	12,806		20	320	320	320	51
52	Handrails/Bumper Guards/Wall Protections - Dining Rm	2015	2,081		20	52	52	52	52
53	& Kitchen, Fitness Ctr, Shower Rms								53
54	Flooring/Cove Base - Dining & Service Hall, Offices, Closet	2015	9,144		20	229	229	229	54
55	Blinds & Windowcoverings - Res Rms, Dining, Offices, Fitness Ctr	2015	2,950		20	74	74	74	55
56	Light Fixtures/Sconces - Resident Bathrooms, Conference Rm	2015	1,696		20	42	42	42	56
57	Shower Tile - Resident Shower Rms	2015	1,684		20	42	42	42	57
58	Interior Design Development Fee	2015	5,000		20	125	125	125	58
59	Room/Hall and Outdoor signs, Paint & Constr Supplies, Tile	2015	4,292		20	107	107	107	59
60	Labor - Drywall Finishing/Painting/Wallpapering/Staining	2015	26,899		20	672	672	672	60
61	throughout Facility								61
62	New Door, Reception Window & Replace Front Door Glass	2015	4,570		20	114	114	114	62
63	Wall light fixtures & Outdoor Sign	2015	3,165		20	79	79	79	63
64	Built in Cabinets-Activity Rm, Door Protectors & Bumper Guards	2015	6,170		20	154	154	154	64
65									65
66									66
67	Depreciation - Book			98,839			(98,839)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 900,015	$ 98,839		$ 57,389	$ (41,450)	$ 72,701	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 1/1/15 Ending: 12/31/15

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	$ 221,389	$	$ 32,750	$ 32,750	3-7 yrs	$ 48,270	71
72	Current Year Purchases	82,873		7,977	7,977	5-7 yrs	7,977	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.			539	539			74
75	TOTALS	$ 304,262	$	$ 41,266	$ 41,266		$ 56,247	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	2015 Kia Sorrento	2014	$ 4,331	$	$ 866	$ 866	5	$ 1,443	76
77	Administrative	2001 Mustang	2014	640		128	128	5	203	77
78										78
79										79
80	TOTALS			$ 4,971	$	$ 994	$ 994		$ 1,646	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)	$ 1,219,248	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 98,839	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 99,649	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 810	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 130,594	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 1,426 Description: Medical Equipment $1,379 ; Office Equipment $47
    (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' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$		$ 43,317	$		$ 43,317	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			14,437			14,437	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			49,212			49,212	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				51,899		51,899	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			$		$ 106,966	$ 51,899		$ 158,865	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ 157,444	$ 157,444	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	306,295	306,295	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	19,171	19,171	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 482,910	$ 482,910	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,067	4,067	12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	20,245	45,045	14
15	Leasehold Improvements, at Historical Cost	762,556	854,970	15
16	Equipment, at Historical Cost	320,226	309,233	16
17	Accumulated Depreciation (book methods)	(129,397)	(130,594)	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	4,334	4,334	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 992,031	$ 1,097,055	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,474,941	$ 1,579,965	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 28,465	$ 28,465	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,380,435	1,380,435	29
30	Accrued Salaries Payable	22,998	22,998	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,965	5,965	31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,994	14,994	32
33	Accrued Interest Payable	8,781	8,781	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)**	$ 1,461,638	$ 1,461,638	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)**	$ 1,461,638	$ 1,461,638	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,303	$ 118,327	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,474,941	$ 1,579,965	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (27,387)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	6,367	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (21,020)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,053	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	(730)	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)**	$ 34,323	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)**	$ 13,303	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$ 1,857,003	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,857,003	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	16,952	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 16,952	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***	55	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 55	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SI Management Income/Loss	(2,298)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2,298)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,871,712	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	408,882	31
32	Health Care	701,136	32
33	General Administration	396,856	33
	B. Capital Expense		
34	Ownership	176,613	34
	C. Ancillary Expense		
35	Special Cost Centers	56,828	35
36	Provider Participation Fee	96,344	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,836,659	40
41	**Income before Income Taxes (line 30 minus line 40)****	35,053	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 35,053	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,064,236	44
45	Private Pay - Net Inpatient Revenue	274,978	45
46	Medicare - Net Inpatient Revenue	491,331	46
47	Other-(specify) Insurance	26,458	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,857,003	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' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	2,244	2,268	$ 48,822	$ 21.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,057	6,157	131,650	21.38	3
4	Licensed Practical Nurses	3,952	3,991	61,326	15.37	4
5	CNAs & Orderlies	26,991	27,819	260,590	9.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,904	1,987	18,668	9.40	10
11	Social Service Workers	1,805	1,837	20,544	11.18	11
12	Dietician					12
13	Food Service Supervisor	2,045	2,116	26,299	12.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,328	6,458	58,043	8.99	15
16	Dishwashers					16
17	Maintenance Workers	1,464	1,609	17,977	11.17	17
18	Housekeepers	7,298	7,414	67,935	9.16	18
19	Laundry	3,750	3,777	33,834	8.96	19
20	Administrator	1,992	2,080	52,962	25.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	664	664	7,568	11.40	23
24	Clerical	126	126	1,100	8.73	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)	66,620	68,303	$ 807,318 *	$ 11.82	34

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	70	$ 3,981	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	71	4,506	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	141	$ 14,487		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeffrey McDaniel	Administrator	0	$ 52,962
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,962

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 119,076
TOTAL (agree to Schedule V, line 17, col. 3)	$ 119,076
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Adam Lawler Law Firm	Legal	$ 1,313
Kerns Frost & Pearlman	Legal	2,152
Daniel Maher	Legal	282
Templin Healthcare Accounting	Accounting	2,510
James Henson, PC	Accounting	5,222
Payroll Services by Extra Help	Payroll Service	1,565
Passport Software	Accounting Software	623
IT Next Gen	Web Hosting Service	190
Lintech	LTC Software	7,433
American Health Tech	LTC Software	3,561
Ability/ESolutions Network	Health Info Management	1,351
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 26,202

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,585
Unemployment Compensation Insurance	25,756
FICA Taxes	61,847
Employee Health Insurance	4,801
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Incentive Expenses	1,596
Life Insurance / Disability	872
Other Employee Benefits	1,582
TOTAL (agree to Schedule V, line 22, col.8)	$ 138,039

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	$ 3,980
Advertising: Employee Recruitment	2,132
Health Care Worker Background Check	
(Indicate # of checks performed 5)	366
Patient Background Checks 47	720
License & Permits	953
Dues & Subcriptions	730
Allocated From RDK/SI Management	96
Less: Public Relations Expense	(100)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,877

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,135
Seminar Expense	619
Allocated From RDK/SI Management	159
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,913

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0052704 Report Period Beginning: 1/1/15 Ending: 12/31/15

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? **5-7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,086** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **96,344**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **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.