



Facility Name & ID Number Pinckneyville Nrsing & Rehab

# 0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

**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	17	Skilled (SNF)	17	6,222	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,738	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,960	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			1,835	1,835	8
9	SNF/PED					9
10	ICF	9,848	4,621		14,469	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,848	4,621	1,835	16,304	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 74.24%

**D. How many bed-hold days during this year were paid by the Department?**

None (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.**

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

Yes

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**

YES  NO  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 2/1/2014

**J. Was the facility purchased or leased after January 1, 1978?**

YES  Date 2/1/2014 NO

**K. Was the facility certified for Medicare during the reporting year?**

YES  NO  If YES, enter number of beds certified 17 and days of care provided 1,755

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

**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
	<b>A. General Services</b>										
1	Dietary	113,290	9,311	4,359	126,960		126,960		126,960		1
2	Food Purchase		81,787		81,787		81,787		81,787		2
3	Housekeeping	81,212	8,968		90,180		90,180	2,399	92,579		3
4	Laundry	45,924	4,314		50,238		50,238		50,238		4
5	Heat and Other Utilities			50,836	50,836		50,836	217	51,053		5
6	Maintenance	27,308	3,491	17,143	47,942		47,942	1,755	49,697		6
7	Other (specify):* Waste Rem/RDK/SI Benefits A			2,801	2,801		2,801	1,010	3,811		7
8	<b>TOTAL General Services</b>	267,734	107,871	75,139	450,744		450,744	5,381	456,125		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	697,884	33,058	1,200	732,142		732,142	19,773	751,915		10
10a	Therapy										10a
11	Activities	27,823			27,823		27,823		27,823		11
12	Social Services	24,459	2,390	4,403	31,252		31,252		31,252		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RDK/SI Benefits Alloc							2,637	2,637		15
16	<b>TOTAL Health Care and Programs</b>	750,166	35,448	10,403	796,017		796,017	22,410	818,427		16
	<b>C. General Administration</b>										
17	Administrative	33,807		139,495	173,302		173,302	(60,280)	113,022		17
18	Directors Fees										18
19	Professional Services			33,079	33,079		33,079	(3,981)	29,098		19
20	Dues, Fees, Subscriptions & Promotions			4,849	4,849		4,849	345	5,194		20
21	Clerical & General Office Expenses	35,696	11,511	8,056	55,263		55,263	17,129	72,392		21
22	Employee Benefits & Payroll Taxes			173,753	173,753		173,753		173,753		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,471	2,471		2,471	48	2,519		24
25	Other Admin. Staff Transportation			1,241	1,241		1,241	3,596	4,837		25
26	Insurance-Prop.Liab.Malpractice			31,270	31,270		31,270	833	32,103		26
27	Other (specify):* RDK/SI Benefits Alloc							8,433	8,433		27
28	<b>TOTAL General Administration</b>	69,503	11,511	394,214	475,228		475,228	(33,877)	441,351		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,087,403	154,830	479,756	1,721,989		1,721,989	(6,086)	1,715,903		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 Pinckneyville Nrsing & Rehab

#0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

## 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	
	<b>D. Ownership</b>											
30	Depreciation			106,459	106,459		106,459	397	106,856			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,166	69,166		69,166	(34)	69,132			32
33	Real Estate Taxes			17,398	17,398		17,398	117	17,515			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,241	5,241		5,241		5,241			35
36	Other (specify):* <b>Loan Cost Amort</b>			5,109	5,109		5,109		5,109			36
37	<b>TOTAL Ownership</b>			203,373	203,373		203,373	480	203,853			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,555	120,351	175,906		175,906		175,906			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,597	101,597		101,597		101,597			42
43	Other (specify):* <b>Disallowed Costs</b>			1,079	1,079		1,079	(1,079)				43
44	<b>TOTAL Special Cost Centers</b>		55,555	223,027	278,582		278,582	(1,079)	277,503			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,087,403	210,385	906,156	2,203,944		2,203,944	(6,685)	2,197,259			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	(2,850)	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	(45)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	43		13
14	Non-Care Related Interest	(34)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(100)	20		17
18	Fines and Penalties	(54)	43		18
19	Entertainment	(225)	43		19
20	Contributions	(593)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,167)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	15,361	43		24
25	Fund Raising, Advertising and Promotional	(11,168)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax		43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,764)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (6,698)</b>		<b>\$</b>	<b>30</b>

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)	13		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 13</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (6,685)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Pinckneyville Nrsing & Rehab

ID# 0054577

Report Period Beginning: 1/1/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Goodwill Amortization	\$ (333)	43	1
2	Birthday Expense	(997)	43	2
3	Gifts	(161)	43	3
4	Miscellaneous Income Offset	(273)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,764)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pinckneyville Nrsing & Rehab

# 0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	2,399	0	0	0	0	0	0	0	0	2,399	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	217	0	0	0	0	0	0	0	0	217	5
6	Maintenance	0	0	1,755	0	0	0	0	0	0	0	0	1,755	6
7	Other (specify):*	0	0	1,010	0	0	0	0	0	0	0	0	1,010	7
8	<b>TOTAL General Services</b>	0	0	5,381	0	0	0	0	0	0	0	0	5,381	8
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	19,773	0	0	0	0	0	0	0	0	0	19,773	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	2,637	0	0	0	0	0	0	0	0	0	2,637	15
16	<b>TOTAL Health Care and Programs</b>	0	22,410	0	0	0	0	0	0	0	0	0	22,410	16
<b>C. General Administration</b>														
17	Administrative	0	(52,429)	(7,851)	0	0	0	0	0	0	0	0	(60,280)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,167)	699	487	0	0	0	0	0	0	0	0	(3,981)	19
20	Fees, Subscriptions & Promotions	(100)	388	57	0	0	0	0	0	0	0	0	345	20
21	Clerical & General Office Expenses	(273)	15,627	1,775	0	0	0	0	0	0	0	0	17,129	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	23	25	0	0	0	0	0	0	0	0	48	24
25	Other Admin. Staff Transportation	0	1,786	1,810	0	0	0	0	0	0	0	0	3,596	25
26	Insurance-Prop.Liab.Malpractice	0	347	486	0	0	0	0	0	0	0	0	833	26
27	Other (specify):*	0	6,511	1,922	0	0	0	0	0	0	0	0	8,433	27
28	<b>TOTAL General Administration</b>	(5,540)	(27,048)	(1,289)	0	0	0	0	0	0	0	0	(33,877)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(5,540)	(4,638)	4,092	0	0	0	0	0	0	0	0	(6,086)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pinckneyville Nrsing & Rehab

# 0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(45)	442	0	0	0	0	0	0	0	0	0	397	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(34)	0	0	0	0	0	0	0	0	0	0	(34)	32
33	Real Estate Taxes	0	0	117	0	0	0	0	0	0	0	0	117	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(79)</b>	<b>442</b>	<b>117</b>	<b>0</b>	<b>480</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,079)	0	0	0	0	0	0	0	0	0	0	(1,079)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,079)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,079)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(6,698)</b>	<b>(4,196)</b>	<b>4,209</b>	<b>0</b>	<b>(6,685)</b>	<b>45</b>							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steven B. Herrin	33.33	Carrier Mills Nursing & Rehab	Carrier Mills	RDK Management, Inc	Harrisburg	Management Co.
Dr. Roger Herrin	33.33	Saline Care Center	Harrisburg	SI Management Svc, L	Harrisburg	Management Co.
Scott Stout	33.33	Stonebridge Senior Living Center	Benton			
		DuQuoin Nursing & Rehab	DuQuoin			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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	10 Nursing Wages	\$	SI Management Services, LLC	100.00%	\$ 19,773	\$ 19,773	1
2	V	15 Health Care and Prog. Emp. Ben.		SI Management Services, LLC	100.00%	2,637	2,637	2
3	V	17 Administrative	85,930	SI Management Services, LLC	100.00%	33,501	(52,429)	3
4	V	19 Professional Fees		SI Management Services, LLC	100.00%	699	699	4
5	V	20 Fees, Subscriptions		SI Management Services, LLC	100.00%	388	388	5
6	V	21 Clerical And General		SI Management Services, LLC	100.00%	15,627	15,627	6
7	V	24 Travel and Seminar		SI Management Services, LLC	100.00%	23	23	7
8	V	25 Admin. Staff Trans.		SI Management Services, LLC	100.00%	1,786	1,786	8
9	V	26 Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	347	347	9
10	V	27 Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	6,511	6,511	10
11	V	30 Depreciation		SI Management Services, LLC	100.00%	442	442	11
12	V							12
13	V							13
14	Total		\$ 85,930			\$ 81,734	\$ * (4,196)	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	3 <u>Housekeeping</u>	\$	<u>RDK Management, Inc.</u>	100.00%	\$ 2,399	\$	2,399	15
16	V	5 <u>Utilities</u>		<u>RDK Management, Inc.</u>	100.00%	217		217	16
17	V	6 <u>Maintenance</u>		<u>RDK Management, Inc.</u>	100.00%	1,755		1,755	17
18	V	7 <u>General Svcs. Emp. Ben.</u>		<u>RDK Management, Inc.</u>	100.00%	1,010		1,010	18
19	V	17 <u>Administrative</u>	53,565	<u>RDK Management, Inc.</u>	100.00%	45,714		(7,851)	19
20	V	19 <u>Professional Services</u>		<u>RDK Management, Inc.</u>	100.00%	487		487	20
21	V	20 <u>Dues, Fees, Subs &amp; Promotions</u>		<u>RDK Management, Inc.</u>	100.00%	57		57	21
22	V	21 <u>Clerical and General Office</u>		<u>RDK Management, Inc.</u>	100.00%	1,775		1,775	22
23	V	24 <u>Travel and Seminar</u>		<u>RDK Management, Inc.</u>	100.00%	25		25	23
24	V	25 <u>Other Admin. Staff Transport.</u>		<u>RDK Management, Inc.</u>	100.00%	1,810		1,810	24
25	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>RDK Management, Inc.</u>	100.00%	486		486	25
26	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>RDK Management, Inc.</u>	100.00%	1,922		1,922	26
27	V	33 <u>Real Estate Taxes</u>		<u>RDK Management, Inc.</u>	100.00%	117		117	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	<b>Total</b>		\$ 53,565			\$ 57,774	\$ *	4,209	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab # 0054577 Report Period Beginning: 1/1/16 Ending: 12/31/16

## 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	Dr. Roger Herrin	Owner	Administrative	0.33	See Att Sch 7A	7.29	10.72	Alloc. Fee	\$ 38,478	L17, C7	1
2	Steven Herrin	Owner	Administrative	0.33	147,500						2
3	Scott Stout	Owner	Administrative	0.33	See Att Sch 7A	7.29	12.15	Alloc. Salary	15,555	L17, C7	3
4											4
5											5
6											6
7											7
8	Steven Herrin received \$120,000 of wages from Stonebridge Senior Living Center and \$27,500 of guaranteed payments from Duquoin Nursing and Rehab										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 54,033		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab

# 0054577

Report Period Beginning:

1/1/16

Ending: 12/31/16

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

SI Management Services, LLC

Street Address

607 South Commercial

City / State / Zip Code

Harrisburg, Illinois

Phone Number

( 618) 252-7707

Fax Number

( )

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	10	Nursing Wages	Census	134,154	5	162,702	162,702	16,304	\$ 19,773	1
2	15	Health Care and Prog Emp. Ben.	Census	134,154	5	21,694		16,304	2,637	2
3	17	Administrative	Census	134,154	5	275,658	275,657	16,304	33,501	3
4	19	Professional Fees	Census	134,154	5	5,751		16,304	699	4
5	20	Fees, Subscriptions	Census	134,154	5	3,189		16,304	388	5
6	21	Clerical And General	Census	134,154	5	128,583	126,166	16,304	15,627	6
7	24	Travel and Seminar	Census	134,154	5	191		16,304	23	7
8	25	Admin. Staff Trans.	Census	134,154	5	14,698		16,304	1,786	8
9	26	Insurance-Prop./Liab./Malprac.	Census	134,154	5	2,853		16,304	347	9
10	27	Gen. Admin. Emp. Ben.	Census	134,154	5	53,576		16,304	6,511	10
11	30	Depreciation	Census	134,154	5	3,634		16,304	442	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 672,529	\$ 564,525		\$ 81,734	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pinckneyville Nrsing & Rehab

# 0054577

Report Period Beginning:

1/1/16

Ending: 12/31/16

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 RDK Management, Inc.  
 Street Address 607 South Commercial  
 City / State / Zip Code Harrisburg, Illinois  
 Phone Number ( 618) 252-7707  
 Fax Number ( )

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	134,154	5	19,736	19,736	16,304	\$ 2,399	1
2	5	Utilities	Census	134,154	5	1,783		16,304	217	2
3	6	Maintenance	Census	134,154	5	14,444	11,560	16,304	1,755	3
4	7	General Svcs. Emp. Ben.	Census	134,154	5	8,314		16,304	1,010	4
5	17	Administrative	Census	134,154	5	376,148	59,539	16,304	45,714	5
6	19	Professional Services	Census	134,154	5	4,010		16,304	487	6
7	20	Dues, Fees, Subs & Promotions	Census	134,154	5	471		16,304	57	7
8	21	Clerical and General Office	Census	134,154	5	14,604		16,304	1,775	8
9	24	Travel and Seminar	Census	134,154	5	207		16,304	25	9
10	25	Other Admin. Staff Transport.	Census	134,154	5	14,897		16,304	1,810	10
11	26	Ins.-Prop.Liab.Malpractice	Census	134,154	5	3,999		16,304	486	11
12	27	Mgmt. Allocation of Benefits	Census	134,154	5	15,817		16,304	1,922	12
13	33	Real Estate Taxes	Census	134,154	5	962		16,304	117	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 475,392	\$ 90,835		\$ 57,774	25

SEE ACCOUNTANTS' PREPARATION REPORT





**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Pinckneyville Nrsing & Rehab COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0054577

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 252-7707 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>1-53-0360-150</u>	<u>Long Term Care Property</u>	\$ <u>15,781.38</u>	\$ <u>15,781.38</u>
2. <u>06-2-275-02</u>	<u>Home Office Allocation</u>	\$ <u>963.32</u>	\$ <u>117.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>16,744.70</u></u>	\$ <u><u>15,898.38</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? X YES        NO

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

**C. Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab

# 0054577 Report Period Beginning:

1/1/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,097 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 1

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

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

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

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

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

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

N/A

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

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers. Row 1: Facility, 108,900, 2014, \$ 10,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 108,900, (blank), \$ 10,000, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Pinckneyville Nrsing &amp; Rehab

# 0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

**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	60		2014	1971	\$ 20,245	\$	39	\$ 519	\$ 519	\$ 1,557	4
5	Sprinkler			2013	24,800		7	3,543	3,543	7,131	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Pole Barn		2014		35,343		39	906	906	2,265	9
10	New Windows		2014		22,000		39	564	564	1,410	10
11	All Bathroom/Shower Rooms - cabinets, countertops, drywall,		2014		46,695		15	3,113	3,113	7,264	11
12	plumbing, electric, mirrors, paint										12
13	Replace/Repair walls & drywall, relocate plumbing & electric,		2014		146,393		39	3,754	3,754	7,821	13
14	New Doors, Paint & Molding for entire facility										14
15	Generator		2014		39,000		7	5,571	5,571	15,194	15
16	Generator-Additional Wiring and Hookup		2014		9,621		15	641	641	2,208	16
17	New Roof		2014		41,660		15	2,777	2,777	6,480	17
18	Parking Lot Paving		2014		25,411		15	1,694	1,694	4,235	18
19	Landscaping		2014		12,540		15	836	836	1,811	19
20	New Entry Doors		2014		16,610		15	1,107	1,107	2,306	20
21	Sprinkler System - Add & Relocate Sprinklers in Soffits		2014		11,129		7	1,590	1,590	3,563	21
22	Installed new Air Maint System, 9 AC Units with Sleeves,		2014		9,793		7	1,399	1,399	3,181	22
23	Phone wiring in offices, Side Entry Awning										23
24	Facility Camera Detector System		2014		5,895		7	842	842	1,824	24
25	Install Therapure Side Entry Bath		2014		9,530		7	1,361	1,361	2,949	25
26	Wall Vinyl - Res Rms, Hallways, Nurses Station, Dining Rm		2014		22,626		7	3,232	3,232	7,239	26
27	Privacy Tracks/Draperies - Resident Rms, Shower/Tub Room		2014		3,023		7	432	432	968	27
28	Handrails/bumper guards-Halls A, B, C, Service and Dining		2014		8,813		7	1,259	1,259	2,820	28
29	Flooring/cove base-Res Rms, Halls A, B, C and Service, Toilet		2014		64,122		7	9,160	9,160	20,515	29
30	& Shower Rms, Nurses Station, Beauty Shop, Fitness Rm										30
31	Blinds/windowcoverings - Resident Rms, Corridors A, B & C,		2014		8,766		7	1,252	1,252	2,804	31
32	Kitchen, Dining Rm, Laundry, Offices, Fitness Center										32
33	Light fixtures/sconces- Res Rms, Halls A, B & C, Shower		2014		9,771		7	1,396	1,396	3,127	33
34	& Toilet Rms, Beauty Shop, Fitness Center, Nurses Station										34
35	Interior Design Development Fee		2014		10,000		7	1,429	1,429	3,394	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Pinckneyville Nrsing &amp; Rehab

# 0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Room/Hall and Outdoor signs, Paint & Constr Supplies, Tile	2014	6,510	\$	20	325	\$ 325	\$ 650	37
38	Labor - Drywall Finishing/Painting/Wallpapering/Staining	2014	57,889		20	2,894	2,894	5,788	38
39	throughout Facility								39
40	Kithchen & Bathroom Fixtures, Repair & Replace Drywall,	2015	136,082		20	6,804	6,804	10,206	40
41	Doors & Jambs, Moldings, Painting, Wallpapering,								41
42	Electrical & Plumbing Facility wide								42
43	New Landscaping shrubs	2015	539		20	27	27	40	43
44	Relocate Sprinklers in Conference Rm & Install Dry	2015	2,677		20	134	134	201	44
45	Sidewall Piping under Awning								45
46	Wiring & Installation of New Phone System in new Offices	2015	2,815		20	141	141	211	46
47	Side Entry Awning & 3 new Air Conditioner units	2015	3,256		20	163	163	244	47
48	Rewire Camera Sys & Repair Motion Detector on Front Door	2015	2,845		20	142	142	213	48
49	Room Signs and Wallboards	2015	2,025		20	101	101	152	49
50	Wall Vinyl - Resident Rooms	2015	1,134		20	57	57	85	50
51	Privacy Tracks/Draperies - Res Rms, Shower Rms, Fitness Ctr	2015	12,806		20	640	640	960	51
52	Handrails/Bumper Guards/Wall Protections - Dining Rm	2015	2,081		20	104	104	156	52
53	& Kitchen, Fitness Ctr, Shower Rms								53
54	Flooring/Cove Base - Dining & Service Hall, Offices, Closet	2015	9,144		20	457	457	686	54
55	Blinds & Windowcoverings - Res Rms, Dining, Offices, Fitness Ctr	2015	2,950		20	148	148	222	55
56	Light Fixtures/Sconces - Resident Bathrooms, Conference Rm	2015	1,696		20	85	85	127	56
57	Shower Tile - Resident Shower Rms	2015	1,684		20	84	84	126	57
58	Interior Design Development Fee	2015	5,000		20	250	250	375	58
59	Room/Hall and Outdoor signs, Paint & Constr Supplies, Tile	2015	4,292		20	215	215	322	59
60	Labor - Drywall Finishing/Painting/Wallpapering/Staining	2015	26,899		20	1,345	1,345	2,017	60
61	throughout Facility								61
62	New Door, Reception Window & Replace Front Door Glass	2015	4,570		20	229	229	343	62
63	Wall light fixtures & Outdoor Sign	2015	3,165		20	158	158	237	63
64	Built in Cabinets-Activity Rm, Door Protectors & Bumper Guards	2015	6,170		20	309	309	463	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 900,015	\$		\$ 63,189	\$ 63,189	\$ 135,890	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Pinckneyville Nrsing & Rehab

# 0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 900,015	\$		\$ 63,189	\$ 63,189	\$ 135,890	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27	Financial Statement Depreciation			106,459			(106,459)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 900,015	\$ 106,459		\$ 63,189	\$ (43,270)	\$ 135,890	34

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	\$ 304,262	\$	\$ 42,107	\$ 42,107	3-7 yrs	\$ 98,354	71
72	Current Year Purchases	1,753		124	124	5-7 yrs	124	72
73	Fully Depreciated Assets							73
74	SI Management Allocation			442	442			74
75	TOTALS	\$ 306,015	\$	\$ 42,673	\$ 42,673		\$ 98,478	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	2015 Kia Sorrento	2014	\$ 4,331	\$	\$ 866	\$ 866	5	\$ 2,309	76
77	Administrative	2001 Mustang	2014	640		128	128	5	331	77
78										78
79										79
80	TOTALS			\$ 4,971	\$	\$ 994	\$ 994		\$ 2,640	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,221,001	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,459	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,856	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 397	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 237,008	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: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**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: \$ 5,241 Description: Medical Equipment \$4,927; Office Equipment \$314

(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>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 46,211	\$		\$ 46,211	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			20,545			20,545	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			53,595			53,595	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				55,555		55,555	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	<b>TOTAL</b>			\$		\$ 120,351	\$ 55,555		\$ 175,906	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

# 0054577

Report Period Beginning: 1/1/16

Ending:

12/31/16

As of 12/31/16

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 101,643	\$ 101,643	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	898,622	898,622	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	264	264	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,000,529	\$ 1,000,529	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,017	5,017	12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	20,245	45,045	14
15	Leasehold Improvements, at Historical Cost	762,556	854,970	15
16	Equipment, at Historical Cost	321,979	310,986	16
17	Accumulated Depreciation (book methods)	(235,856)	(237,008)	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): <u>Goodwill</u>	4,000	4,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 887,941	\$ 993,010	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,888,470	\$ 1,993,539	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 34,183	\$ 34,183	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	170,000	170,000	29
30	Accrued Salaries Payable	36,111	36,111	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,773	1,773	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,610	16,610	32
33	Accrued Interest Payable	1,562	1,562	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 260,239	\$ 260,239	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,359,173	1,359,173	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,359,173	\$ 1,359,173	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,619,412	\$ 1,619,412	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 269,058	\$ 374,127	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,888,470	\$ 1,993,539	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>13,303</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>(1)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>13,302</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>449,151</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(195,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Record Invest. SI Management</b>	<b>1,605</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>255,756</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>269,058</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,626,401	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,626,401	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	27,042	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 27,042	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	34	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 34	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous</u>	273	28
28a	<u>SI Management Income/Loss</u>	(655)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (382)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,653,095	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	450,744	31
32	Health Care	796,017	32
33	General Administration	475,228	33
<b>B. Capital Expense</b>			
34	Ownership	203,373	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	176,985	35
36	Provider Participation Fee	101,597	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,203,944	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	449,151	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 449,151	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,236,601	44
45	Private Pay - Net Inpatient Revenue	668,297	45
46	Medicare - Net Inpatient Revenue	679,319	46
47	Other-(specify) <u>Insurance</u>	42,184	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,626,401	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 Pinckneyville Nrsing & Rehab

# 0054577

Report Period Beginning:

1/1/16

Ending:

12/31/16

**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	2,103	2,147	\$ 59,758	\$ 27.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,439	4,622	100,223	21.68	3
4	Licensed Practical Nurses	8,690	8,727	170,084	19.49	4
5	CNAs & Orderlies	32,563	33,884	367,819	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,284	2,288	27,823	12.16	10
11	Social Service Workers	2,267	2,275	24,459	10.75	11
12	Dietician					12
13	Food Service Supervisor	2,269	2,400	29,735	12.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,263	9,521	83,555	8.78	15
16	Dishwashers					16
17	Maintenance Workers	1,970	2,120	27,308	12.88	17
18	Housekeepers	8,267	8,464	81,212	9.59	18
19	Laundry	4,708	4,937	45,924	9.30	19
20	Administrator	1,484	1,615	33,807	20.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,217	3,351	35,696	10.65	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)	83,524	86,351	\$ 1,087,403 *	\$ 12.59	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	82	\$ 4,359	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	69	4,403	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	151	\$ 14,762		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

Facility Name & ID Number Pinckneyville Nrsing & Rehab

# 0054577

Report Period Beginning: 1/1/16

Ending: 12/31/16

**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	
Jeffrey McDaniel	Administrator	0	\$ 10,262	Workers' Compensation Insurance	\$ 49,680	IDPH License Fee	\$	
Charity Bathon	Administrator	0	23,545	Unemployment Compensation Insurance	29,666	Advertising: Employee Recruitment	2,240	
				FICA Taxes	80,851	Health Care Worker Background Check		
				Employee Health Insurance	8,294	(Indicate # of checks performed 15 )	765	
				Employee Meals		Patient Background Checks	896	
				Illinois Municipal Retirement Fund (IMRF)*		License & Permits	500	
				Incentive Expenses	2,497	Dues & Subscriptions	348	
				Life/Disability Insurance	2,765	Allocated From RDK/SI Management	445	
				Other Employee Benefits				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 33,807					
(List each licensed administrator separately.)								
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			\$ 139,495	N/A			Out-of-State Travel	\$
							In-State Travel	1,103
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 139,495				Seminar Expense	1,368
(Attach a copy of any management service agreement)							Allocated From RDK/SI Management	48
C. Professional Services				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type		Amount			\$ 173,753		\$ 5,194
Adam Lawler Law Firm	Legal		\$ 737					
Lawler Brown Law Firm	Legal		4,325					
Daniel Maher	Legal		27					
Thomas Wolf Jr, PC	Legal		105					
Templin Healthcare Accounting	Accounting		4,189					
James Henson, PC	Accounting		8,067					
Payroll Services by Extra Help	Payroll Service		1,076					
Passport Software	Accounting Software		384					
IT Next Gen	Web Hosting Service		190					
Information Controls	LTC Software		1,165					
American Health Tech	LTC Software		11,906					
ESolutions Network	Health Info Management		908					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 33,079					
(For legal fee disclosure, see page 39 of instructions)								

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

\*\*See instructions.



**Pinckneyville Nrsing & Rehab**

**Period Beginning**                    **1/1/16**  
**Period End**                            **12/31/16**

**SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION**

**Care Related Vehicle Expenses:**

<b>Mileage reimbursement for allowable travel</b>	<b>552</b>
<b>Fuel and miscellaneous supplies</b>	<b>689</b>
<b>Allocated from Mgmt Co</b>	<b>3,596</b>
	<hr/>
	<b>4,837</b>
	<hr/> <hr/>