

Facility Name & ID Number Greenville Nursing and Rehabilitation Center

0054726 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 _____

	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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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			3,262	3,262	8
9	SNF/PED					9
10	ICF	13,180	5,932		19,112	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,180	5,932	3,262	22,374	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.11%

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 12/1/17

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 12/1/17 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 34 and days of care provided 3,032

Medicare Intermediary National Government Services

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 & ID Number Greenville Nursing and Rehabilitation Center # 0054726 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	159,093	6,551	7,185	172,829		172,829		172,829		1
2	Food Purchase		134,963		134,963		134,963		134,963		2
3	Housekeeping	130,909	13,702		144,611		144,611	842	145,453		3
4	Laundry	35,566	12,264		47,830		47,830		47,830		4
5	Heat and Other Utilities			87,340	87,340		87,340	288	87,628		5
6	Maintenance	94,886	5,219	26,358	126,463		126,463	(16,674)	109,789		6
7	Other (specify):* Waste Removal			14,202	14,202		14,202	75	14,277		7
8	TOTAL General Services	420,454	172,699	135,085	728,238		728,238	(15,469)	712,769		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,102,666	57,089	2,400	1,162,155		1,162,155		1,162,155		10
10a	Therapy			1,705	1,705		1,705		1,705		10a
11	Activities	53,505	2,767	2,215	58,487		58,487		58,487		11
12	Social Services	41,969		1,474	43,443		43,443		43,443		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,198,140	59,856	25,794	1,283,790		1,283,790		1,283,790		16
	C. General Administration										
17	Administrative	82,101		253,930	336,031		336,031	(230,600)	105,431		17
18	Directors Fees										18
19	Professional Services			55,795	55,795		55,795	1,211	57,006		19
20	Dues, Fees, Subscriptions & Promotions			14,226	14,226		14,226	(2,215)	12,011		20
21	Clerical & General Office Expenses	44,101	14,099	38,587	96,787		96,787	66,554	163,341		21
22	Employee Benefits & Payroll Taxes			229,547	229,547		229,547		229,547		22
23	Inservice Training & Education			332	332		332		332		23
24	Travel and Seminar			16,516	16,516		16,516	(11,795)	4,721		24
25	Other Admin. Staff Transportation			14,636	14,636		14,636	810	15,446		25
26	Insurance-Prop.Liab.Malpractice			157,826	157,826		157,826	220	158,046		26
27	Other (specify):* WLC Benefits Alloc							7,908	7,908		27
28	TOTAL General Administration	126,202	14,099	781,395	921,696		921,696	(167,907)	753,789		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,744,796	246,654	942,274	2,933,724		2,933,724	(183,376)	2,750,348		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.

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			303,727	303,727		303,727	(288,689)	15,038			30
31	Amortization of Pre-Op. & Org.							377	377			31
32	Interest			31,410	31,410		31,410	572	31,982			32
33	Real Estate Taxes			44,955	44,955		44,955	565	45,520			33
34	Rent-Facility & Grounds			454,148	454,148		454,148	1,021	455,169			34
35	Rent-Equipment & Vehicles			21,973	21,973		21,973		21,973			35
36	Other (specify):*											36
37	TOTAL Ownership			856,213	856,213		856,213	(286,154)	570,059			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			321	321		321		321			38
39	Ancillary Service Centers		87,419	568,508	655,927		655,927		655,927			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,986	166,986		166,986		166,986			42
43	Other (specify):* Disallowed Costs			78,916	78,916		78,916	(78,916)				43
44	TOTAL Special Cost Centers		87,419	814,731	902,150		902,150	(78,916)	823,234			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,744,796	334,073	2,613,218	4,692,087		4,692,087	(548,446)	4,143,641			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	(6,229)	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	(293,286)	30		9
10	Interest and Other Investment Income	(54)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(184)	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	(2,215)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,873)	43		24
25	Fund Raising, Advertising and Promotional	(10,918)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(30,897)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (404,656)		\$	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)	(143,790)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (143,790)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (548,446)		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	

SEE ACCOUNTANTS' PREPARATION REPORT

Greenville Nursing and Rehabilitation Center

ID# 0054726

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gifts	\$ (712)	43	1
2	Miscellaneous income offset	(1,140)	21	2
3	Capitalized Labor for Renovation	(17,235)	6	3
4	Capitalized Travel Costs for Renovation	(11,810)	24	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(30,897)		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.
		Duquoin Nursing & Rehabilitation Center	Duquoin			
		Eldorado Rehab and Healthcare	Eldorado			
		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%	\$ 842	\$ 842	1
2	V	5 Utilities		WLC Management Firm, LLC	100.00%	288	288	2
3	V	6 Maintenance		WLC Management Firm, LLC	100.00%	561	561	3
4	V	7 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	75	75	4
5	V	17 Administrative	253,930	WLC Management Firm, LLC	100.00%	23,330	(230,600)	5
6	V	19 Professional Services		WLC Management Firm, LLC	100.00%	1,211	1,211	6
7	V	21 Clerical & General Office		WLC Management Firm, LLC	100.00%	67,694	67,694	7
8	V	24 Travel & Seminar		WLC Management Firm, LLC	100.00%	15	15	8
9	V	25 Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	810	810	9
10	V	26 Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	220	220	10
11	V	27 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	7,908	7,908	11
12	V	30 Depreciation		WLC Management Firm, LLC	100.00%	4,597	4,597	12
13	V	31 Amortization-Pre Org Costs		WLC Management Firm, LLC	100.00%	377	377	13
14	Total		\$ 253,930			\$ 107,928	\$ * (146,002)	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%	\$ 626	\$	626	15
16	V	33 Real Estate Taxes		WLC Management Firm, LLC	100.00%	565		565	16
17	V	34 Rent-Facility & Grounds		WLC Management Firm, LLC	100.00%	1,021		1,021	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		\$			\$ 2,212	\$ *	2,212	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greenville Nursing and Rehabilitation Cente # 0054726 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	5.04	12.60	Alloc. Salary	\$ 23,330	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	\$ 23,330		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 Greenville Nursing and Rehabilitation Center # 0054726 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	22,374	\$ 842	1
2	5	Utilities	Census	177,417	7	2,280		22,374	288	2
3	6	Maintenance	Census	177,417	7	4,451		22,374	561	3
4	7	Mgmt Allocation of Benefits	Census	177,417	7	593		22,374	75	4
5	17	Administrative	Census	177,417	7	185,000	185,000	22,374	23,330	5
6	19	Professional Services	Census	177,417	7	9,603		22,374	1,211	6
7	21	Clerical & General Office	Census	177,417	7	536,784	522,122	22,374	67,694	7
8	24	Travel & Seminar	Census	177,417	7	115		22,374	15	8
9	25	Other Admin Staff Transport	Census	177,417	7	6,420		22,374	810	9
10	26	Insurance-Prop/Liab/Malprac	Census	177,417	7	1,744		22,374	220	10
11	27	Mgmt Allocation of Benefits	Census	177,417	7	62,710		22,374	7,908	11
12	30	Depreciation	Census	177,417	7	36,453		22,374	4,597	12
13	31	Amortization-Pre Org Costs	Census	177,417	7	2,991		22,374	377	13
14	32	Interest	Census	177,417	7	4,967		22,374	626	14
15	33	Real Estate Taxes	Census	177,417	7	4,478		22,374	565	15
16	34	Rent-Facility & Grounds	Census	177,417	7	8,098		22,374	1,021	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 873,366	\$ 713,801		\$ 110,140	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	Legence Bank	X	Line of Credit		11/16/18	804,000	804,000	11/30/19	0.0525	31,410										
7																				
8																				
9	TOTAL Facility Related					\$ 804,000	\$ 804,000			\$ 31,410										
B. Non-Facility Related*																				
10																				
11								Interest Income Offset		(54)										
12								Allocated From WLC		626										
13																				
14	TOTAL Non-Facility Related					\$	\$			\$ 572										
15	TOTALS (line 9+line14)					\$ 804,000	\$ 804,000			\$ 31,982										

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.		\$		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	\$	40,932	2
3. Under or (over) accrual (line 2 minus line 1).		\$	40,932	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	40,932	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.			(37,112)	
			768	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	45,520	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	_____	8	
	2014	_____	9	
	2015	_____	10	
	2016	_____	11	
	2017	40,932	12	
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 Greenville Nursing and Rehabilitation Center COUNTY Bond

FACILITY IDPH LICENSE NUMBER 0054726

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>05-10-14-330-001</u>	<u>Long Term Care Property</u>	\$ <u>40,931.98</u>	\$ <u>40,931.98</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>40,931.98</u></u>	\$ <u><u>40,931.98</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 Greenville Nursing and Rehabilitation Center

0054726 Report Period Beginning:

1/1/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,000 B. General Construction Type: Exterior Brick Frame Wood 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: 4,485 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 377 4. Dates Incurred: 2017

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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	Facility Remodel:								
10	Carpet/Tile/Flooring	2018		49,155		20	1,229	1,229	1,229
11	Cabinetry/Sink/Plumbing	2018		41,303		20	1,033	1,033	1,033
12	Construction Supplies/Permits	2018		35,378		20	884	884	884
13	Painting/Paint Supplies	2018		7,428		20	186	186	186
14	Lighting	2018		17,346		20	434	434	434
15	Doors	2018		9,039		20	226	226	226
16	Trim/Cove Base/Cornerguards	2018		4,934		20	123	123	123
17	Handrails	2018		9,186		20	230	230	230
18	Ceiling Tiles	2018		3,531		20	88	88	88
19	Design Fee	2018		9,976		20	249	249	249
20	PTAC/AC Units	2018		5,313		20	133	133	133
21	Electrical	2018		2,742		20	69	69	69
22	Window Treatments	2018		9,970		20	249	249	249
23	Labor/Travel Costs	2018		53,328		20	1,333	1,333	1,333
24	Cubicle Curtains	2018		8,545		20	214	214	214
25	Sprinkler	2018		3,351		20	84	84	84
26	Air Handlers	2018		6,251		20	156	156	156
27	Annunciators	2018		1,434		20	36	36	36
28	Phone System	2018		4,720		20	118	118	118
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

Facility Name & ID Number Greenville Nursing and Rehabilitation Center

0054726

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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		\$	\$		\$	\$	\$
38							
39							
40			303,727			(303,727)	
41							
42							
43							
44	2018	50,697		25	1,014	1,014	1,014
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70		\$ 333,627	\$ 303,727		\$ 8,088	\$ (295,639)	\$ 8,088

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	\$ 8,747	\$	\$ 875	\$ 875	10	\$ 948	71
72	Current Year Purchases	49,842		2,492	2,492	10	2,492	72
73	Fully Depreciated Assets							73
74	Allocated from WLC Mgmt	626		63	63		104	74
75	TOTALS	\$ 59,215	\$	\$ 3,430	\$ 3,430		\$ 3,544	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78	Allocated from WLC Mgmt			20,169		3,520	3,520		5,078	78
79										79
80	TOTALS			\$ 20,169	\$	\$ 3,520	\$ 3,520		\$ 5,078	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)	\$ 413,011	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 303,727	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,038	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (288,689)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 16,710	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:		99	12/1/17	\$ 454,148			3
4	Additions							4
5		Allocated from WLC			1,021			5
6								6
7	TOTAL		99		\$ 455,169			7

10. Effective dates of current rental agreement:

Beginning 12/1/17

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>453,528</u>
13.	<u>2/29/2020</u>	\$ <u>468,268</u>
14.	<u>2/28/2021</u>	\$ <u>483,486</u>

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease 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: \$ 21,973 Description: Medical Equipment \$18,836; Office Equipment \$2,017; Container lease \$1,120

(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	\$	11,284	\$ 202,843	\$	11,284	\$ 202,843	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		6,796	142,500		6,796	142,500	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3),39(3)	hrs		11,573	207,583		11,573	207,583	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				87,419		87,419	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			\$	29,653	\$ 552,926	\$ 87,419	29,653	\$ 640,345	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.

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	\$ 158,804	\$ 158,804	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>5,550</u>)	543,703	543,703	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,420	29,420	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 731,927	\$ 731,927	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	286,124	333,627	15
16	Equipment, at Historical Cost	27,329	79,384	16
17	Accumulated Depreciation (book methods)	(313,453)	(16,710)	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)	\$	\$ 396,301	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 731,927	\$ 1,128,228	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 116,768	\$ 116,768	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	804,000	804,000	29
30	Accrued Salaries Payable	67,196	67,196	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,425	4,425	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,932	40,932	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	47	47	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,033,368	\$ 1,033,368	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,033,368	\$ 1,033,368	46
47	TOTAL EQUITY(page 18, line 24)	\$ (301,441)	\$ 94,860	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 731,927	\$ 1,128,228	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (28,837)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (28,837)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(272,604)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (272,604)	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)	\$ (301,441)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greenville Nursing and Rehabilitation Center

0054726

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	\$ 3,990,784	1
2	Discounts and Allowances for all Levels	27,924	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,018,708	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	395,804	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 395,804	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	3,615	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	84	19
20	Radiology and X-Ray		20
21	Other Medical Services	78	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,777	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	54	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 54	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	1,140	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,140	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,419,483	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	728,238	31
32	Health Care	1,283,790	32
33	General Administration	921,696	33
B. Capital Expense			
34	Ownership	856,213	34
C. Ancillary Expense			
35	Special Cost Centers	735,164	35
36	Provider Participation Fee	166,986	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,692,087	40
41	Income before Income Taxes (line 30 minus line 40)**	(272,604)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (272,604)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,694,642	44
45	Private Pay - Net Inpatient Revenue	830,534	45
46	Medicare - Net Inpatient Revenue	1,402,658	46
47	Other-(specify) <u>Insurance</u>	90,874	47
48	Other-(specify) <u>VA</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,018,708	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 Greenville Nursing and Rehabilitation Center

0054726

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	2,024	2,064	\$ 72,288	\$ 35.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,828	8,978	257,129	28.64	3
4	Licensed Practical Nurses	10,813	10,925	254,545	23.30	4
5	CNAs & Orderlies	38,711	39,053	518,704	13.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,944	1,976	30,084	15.22	9
10	Activity Assistants	1,701	1,729	23,421	13.55	10
11	Social Service Workers	1,978	2,010	41,969	20.88	11
12	Dietician					12
13	Food Service Supervisor	2,567	2,591	44,732	17.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,291	11,365	114,361	10.06	15
16	Dishwashers					16
17	Maintenance Workers	4,477	4,520	94,886	20.99	17
18	Housekeepers	12,042	12,173	130,909	10.75	18
19	Laundry	2,838	2,875	35,566	12.37	19
20	Administrator	2,087	2,095	82,101	39.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,323	3,372	44,101	13.08	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)	104,624	105,726	\$ 1,744,796 *	\$ 16.50	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	136	\$ 7,185	L1, C3	35
36	Medical Director	Monthly	18,000	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	27	1,474	L11, C3	44
45	Social Service Consultant	27	1,474	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	190	\$ 30,533		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

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? Yes
If YES, give association name and amount. 5,940 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,791 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 166,986
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' 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 For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 7,134 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees