

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 & Rehabilitation Center</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><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><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>1/1/2018</u> to <u>12/31/2018</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="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 & Rehabilitation Center

0054569 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 9/28/18

	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)	72	26,820	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	72	26,820	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			3,396	3,396	8
9	SNF/PED					9
10	ICF	10,431	6,288		16,719	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,431	6,288	3,396	20,115	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.00%

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 3,193

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Duquoin Nursing & Rehabilitation Center
ID#: 0054569
Period Ending: 12/31/2018

III. Statistical Data

Bed Days Available Calculation:

Skilled (SNF)

From	To	# of Days	Beds	Bed Days Available
1/1/2018	9/27/2018	270	74	19,980
9/28/2018	12/31/2018	<u>95</u>	72	<u>6,840</u>
	Total	<u><u>365</u></u>		<u><u>26,820</u></u>

Facility Name & ID Number Duquoin Nursing & Rehabilitation Center # 0054569 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	122,838	7,012	4,713	134,563		134,563		134,563		1
2	Food Purchase		108,593		108,593		108,593		108,593		2
3	Housekeeping	110,761	7,954		118,715		118,715	757	119,472		3
4	Laundry	49,383	7,037		56,420		56,420		56,420		4
5	Heat and Other Utilities			55,648	55,648		55,648	258	55,906		5
6	Maintenance	29,122	12,160	17,817	59,099		59,099	505	59,604		6
7	Other (specify):* Waste Removal			2,266	2,266		2,266	67	2,333		7
8	TOTAL General Services	312,104	142,756	80,444	535,304		535,304	1,587	536,891		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	891,480	37,960	2,400	931,840		931,840		931,840		10
10a	Therapy			1,159	1,159		1,159		1,159		10a
11	Activities	29,034	2,608	3,470	35,112		35,112		35,112		11
12	Social Services	33,886	3	1,442	35,331		35,331		35,331		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	954,400	40,571	13,271	1,008,242		1,008,242		1,008,242		16
	C. General Administration										
17	Administrative	81,227		225,204	306,431		306,431	(204,229)	102,202		17
18	Directors Fees										18
19	Professional Services			40,331	40,331		40,331	1,089	41,420		19
20	Dues, Fees, Subscriptions & Promotions			8,243	8,243		8,243	(125)	8,118		20
21	Clerical & General Office Expenses	37,874	9,757	8,018	55,649		55,649	60,632	116,281		21
22	Employee Benefits & Payroll Taxes			192,567	192,567		192,567		192,567		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,343	2,343		2,343	13	2,356		24
25	Other Admin. Staff Transportation			5,908	5,908		5,908	728	6,636		25
26	Insurance-Prop.Liab.Malpractice			34,739	34,739		34,739	198	34,937		26
27	Other (specify):* WLC Benefits Alloc							7,110	7,110		27
28	TOTAL General Administration	119,101	9,757	517,353	646,211		646,211	(134,584)	511,627		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,385,605	193,084	611,068	2,189,757		2,189,757	(132,997)	2,056,760		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Duquoin Nursing & Rehabilitation Center

#0054569

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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			52,332	52,332		52,332	(44,665)	7,667			30
31	Amortization of Pre-Op. & Org.							339	339			31
32	Interest							484	484			32
33	Real Estate Taxes			20,195	20,195		20,195	508	20,703			33
34	Rent-Facility & Grounds			482,396	482,396		482,396	918	483,314			34
35	Rent-Equipment & Vehicles			12,278	12,278		12,278		12,278			35
36	Other (specify):*											36
37	TOTAL Ownership			567,201	567,201		567,201	(42,416)	524,785			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,919	474,405	548,324		548,324		548,324			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			139,447	139,447		139,447		139,447			42
43	Other (specify):* Disallowed Costs			99,281	99,281		99,281	(99,281)				43
44	TOTAL Special Cost Centers		73,919	713,133	787,052		787,052	(99,281)	687,771			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,385,605	267,003	1,891,402	3,544,010		3,544,010	(274,694)	3,269,316			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	(7,478)	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	(48,798)	30		9
10	Interest and Other Investment Income	(79)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(513)	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	(338)	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	(67,724)	43		24
25	Fund Raising, Advertising and Promotional	(20,766)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,192)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(497)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (148,510)		\$	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)	(126,184)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (126,184)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (274,694)		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 & Rehabilitation Center

ID# 0054569

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gifts	\$ (270)	43	1
2	Miscellaneous income offset	(227)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(497)		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.
		Eldorado Rehab and Healthcare	Eldorado			
		Greenville Nursing and Rehab Center	Greenville			
		Pinckneyville Nursing and Rehab Center	Pinckneyville			
		Saline Care Nursing and Rehab Center	Harrisburg			
		Stonebridge Nursing and Rehab Center	Benton			

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	3 Housekeeping	\$	WLC Management Firm, LLC	100.00%	\$ 757	\$	757 1
2	V	5 Utilities		WLC Management Firm, LLC	100.00%	258		258 2
3	V	6 Maintenance		WLC Management Firm, LLC	100.00%	505		505 3
4	V	7 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	67		67 4
5	V	17 Administrative	225,204	WLC Management Firm, LLC	100.00%	20,975		(204,229) 5
6	V	19 Professional Services		WLC Management Firm, LLC	100.00%	1,089		1,089 6
7	V	21 Clerical & General Office		WLC Management Firm, LLC	100.00%	60,859		60,859 7
8	V	24 Travel & Seminar		WLC Management Firm, LLC	100.00%	13		13 8
9	V	25 Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	728		728 9
10	V	26 Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	198		198 10
11	V	27 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	7,110		7,110 11
12	V	30 Depreciation		WLC Management Firm, LLC	100.00%	4,133		4,133 12
13	V	31 Amortization-Pre Org Costs		WLC Management Firm, LLC	100.00%	339		339 13
14	Total		\$ 225,204			\$ 97,031	\$ *	(128,173) 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%	\$ 563	\$	563	15
16	V	33 Real Estate Taxes		WLC Management Firm, LLC	100.00%	508		508	16
17	V	34 Rent-Facility & Grounds		WLC Management Firm, LLC	100.00%	918		918	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		\$			\$ 1,989	\$ *	1,989	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehabilitation Center # 0054569 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	4.54	11.35	Alloc. Salary	\$ 20,975	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	\$ 20,975		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 & Rehabilitation Center # 0054569 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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

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

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

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	177,417	7	\$ 6,679	\$ 6,679	20,115	\$ 757	1
2	5	Utilities	Census	177,417	7	2,280		20,115	258	2
3	6	Maintenance	Census	177,417	7	4,451		20,115	505	3
4	7	Mgmt Allocation of Benefits	Census	177,417	7	593		20,115	67	4
5	17	Administrative	Census	177,417	7	185,000	185,000	20,115	20,975	5
6	19	Professional Services	Census	177,417	7	9,603		20,115	1,089	6
7	21	Clerical & General Office	Census	177,417	7	536,784	522,122	20,115	60,859	7
8	24	Travel & Seminar	Census	177,417	7	115		20,115	13	8
9	25	Other Admin Staff Transport	Census	177,417	7	6,420		20,115	728	9
10	26	Insurance-Prop/Liab/Malprac	Census	177,417	7	1,744		20,115	198	10
11	27	Mgmt Allocation of Benefits	Census	177,417	7	62,710		20,115	7,110	11
12	30	Depreciation	Census	177,417	7	36,453		20,115	4,133	12
13	31	Amortization-Pre Org Costs	Census	177,417	7	2,991		20,115	339	13
14	32	Interest	Census	177,417	7	4,967		20,115	563	14
15	33	Real Estate Taxes	Census	177,417	7	4,478		20,115	508	15
16	34	Rent-Facility & Grounds	Census	177,417	7	8,098		20,115	918	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 873,366	\$ 713,801		\$ 99,020	25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6																				
7																				
8																				
9	TOTAL Facility Related					\$	\$		\$											
B. Non-Facility Related*																				
10																				
11								Interest Income Offset	(79)	11										
12								WLC Mgmt Allocation	563	12										
13																				
14	TOTAL Non-Facility Related					\$	\$		\$ 484	14										
15	TOTALS (line 9+line14)					\$	\$		\$ 484	15										

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

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

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

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

B. Real Estate Taxes

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 2017 report.		\$	19,840	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.)	2017	\$	19,916	2
3. Under or (over) accrual (line 2 minus line 1).		\$	76	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	19,916	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 Mgmt Co			711	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	711	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	20,703	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	_____	8	
	2014	_____	9	
	2015	_____	10	
	2016	20,073	11	
	2017	19,916	12	
Note: Beginning balance adjusted to actual (corrected due from prior owner)				

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Duquoin Nursing & Rehabilitation Center 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 2017 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 2017.

(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>19,915.80</u>	\$ <u>19,915.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>19,915.80</u></u>	\$ <u><u>19,915.80</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 & Rehabilitation Center

0054569

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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: 5,085 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 339 4. Dates Incurred: 2017

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 contains 'TOTALS'.

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Install 7.5 Ton Gas / Electric Rooftop HVAC System		2017	10,975		20	549	549	823
10	Sprinkler System - Install Backflow Preventer		2018	6,527		20	163	163	163
11	New Trees/Landscape Gravel/Irrigation System/Concrete		2018	30,000		20	750	750	750
12									
13									
14									
15									
16									
17									
18									
19	Financial Statement Depreciation				52,332			(52,332)	
20									
21									
22									
23	Allocated from WLC Management		2018	40,558		25	812	812	812
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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)	\$ 88,060	\$ 52,332		\$ 2,274	\$ (50,058)	\$ 2,548	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	\$ 6,301	\$	\$ 630	\$ 630	10 yrs	\$ 945	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from WLC Mgmt	501		50	50		83	74
75	TOTALS	\$ 6,802	\$	\$ 680	\$ 680		\$ 1,028	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2014 Dodge Grand Caravan	2018	\$ 14,420	\$	\$ 1,442	\$ 1,442	5	\$ 1,442	76
77										77
78	Allocated from WLC Mgmt			16,135		3,271	3,271		4,063	78
79										79
80	TOTALS			\$ 30,555	\$	\$ 4,713	\$ 4,713		\$ 5,505	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)	\$ 125,417	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,332	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 7,667	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (44,665)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,081	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>1966</u>	<u>72</u>	<u>2/17/17</u>	\$ <u>482,396</u>			3
4	Additions							4
5		<u>Allocated from WLC</u>			<u>918</u>			5
6								6
7	TOTAL		<u>72</u>		\$ <u>483,314</u>			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>2/28/2019</u>	\$ <u>484,032</u>
13.	<u>2/29/2020</u>	\$ <u>499,763</u>
14.	<u>2/28/2021</u>	\$ <u>516,005</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 _____.

N/A

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: \$ 12,278 Description: Medical Equipment \$11,096; Dietary Equipment \$1,182

(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			\$ _____	\$ _____	17
18			\$ _____	\$ _____	18
19			\$ _____	\$ _____	19
20			\$ _____	\$ _____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$	11,268	\$ 193,510	\$	11,268	\$ 193,510	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,476	62,435		3,476	62,435	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3), 39(3)	hrs		11,987	208,899		11,987	208,899	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 prescripts				73,919		73,919	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			\$	26,731	\$ 464,844	\$ 73,919	26,731	\$ 538,763	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 & Rehabilitation Center**

0054569

Report Period Beginning: **1/1/2018**

Ending:

12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(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	\$ 538,016	\$ 538,016	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>20,710</u>)	708,439	708,439	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,876	5,876	6
7	Other Prepaid Expenses	3,807	3,807	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,256,138	\$ 1,256,138	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	48,107	88,060	15
16	Equipment, at Historical Cost	20,721	37,357	16
17	Accumulated Depreciation (book methods)	(56,629)	(9,081)	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)	\$ 12,199	\$ 116,336	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,268,337	\$ 1,372,474	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,893	\$ 88,893	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,782	52,782	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,077	1,077	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,916	19,916	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)	\$ 162,668	\$ 162,668	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)	\$ 162,668	\$ 162,668	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,105,669	\$ 1,209,806	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,268,337	\$ 1,372,474	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 564,158	1
2	Restatements (describe):		2
3	Prior Period Adjustment-Depreciation	(4,285)	3
4	Prior Period Adjustment-Miscellaneous	(12)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 559,861	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	676,808	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	(131,000)	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)	\$ 545,808	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,105,669	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehabilitation Center

0054569

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	\$ 4,008,527	1
2	Discounts and Allowances for all Levels	7,235	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,015,762	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	202,934	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 202,934	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	1,725	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	52	19
20	Radiology and X-Ray		20
21	Other Medical Services	39	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,816	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	79	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 79	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	227	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 227	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,220,818	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	535,304	31
32	Health Care	1,008,242	32
33	General Administration	646,211	33
B. Capital Expense			
34	Ownership	567,201	34
C. Ancillary Expense			
35	Special Cost Centers	647,605	35
36	Provider Participation Fee	139,447	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,544,010	40
41	Income before Income Taxes (line 30 minus line 40)**	676,808	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 676,808	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,423,583	44
45	Private Pay - Net Inpatient Revenue	861,601	45
46	Medicare - Net Inpatient Revenue	1,642,225	46
47	Other-(specify) <u>Insurance</u>	88,353	47
48	Other-(specify) <u>VA</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,015,762	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 & Rehabilitation Center

0054569

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,032	2,096	\$ 63,217	\$ 30.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,203	5,337	139,076	26.06	3
4	Licensed Practical Nurses	11,077	11,463	238,007	20.76	4
5	CNAs & Orderlies	37,102	38,222	451,180	11.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,869	1,948	20,298	10.42	9
10	Activity Assistants	915	941	8,736	9.28	10
11	Social Service Workers	2,036	2,180	33,886	15.54	11
12	Dietician					12
13	Food Service Supervisor	2,049	2,249	27,984	12.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,918	10,307	94,854	9.20	15
16	Dishwashers					16
17	Maintenance Workers	1,950	2,025	29,122	14.38	17
18	Housekeepers	11,473	11,963	110,761	9.26	18
19	Laundry	4,759	4,940	49,383	10.00	19
20	Administrator	2,719	2,823	81,227	28.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,628	2,714	37,874	13.96	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)	95,730	99,208	\$ 1,385,605 *	\$ 13.97	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	102	\$ 4,713	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,442	L11, C3	44
45	Social Service Consultant	26	1,442	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	\$ 14,797		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Merle Taylor	Administrator	0	\$ 47,500	Workers' Compensation Insurance	\$ 48,551	IDPH License Fee	\$ 1,990	
Brock McGee	Administrator	0	33,727	Unemployment Compensation Insurance	10,799	Advertising: Employee Recruitment	1,839	
				FICA Taxes	104,137	Health Care Worker Background Check (Indicate # of checks performed 19)	813	
				Employee Health Insurance	14,586	Patient Background Checks	1,702	
				Employee Meals	1,291	License & Permits	605	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,169	
				Employee Physicals/Drug Tests	4,623			
				Life/Disability Insurance	6,002			
				Other Employee Benefits	2,578			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,227					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 192,567		\$ 8,118	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 225,204			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 225,204	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Sandberg Phoenix & Von Gontard	Legal		\$ 4,300	N/A			Out-of-State Travel	\$
E-Solutions, Inc.	Health Info Management		1,731					
American Healthtech	LTC Software		20,332				In-State Travel	1,147
Information Controls	Payroll Service		2,730					
WH Administrators, Inc	ACA Compliance Consultant		5,300				Seminar Expense	1,196
Templin Healthcare Accounting	Accounting Services		4,438				Allocated From WLC Mgmt Firm	13
Kemper CPA Group	Accounting Services		1,500				Entertainment Expense	()
							TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 40,331	TOTAL		\$	TOTAL	\$ 2,356

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

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
(3) Did the nursing home make political contributions or payments to a political action organization? No
(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No
(5) Have you properly capitalized all major repairs and equipment purchases? Yes
(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
(8) Are you presently operating under a sale and leaseback arrangement? Yes
(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
(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 139,447
(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No

SEE ACCOUNTANTS' PREPARATION 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
(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,291 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
b. Do you have a separate contract with the Department to provide medical transportation for residents? No
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
(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