

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

<p>I. IDPH License ID Number: <u>0054569</u></p> <p>Facility Name: <u>Duquoin Nursing & Rehab</u></p> <p>Address: <u>514 East Jackson St</u> <u>Duquoin</u> <u>62832</u> Number City Zip Code</p> <p>County: <u>Perry</u></p> <p>Telephone Number: <u>(618) 542-4731</u> Fax # <u>(618) 542-2651</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/1/2017</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>3/1/2017</u> to <u>12/31/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab

0054569 Report Period Beginning: 3/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,973	1,973	8
9	SNF/PED					9
10	ICF	10,291	4,750		15,041	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,291	4,750	1,973	17,014	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.99%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 3/1/17

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/1/17 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 74 and days of care provided 1,782

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	103,463	7,816	3,895	115,174		115,174		115,174		1
2	Food Purchase		90,515		90,515		90,515		90,515		2
3	Housekeeping	93,017	7,739		100,756		100,756	452	101,208		3
4	Laundry	29,589	3,028		32,617		32,617		32,617		4
5	Heat and Other Utilities			44,335	44,335		44,335	43	44,378		5
6	Maintenance	19,733	6,276	13,984	39,993		39,993	952	40,945		6
7	Other (specify):* Waste Rem/WLC Benefits All			1,752	1,752		1,752	63	1,815		7
8	TOTAL General Services	245,802	115,374	63,966	425,142		425,142	1,510	426,652		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	646,181	33,276	2,000	681,457		681,457		681,457		10
10a	Therapy										10a
11	Activities	23,255	2,729	1,775	27,759		27,759		27,759		11
12	Social Services	26,084	11	1,281	27,376		27,376		27,376		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	695,520	36,016	9,056	740,592		740,592		740,592		16
	C. General Administration										
17	Administrative	52,475		166,932	219,407		219,407	(144,974)	74,433		17
18	Directors Fees										18
19	Professional Services			41,483	41,483		41,483	1,032	42,515		19
20	Dues, Fees, Subscriptions & Promotions			6,080	6,080		6,080	85	6,165		20
21	Clerical & General Office Expenses	26,214	8,665	7,036	41,915		41,915	63,307	105,222		21
22	Employee Benefits & Payroll Taxes			165,252	165,252		165,252		165,252		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,486	2,486		2,486	509	2,995		24
25	Other Admin. Staff Transportation			115	115		115	1,451	1,566		25
26	Insurance-Prop.Liab.Malpractice			34,902	34,902		34,902	754	35,656		26
27	Other (specify):* WLC Benefits Alloc							11,346	11,346		27
28	TOTAL General Administration	78,689	8,665	424,286	511,640		511,640	(66,490)	445,150		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,020,011	160,055	497,308	1,677,374		1,677,374	(64,980)	1,612,394		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

Duquoin Nursing & Rehab

#0054569

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							1,675	1,675			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,588	6,588		6,588	250	6,838			32
33	Real Estate Taxes			16,828	16,828		16,828		16,828			33
34	Rent-Facility & Grounds			395,180	395,180		395,180	1,219	396,399			34
35	Rent-Equipment & Vehicles			5,060	5,060		5,060		5,060			35
36	Other (specify):* Loan Costs			686	686		686		686			36
37	TOTAL Ownership			424,342	424,342		424,342	3,144	427,486			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			564	564		564		564			38
39	Ancillary Service Centers		41,889	191,399	233,288		233,288		233,288			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,981	97,981		97,981		97,981			42
43	Other (specify):* Disallowed Costs			24,442	24,442		24,442	(24,442)				43
44	TOTAL Special Cost Centers		41,889	314,386	356,275		356,275	(24,442)	331,833			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,020,011	201,944	1,236,036	2,457,991		2,457,991	(86,278)	2,371,713			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,499)	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	589	30		9
10	Interest and Other Investment Income	(23)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(557)	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	(125)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(176)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,987)	43		24
25	Fund Raising, Advertising and Promotional	(12,223)	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	440			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,561)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(62,717)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (62,717)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (86,278)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Duquoin Nursing & Rehab

ID# 0054569

Report Period Beginning: 3/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous income offset	\$ (165)	21	1
2	Expense Leasehold Improvements under \$2,500	605	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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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	440		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Scott Stout	100	Carrier Mills Nursing & Rehab Center	Carrier Mills	WLC Management Fir	Harrisburg	Management Co.
		Pinckneyville Nursing and Rehab Center	Pinckneyville			
		Saline Care Nursing and Rehab Center	Harrisburg			
		Stonebridge Nursing and Rehab Center	Benton			
		Eldorado Rehab and Healthcare	Eldorado			
		Greenville Nursing and Rehab Center	Greenville			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	3 Housekeeping	\$	WLC Management Firm, LLC	100.00%	\$ 452	\$	452	1
2	V	5 Utilities		WLC Management Firm, LLC	100.00%	43		43	2
3	V	6 Maintenance		WLC Management Firm, LLC	100.00%	347		347	3
4	V	7 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	63		63	4
5	V	17 Administrative	166,932	WLC Management Firm, LLC	100.00%	21,958		(144,974)	5
6	V	19 Professional Services		WLC Management Firm, LLC	100.00%	1,032		1,032	6
7	V	20 Dues, Fees, Subs & Promotion		WLC Management Firm, LLC	100.00%	210		210	7
8	V	21 Clerical & General Office		WLC Management Firm, LLC	100.00%	63,472		63,472	8
9	V	24 Travel & Seminar		WLC Management Firm, LLC	100.00%	509		509	9
10	V	25 Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	1,451		1,451	10
11	V	26 Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	754		754	11
12	V	27 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	11,346		11,346	12
13	V	30 Depreciation		WLC Management Firm, LLC	100.00%	1,086		1,086	13
14	Total		\$ 166,932			\$ 102,723	\$ *	(64,209)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	32 Interest	\$	WLC Management Firm, LLC	100.00%	\$ 273	\$	273	15
16	V	34 Rent-Facility & Grounds		WLC Management Firm, LLC	100.00%	1,219		1,219	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 1,492	\$ *	1,492	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Duquoin Nursing & Rehab

0054569

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Stout	Stockholder	Administrative	100.00	See Att Sch 7A	5.42	13.55	Alloc. Salary	\$ 21,958	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,958		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab

0054569

Report Period Beginning:

3/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization WLC Management Firm, LLC
 Street Address 105 South Commercial Street Suite 1
 City / State / Zip Code Harrisburg, IL 62946
 Phone Number (618) 294-8696
 Fax Number (618) 294-8699

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Census	125,586	7	\$ 3,337	\$ 17,014	\$ 452	1
2	5	Utilities	Census	125,586	7	315	17,014	43	2
3	6	Maintenance	Census	125,586	7	2,562	17,014	347	3
4	7	Mgmt Allocation of Benefits	Census	125,586	7	464	17,014	63	4
5	17	Administrative	Census	125,586	7	162,078	17,014	21,958	5
6	19	Professional Services	Census	125,586	7	7,618	17,014	1,032	6
7	20	Dues, Fees, Subs & Promotion	Census	125,586	7	1,551	17,014	210	7
8	21	Clerical & General Office	Census	125,586	7	468,507	17,014	63,472	8
9	24	Travel & Seminar	Census	125,586	7	3,760	17,014	509	9
10	25	Other Admin Staff Transport	Census	125,586	7	10,708	17,014	1,451	10
11	26	Insurance-Prop/Liab/Malprac	Census	125,586	7	5,565	17,014	754	11
12	27	Mgmt Allocation of Benefits	Census	125,586	7	83,750	17,014	11,346	12
13	30	Depreciation	Census	125,586	7	8,015	17,014	1,086	13
14	32	Interest	Census	125,586	7	2,016	17,014	273	14
15	34	Rent-Facility & Grounds	Census	125,586	7	9,000	17,014	1,219	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 769,246	\$ 605,663	\$ 104,215	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Duquoin Nursing & Rehab

0054569

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Legence Bank		X	Line of Credit		2/17/17	180,000		3/31/18	0.0275	2,357	6						
7	Legence Bank		X	Line of Credit		2/17/17	287,096		3/31/18	0.0475	2,823	7						
8	Legence Bank		X	Line of Credit		10/23/17	288,069		10/30/18	0.0475	1,408	8						
9	TOTAL Facility Related						\$ 755,165	\$			\$ 6,588	9						
B. Non-Facility Related*																		
10												10						
11										Interest Income Offset	(23)	11						
12										Allocated From WLC	273	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 250	14						
15	TOTALS (line 9+line14)						\$ 755,165	\$			\$ 6,838	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' PREPARATION REPORT

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	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.)	2016	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2012	8	
	2013	9	
	2014	10	
	2015	11	
	2016	20,073	12
<u>Accrual based on prior year tax bill.</u>			

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Duquoin Nursing & Rehab COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0054569

CONTACT PERSON REGARDING THIS REPORT Scott Stout

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1-61-0270-010</u>	<u>Long Term Care Property</u>	\$ <u>20,073.08</u>	\$ <u>20,073.08</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>20,073.08</u></u>	\$ <u><u>20,073.08</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Duquoin Nursing & Rehab

0054569 Report Period Beginning:

3/1/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,703 B. General Construction Type: Exterior Masonry Frame Masonry & Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 is shaded and labeled 'TOTALS'.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab

0054569

Report Period Beginning:

3/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Bed*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	4	
5									5	
6									6	
7									7	
8									8	
Improvement Type**										
9	Install 7.5 Ton Gas / Electric Rooftop HVAC System		2017	10,975		20	274	274	274	9
10										10
11										11
12										12
13	WLC Management Allocation		2017	1,409						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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9							
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation							
37		\$	\$		\$	\$	\$	37						
38								38						
39								39						
40								40						
41								41						
42								42						
43								43						
44								44						
45								45						
46								46						
47								47						
48								48						
49								49						
50								50						
51								51						
52								52						
53								53						
54								54						
55								55						
56								56						
57								57						
58								58						
59								59						
60								60						
61								61						
62								62						
63								63						
64								64						
65								65						
66								66						
67								67						
68								68						
69								69						
70	TOTAL (lines 4 thru 69)	\$	12,384	\$		\$	274	\$	274	\$	274	\$	274	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>6,301</u>		<u>315</u>	<u>315</u>	<u>10 yrs</u>	<u>315</u>	72
73	Fully Depreciated Assets							73
74	<u>WLC Mgmt Allocation</u>	<u>674</u>						74
75	TOTALS	\$ <u>6,975</u>	\$	\$ <u>315</u>	\$ <u>315</u>		\$ <u>315</u>	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				\$	\$	\$	\$		\$	76
77	<u>WLC Mgmt Allocation</u>			<u>8,561</u>		<u>1,086</u>	<u>1,086</u>			77
78										78
79										79
80	TOTALS			\$ <u>8,561</u>	\$	\$ <u>1,086</u>	\$ <u>1,086</u>		\$	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)	\$ 27,920	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,675	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,675	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 589	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CTR Partnership, LP

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1979</u>	<u>42</u>	<u>2/17/17</u>	\$ <u>395,180</u>			<u>3</u>
4	Additions	<u>1992</u>	<u>57</u>					<u>4</u>
5		<u>Allocated from WLC</u>			<u>1,219</u>			<u>5</u>
6								<u>6</u>
7	TOTAL		99		\$ 396,399			7

10. Effective dates of current rental agreement:

Beginning 3/1/2017

Ending 2/29/2032

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

Fiscal Year Ending Annual Rent

12.	<u>2/28/2018</u>	\$ <u>474,216</u>
13.	<u>2/28/2019</u>	\$ <u>489,628</u>
14.	<u>2/29/2020</u>	\$ <u>505,541</u>

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 _____.

0
N/A

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,060 Description: Medical Equipment \$4,372; Dietary Equipment \$688

(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	<u>N/A</u>		\$ _____	\$ _____	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	TOTAL		\$ _____	\$ _____	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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' PREPARATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$		\$ 69,931	\$		\$ 69,931	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			34,905			34,905	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs			79,538			79,538	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				41,889		41,889	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			\$		\$ 184,374	\$ 41,889		\$ 226,263	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Duquoin Nursing & Rehab**

0054569

Report Period Beginning: **3/1/2017**

Ending:

12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 114,194	\$ 114,194	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>17,087</u>)	552,489	552,489	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,383	7,383	6
7	Other Prepaid Expenses	440	440	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Prior Owner</u>	20,073	20,073	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 694,579	\$ 694,579	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	11,580	12,384	15
16	Equipment, at Historical Cost	6,301	15,536	16
17	Accumulated Depreciation (book methods)		(589)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,881	\$ 27,331	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 712,460	\$ 721,910	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,080	\$ 88,080	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,480	41,480	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,914	1,914	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,828	16,828	32
33	Accrued Interest Payable			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)	\$ 148,302	\$ 148,302	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)	\$ 148,302	\$ 148,302	46
47	TOTAL EQUITY(page 18, line 24)	\$ 564,158	\$ 573,608	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 712,460	\$ 721,910	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

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)	564,158	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 564,158	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)	\$ 564,158	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab

0054569

Report Period Beginning: 3/1/2017

Ending: 12/31/2017

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,981,022	1
2	Discounts and Allowances for all Levels	(13,065)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,967,957	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,004	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 54,004	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***	23	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	165	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 165	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,022,149	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	425,142	31
32	Health Care	740,592	32
33	General Administration	511,640	33
B. Capital Expense			
34	Ownership	424,342	34
C. Ancillary Expense			
35	Special Cost Centers	258,294	35
36	Provider Participation Fee	97,981	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,457,991	40
41	Income before Income Taxes (line 30 minus line 40)**	564,158	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 564,158	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,347,559	44
45	Private Pay - Net Inpatient Revenue	705,767	45
46	Medicare - Net Inpatient Revenue	829,252	46
47	Other-(specify) <u>Insurance</u>	85,379	47
48	Other-(specify) <u>VA</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,967,957	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab

0054569

Report Period Beginning: 3/1/2017

Ending: 12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,608	1,632	\$ 43,163	\$ 26.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,405	4,421	123,719	27.98	3
4	Licensed Practical Nurses	7,271	7,297	146,534	20.08	4
5	CNAs & Orderlies	26,417	26,512	332,765	12.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,345	1,354	17,178	12.69	9
10	Activity Assistants	667	672	6,077	9.04	10
11	Social Service Workers	1,652	1,676	26,084	15.56	11
12	Dietician					12
13	Food Service Supervisor	2,246	2,246	27,078	12.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,172	8,172	76,385	9.35	15
16	Dishwashers					16
17	Maintenance Workers	979	987	19,733	19.99	17
18	Housekeepers	8,234	8,327	93,017	11.17	18
19	Laundry	2,700	2,717	29,589	10.89	19
20	Administrator	1,600	1,600	52,475	32.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,586	1,641	26,214	15.97	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)	68,882	69,254	\$ 1,020,011 *	\$ 14.73	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	77	\$ 3,895	L1, C3	35
36	Medical Director	Monthly	4,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,000	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	25	1,583	L11, C3	44
45	Social Service Consultant	21	1,281	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	123	\$ 12,759		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Merle Taylor	Administrator	0	\$ 52,475	Workers' Compensation Insurance	\$ 65,828	IDPH License Fee	\$ 3,140		
				Unemployment Compensation Insurance	10,424	Advertising: Employee Recruitment	190		
				FICA Taxes	77,057	Health Care Worker Background Check (Indicate # of checks performed <u>17</u>)	894		
				Employee Health Insurance		Patient Background Checks <u>73</u>	1,418		
				Employee Meals	266	License & Permits	17		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	296		
				Employee Physicals/Drug Tests	4,527	Allocated From WLC Mgmt Firm	210		
				Life/Disability Insurance	5,421	Less: Public Relations Expense ()			
				Other Employee Benefits	1,729	Non-allowable advertising ()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 52,475	TOTAL (agree to Schedule V, line 22, col.8)		\$ 165,252	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,165
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 166,932				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 166,932				In-State Travel		
							Seminar Expense	2,486	
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		
Vendor/Payee	Type	Amount							
Sandberg Phoenix & Von Gontard	Legal	\$ 7,720					Allocated From WLC Mgmt Firm	509	
Thomas J. Wolf, Jr., P.C.	Legal	1,076					Entertainment Expense ()		
E-Solutions, Inc.	Health Info Management	1,140							
American Healthtech	LTC Software	17,596							
Information Controls	Payroll Service	1,831							
WH Administrators, Inc	ACA Compliance Consultant	12,120							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 41,483						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Duquoin Nursing & Rehab

0054569

Report Period Beginning: 3/1/2017

Ending: 12/31/2017

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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? Yes
If YES, give effective date of lease. 2/17/17
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. Duquoin Nursing & Rehabilitation Center, ID #0052928, 2/17/17
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 97,981
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. \$ 266 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT