

Facility Name & ID Number Duquoin Nursing and Rehab

0052928 Report Period Beginning: 1/1/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	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	29	Skilled (SNF)	29	10,585	1
2		Skilled Pediatric (SNF/PED)			2
3	45	Intermediate (ICF)	45	16,425	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,349	2,349	8
9	SNF/PED					9
10	ICF	8,328	3,670		11,998	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,328	3,670	2,349	14,347	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.12%

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 9/1/14

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

YES Date 9/1/14 NO

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

YES NO If YES, enter number of beds certified 29 and days of care provided 2,158

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	97,315	4,171	5,479	106,965		106,965		106,965		1
2	Food Purchase		77,134		77,134		77,134		77,134		2
3	Housekeeping	91,553	8,889		100,442		100,442	289	100,731		3
4	Laundry	28,807	6,572		35,379		35,379		35,379		4
5	Heat and Other Utilities			59,086	59,086		59,086	198	59,284		5
6	Maintenance	50,126	349,450	18,279	417,855		417,855	(329,787)	88,068		6
7	Other (specify):* Waste Rem/RDK/SI Benefits			1,564	1,564		1,564	13	1,577		7
8	TOTAL General Services	267,801	446,216	84,408	798,425		798,425	(329,287)	469,138		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	588,395	34,694	2,400	625,489		625,489	14,589	640,078		10
10a	Therapy			161,343	161,343		161,343		161,343		10a
11	Activities	20,971			20,971		20,971		20,971		11
12	Social Services	28,055	3,682	3,525	35,262		35,262		35,262		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RDK/SI Benefits Alloc							1,745	1,745		15
16	TOTAL Health Care and Programs	637,421	38,376	172,068	847,865		847,865	16,334	864,199		16
	C. General Administration										
17	Administrative	67,014		253,299	320,313		320,313	(158,069)	162,244		17
18	Directors Fees										18
19	Professional Services			30,511	30,511		30,511	718	31,229		19
20	Dues, Fees, Subscriptions & Promotions			8,976	8,976		8,976	(11)	8,965		20
21	Clerical & General Office Expenses	35,429	14,702	8,194	58,325		58,325	22,344	80,669		21
22	Employee Benefits & Payroll Taxes			132,984	132,984		132,984		132,984		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,334	2,334		2,334	188	2,522		24
25	Other Admin. Staff Transportation			8,007	8,007		8,007	1,487	9,494		25
26	Insurance-Prop.Liab.Malpractice			32,825	32,825		32,825	241	33,066		26
27	Other (specify):* RDK/SI Benefits Alloc							8,474	8,474		27
28	TOTAL General Administration	102,443	14,702	477,130	594,275		594,275	(124,628)	469,647		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,007,665	499,294	733,606	2,240,565		2,240,565	(437,581)	1,802,984		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Duquoin Nursing and Rehab

#0052928

Report Period Beginning:

1/1/15

Ending:

12/31/15

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			58,131	58,131		58,131	1,514	59,645			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,906	57,906		57,906	(74)	57,832			32
33	Real Estate Taxes			19,664	19,664		19,664	108	19,772			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,316	5,316		5,316		5,316			35
36	Other (specify):*			2,798	2,798		2,798		2,798			36
37	TOTAL Ownership			143,815	143,815		143,815	1,548	145,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,270		80,270		80,270		80,270			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,928	114,928		114,928		114,928			42
43	Other (specify):* Non-allowable Costs			(6,929)	(6,929)		(6,929)	6,929				43
44	TOTAL Special Cost Centers		80,270	107,999	188,269		188,269	6,929	195,198			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,007,665	579,564	985,420	2,572,649		2,572,649	(429,104)	2,143,545			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab

0052928

Report Period Beginning: 1/1/15

Ending: 12/31/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,900)	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	877	30		9
10	Interest and Other Investment Income	(74)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(718)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(125)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,417)	43		19
20	Contributions	(331)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	23,890	43		24
25	Fund Raising, Advertising and Promotional	(5,536)	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	(331,907)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (322,241)		\$	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)	(106,863)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (106,863)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (429,104)		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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY					
48		49		50	51
					52

Duquoin Nursing and Rehab

ID# 0052928

Report Period Beginning: 1/1/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Funeral Expense	\$ (1,232)	43	1
2	Birthday Expense	(669)	43	2
3	Gifts	(158)	43	3
4	Capitalize Renovation expenses	(329,848)	6	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	Total		(331,907)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Duquoin Nursing and Rehab# 0052928

Report Period Beginning:

1/1/15

Ending:

12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	289	0	0	0	0	0	0	0	0	289	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	198	0	0	0	0	0	0	0	0	198	5
6	Maintenance	(329,848)	0	61	0	0	0	0	0	0	0	0	(329,787)	6
7	Other (specify):*	0	0	13	0	0	0	0	0	0	0	0	13	7
8	TOTAL General Services	(329,848)	0	561	0	(329,287)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	14,589	0	0	0	0	0	0	0	0	0	14,589	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,745	0	0	0	0	0	0	0	0	0	1,745	15
16	TOTAL Health Care and Programs	0	16,334	0	0	0	0	0	0	0	0	0	16,334	16
	C. General Administration													
17	Administrative	0	(72,571)	(85,498)	0	0	0	0	0	0	0	0	(158,069)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	266	452	0	0	0	0	0	0	0	0	718	19
20	Fees, Subscriptions & Promotions	(125)	53	61	0	0	0	0	0	0	0	0	(11)	20
21	Clerical & General Office Expenses	0	20,374	1,970	0	0	0	0	0	0	0	0	22,344	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	7	181	0	0	0	0	0	0	0	0	188	24
25	Other Admin. Staff Transportation	0	664	823	0	0	0	0	0	0	0	0	1,487	25
26	Insurance-Prop.Liab.Malpractice	0	241	0	0	0	0	0	0	0	0	0	241	26
27	Other (specify):*	0	5,864	2,610	0	0	0	0	0	0	0	0	8,474	27
28	TOTAL General Administration	(125)	(45,102)	(79,401)	0	(124,628)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(329,973)	(28,768)	(78,840)	0	(437,581)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Duquoin Nursing and Rehab

0052928

Report Period Beginning:

1/1/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	877	0	637	0	0	0	0	0	0	0	0	1,514	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(74)	0	0	0	0	0	0	0	0	0	0	(74)	32
33	Real Estate Taxes	0	0	108	0	0	0	0	0	0	0	0	108	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	803	0	745	0	1,548	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	6,929	0	0	0	0	0	0	0	0	0	0	6,929	43
44	TOTAL Special Cost Centers	6,929	0	0	0	0	0	0	0	0	0	0	6,929	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(322,241)	(28,768)	(78,095)	0	0	0	0	0	0	0	0	(429,104)	45

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
See Page 6 Supp		Carrier Mills Nursing & Rehab	Carrier Mills	RDK Management, In	Harrisburg	Management Co.
		Saline Care Center	Harrisburg	SI Management Svc, I	Harrisburg	Management Co.
		Pinckneyville Nursing & Rehab	Pinckneyville			
		Stonebridge Senior Living Center, LLC	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:	
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%	\$ 14,589	\$ 14,589	1
2	V	15 Health Care and Prog Emp. Ben.		SI Management Services, LLC	100.00%	1,745	1,745	2
3	V	17 Administrative	101,560	SI Management Services, LLC	100.00%	28,989	(72,571)	3
4	V	19 Professional Fees		SI Management Services, LLC	100.00%	266	266	4
5	V	20 Fees, Subscriptions		SI Management Services, LLC	100.00%	53	53	5
6	V	21 Clerical And General		SI Management Services, LLC	100.00%	20,374	20,374	6
7	V	24 Travel and Seminar		SI Management Services, LLC	100.00%	7	7	7
8	V	25 Admin. Staff Trans.		SI Management Services, LLC	100.00%	664	664	8
9	V	26 Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	241	241	9
10	V	27 Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	5,864	5,864	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 101,560			\$ 72,792	\$ * (28,768)	14

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

SEE ACCOUNTANTS' COMPILATION 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 Housekeeping	\$	RDK Management, Inc.	100.00%	\$ 289	\$	289	15
16	V	5 Utilities		RDK Management, Inc.	100.00%	198		198	16
17	V	6 Maintenance		RDK Management, Inc.	100.00%	61		61	17
18	V	7 General Svcs. Emp. Ben.		RDK Management, Inc.	100.00%	13		13	18
19	V	17 Administrative	151,739	RDK Management, Inc.	100.00%	66,241		(85,498)	19
20	V	19 Professional Services		RDK Management, Inc.	100.00%	452		452	20
21	V	20 Dues, Fees, Subs & Promotions		RDK Management, Inc.	100.00%	61		61	21
22	V	21 Clerical and General Office		RDK Management, Inc.	100.00%	1,970		1,970	22
23	V	24 Travel and Seminar		RDK Management, Inc.	100.00%	181		181	23
24	V	25 Other Admin. Staff Transport.		RDK Management, Inc.	100.00%	823		823	24
25	V	27 Mgmt. Allocation of Benefits		RDK Management, Inc.	100.00%	2,610		2,610	25
26	V	30 Depreciation		RDK Management, Inc.	100.00%	637		637	26
27	V	33 Real Estate Taxes		RDK Management, Inc.	100.00%	108		108	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		\$ 151,739			\$ 73,644	\$ *	(78,095)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Ryan Saran	5						1
2	Scott Stout	22						2
3	James Woodward	22						3
4	Penny Sisk	5						4
5	Steven Herrin	22						5
6	Phillip Saran	6						6
7	Lindsay Saran	5						7
8	Virginia Pierce	6						8
9	Dr. Roger Herrin	3						9
10	Lysa Saran	4						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab # 0052928 Report Period Beginning: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1 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	Owner	Administrative	22.00	See Att Sch 7A	6.79	11.32	Alloc. Salary	\$ 13,927	L17, C7	1
2	Steven Herrin	Owner	Administrative	22.00	120,000						2
3	Penny Sisk	Owner	Administrative	5.00	See Att Sch 7A	4.52	11.30	Alloc. Salary	13,048	L17, C7	3
4	Virginia Pierce	Owner	Administrative	6.00	See Att Sch 7A	4.53	11.33	Alloc. Salary	8,307	L17, C7	4
5	Dr. Roger Herrin	Owner	Administrative	3.00	See Att Sch 7A	6.79	9.99	Alloc. Salary	59,949	L17, C7	5
6											6
7											7
8	Steven Herrin received wages from Stonebridge Senior Living Center										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 95,231		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab

0052928

Report Period Beginning:

1/1/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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 ()

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	10	Nursing Wages	Census	126,706	5	128,842	128,842	14,347	\$ 14,589	1
2	15	Health Care and Prog Emp. Ben.	Census	126,706	5	15,408	14,347	14,347	1,745	2
3	17	Administrative	Census	126,706	5	256,018	256,018	14,347	28,989	3
4	19	Professional Fees	Census	126,706	5	2,350	14,347	14,347	266	4
5	20	Fees, Subscriptions	Census	126,706	5	465	14,347	14,347	53	5
6	21	Clerical And General	Census	126,706	5	179,937	177,087	14,347	20,374	6
7	24	Travel and Seminar	Census	126,706	5	61	14,347	14,347	7	7
8	25	Admin. Staff Trans.	Census	126,706	5	5,866	14,347	14,347	664	8
9	26	Insurance-Prop./Liab./Malprac.	Census	126,706	5	2,129	14,347	14,347	241	9
10	27	Gen. Admin. Emp. Ben.	Census	126,706	5	51,789	14,347	14,347	5,864	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 642,865	\$ 561,947		\$ 72,792	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab

0052928

Report Period Beginning:

1/1/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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 ()

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	126,706	5	2,554	2,554	14,347	\$ 289	1
2	5	Utilities	Census	126,706	5	1,746	14,347	198		2
3	6	Maintenance	Census	126,706	5	535	379	14,347	61	3
4	7	General Svcs. Emp. Ben.	Census	126,706	5	117	14,347	13		4
5	17	Administrative	Census	126,706	5	585,011	585,011	14,347	66,241	5
6	19	Professional Services	Census	126,706	5	3,992	14,347	452		6
7	20	Dues, Fees, Subs & Promotions	Census	126,706	5	540	14,347	61		7
8	21	Clerical and General Office	Census	126,706	5	17,394	14,347	1,970		8
9	24	Travel and Seminar	Census	126,706	5	1,600	14,347	181		9
10	25	Other Admin. Staff Transport.	Census	126,706	5	7,267	14,347	823		10
11	27	Mgmt. Allocation of Benefits	Census	126,706	5	23,048	14,347	2,610		11
12	30	Depreciation	Census	126,706	5	5,630	14,347	637		12
13	33	Real Estate Taxes	Census	126,706	5	957	14,347	108		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 650,391	\$ 587,944		\$ 73,644	25

SEE ACCOUNTANTS' COMPILATION 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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	Farmers State Bank		X	Line of Credit/Construction	Interest Only	11/25/15	\$	\$ 1,181,500	11/25/16	4.7500	50,532	6					
7	Farmers State Bank		X	Line of Credit/Construction	Interest Only	11/25/15		370,888	11/25/16	4.7500	7,374	7					
8												8					
9	TOTAL Facility Related						\$	\$ 1,552,388			\$ 57,906	9					
	B. Non-Facility Related*																
10												10					
11								Interest Income Offset			(74)	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (74)	14					
15	TOTALS (line 9+line14)						\$	\$ 1,552,388			\$ 57,832	15					

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION 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 2014 report.			\$ 19,038	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2014		\$ 19,255	2															
3. Under or (over) accrual (line 2 minus line 1).			\$ 217	3															
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 19,447	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Allocated from RDK	108																
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$ 108	6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 19,772	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	_____	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	_____	9																
	2012	_____	10																
	2013	_____	11																
	2014	19,255	12																
2015 Tax Accrual = \$19,255 x 1.01 = \$19,447																			

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Duquoin Nursing and Rehab COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0052928

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>1-61-0270-010</u>	<u>Long Term Care Property</u>	\$ <u>19,254.52</u>	\$ <u>19,254.52</u>
2.	<u>06-2-275-02</u>	<u>Home Office Allocation</u>	\$ <u>958.10</u>	\$ <u>958.10</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>20,212.62</u></u>	\$ <u><u>20,212.62</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>125,722</u>	<u>2014</u>	<u>\$ 19,775</u>	1
2					2
3	TOTALS	125,722		\$ 19,775	3

SEE ACCOUNTANTS' COMPILATION 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	74	2014	1966	\$ 50,000	\$	40	1,250	\$ 1,250	\$ 1,250	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Facility Renovation - See attached schedule of work performed		2015	218,505		20	5,463	5,463	5,463	9
10	Pole Barn		2015	20,840		20	521	521	521	10
11	Interior Design Development Fee		2015	12,000		20	300	300	300	11
12	Electric Rerouting & Rewiring throughout Facility		2015	33,941		20	849	849	849	12
13	Plumbing work - Replace pipings and drains in bathrooms		2015	52,695		20	1,317	1,317	1,317	13
14	and Replace Water Heater									14
15	Install New Phone System		2015	10,215		20	255	255	255	15
16	Install New Facility Camera Detector System		2015	11,875		20	297	297	297	16
17	Install New Nurse Call System		2015	17,950		20	449	449	449	17
18	Install 10 New Heat Pumps with Sleeves		2015	9,382		20	235	235	235	18
19	New Side Entry Therapure Bath		2015	9,201		20	230	230	230	19
20	Install New Ductwork throughout Facility		2015	5,068		20	127	127	127	20
21	Strip and Paint Interior Doors		2015	8,528		20	213	213	213	21
22	New Cabinets and Countertops- Nurse Station, Dining Rm.		2015	75,135		20	1,878	1,878	1,878	22
23	Beauty Shop, Fitness Rm, Shower Rm, Hospice Rm, Offices									23
24	Wall Vinyl-Resident Rms, Lobby, Dining		2015	30,315		20	758	758	758	24
25	Privacy Tracks/Draperies-Resident Rms, Shower Rms, Fitness Rm		2015	23,202		20	580	580	580	25
26	Handrails/bumper guards-Hallways, Dining,		2015	9,553		20	239	239	239	26
27	Flooring/cove base-Res Rms, Dining, Halls, Shower Rms, Offices		2015	40,894		20	1,022	1,022	1,022	27
28	Windowcoverings-Res Rms, Shower Rms, Offices, Fitness, Dining		2015	21,532		20	538	538	538	28
29	Light fixtures/sconces-Dining, Res Rms, Shower Rms, Lobby,		2015	18,949		20	474	474	474	29
30	Beauty Shop, Fitness Rm									30
31	Carpet-Offices, Conference Rm		2015	5,465		20	137	137	137	31
32	Ceramic Floor/Wall tile-Shower Rms, Bistro		2015	13,131		20	328	328	328	32
33	New Doors (Hall A, B & C and Beauty), Closet Doors and Frames		2015	39,582		20	990	990	990	33
34	New Main Entrance Awning		2015	5,150		20	129	129	129	34
35	New Room Signs		2015	4,298		20	107	107	107	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab

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							\$	\$	37
38	Painting/Wallpapering-Hallways & Resident Rms	2015	26,265		20	657	657	657	38
39	Excavating/Drainage, Carport and Tree Removal	2015	8,380		20	210	210	210	39
40	Relocate and Replace Sprinkler Lines and Heads	2015	4,485		20	112	112	112	40
41	Concrete Slabs for Maint Bldg, Fuel Tanks & Trench	2015	5,200		20	130	130	130	41
42	Painting / Carpentry /Tile / Flooring Labor & Dumpster Fees	2015	143,789		20	2,982	2,982	2,982	42
43	for Wing A and Completion of Wing C and Offices								43
44	Interior Design Development Fee-South Corridor	2015	4,000		20	100	100	100	44
45	Electric Rewiring & Rerouting, Light Fixtures & Finish work in	2015	26,519		20	663	663	663	45
46	A, B C wings, Nurses Station, Dining, Kitchen, Therapy, Lobby								46
47	Plumbing C wing-Relocate Plumbing Lines / Install Fixtures	2015	13,140		20	329	329	329	47
48	Nurse Call System Installation Additional Charges	2015	575		20	14	14	14	48
49	Balance due on New Facility Camera Detector System	2015	325		20	143	143	143	49
50	Install New Ductwork - Supplies and Returns	2015	4,462		20	112	112	112	50
51	Rewire & Install Phone Lines in C wing, Offices and Reception	2015	9,144		20	229	229	229	51
52	New Entrance Sign	2015	1,890		20	47	47	47	52
53	New Asphalt Driveway	2015	9,800		20	245	245	245	53
54	Crack fill, Seal Cost and Restripe Parking Lot	2015	3,500		20	88	88	88	54
55	Stain and Varnish Wood Doors	2015	2,337		20	48	48	48	55
56	New Generator	2015	53,500		20	1,338	1,338	1,338	56
57	New Landscaping - Bushes, gravel, weed barriers, edging, tile	2015	13,038		20	326	326	326	57
58	Wallcoverings and Wallguards - Conference Room, SS Office,	2015	11,151		20	279	279	279	58
59	Dining Rms, Resident Rooms, Shower Rooms, Public								59
60	Restrooms, Admin Office, Reception Area								60
61	Privacy Drapes, Light Fixtures, Flooring & Windowcoverings in	2015	3,719		20	93	93	93	61
62	Conference Rm, SS Office, Corridor A, Dining Lounge,								62
63	Resident Restrooms, Kitchen								63
64	Painting/Drywall Repairs/Replace and Repair Wallpaper & Install	2015	48,107		20	1,203	1,203	1,203	64
65	Flooring - Wings A, B & C, Kitchen, Employee Restroom, Admin								65
66	& Business offices, SS Office, Conference Rm & Entryway								66
67	Relocate and Replace Sprinkler heads / Install Door Holders	2015	3,653		20	91	91	91	67
68									68
69	Financial Statement Depreciation			58,131			(58,131)		69
70	TOTAL (lines 4 thru 69)		\$ 1,144,385	\$ 58,131		\$ 28,125	\$ (30,006)	\$ 28,125	70

SEE ACCOUNTANTS' COMPILATION 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	\$ 96,771	\$	\$ 14,183	\$ 14,183	5-7 yrs	\$ 19,751	71
72	Current Year Purchases	164,832		16,700	16,700	7 yrs	16,700	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.			637	637			74
75	TOTALS	\$ 261,603	\$	\$ 31,520	\$ 31,520		\$ 36,451	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	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,425,763	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,131	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,645	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,514	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 64,576	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab

0052928

Report Period Beginning: 1/1/15

Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 5,316 Description: Medical Equipment \$4,480 ; Office Equipment \$836

(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	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab # 0052928 Report Period Beginning: 1/1/15 Ending: 12/31/15
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? 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>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$		\$ 70,690	\$		\$ 70,690	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			22,003			22,003	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			68,650			68,650	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				80,270		80,270	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			\$		\$ 161,343	\$ 80,270		\$ 241,613	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab

0052928

Report Period Beginning: 1/1/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 93,923	\$ 93,923	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	545,496	545,496	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	35,025	35,025	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 674,444	\$ 674,444	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	19,775	19,775	13
14	Buildings, at Historical Cost	49,438	50,000	14
15	Leasehold Improvements, at Historical Cost	694,524	1,094,385	15
16	Equipment, at Historical Cost	331,406	261,603	16
17	Accumulated Depreciation (book methods)	(64,181)	(64,576)	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)	\$ 1,030,962	\$ 1,361,187	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,705,406	\$ 2,035,631	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 55,545	\$ 55,545	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,552,388	1,552,388	29
30	Accrued Salaries Payable	26,723	26,723	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,419	1,419	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,447	19,447	32
33	Accrued Interest Payable	7,374	7,374	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,662,896	\$ 1,662,896	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)	\$ 1,662,896	\$ 1,662,896	46
47	TOTAL EQUITY(page 18, line 24)	\$ 42,510	\$ 372,735	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,705,406	\$ 2,035,631	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 48,606	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 48,606	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,239)	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	(857)	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)	\$ (6,096)	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)	\$ 42,510	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,475,786	1
2	Discounts and Allowances for all Levels	(10,048)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,465,738	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	38,095	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 38,095	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	74	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 74	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Insurance Proceeds</u>	63,503	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 63,503	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,567,410	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	798,425	31
32	Health Care	847,865	32
33	General Administration	594,275	33
B. Capital Expense			
34	Ownership	143,815	34
C. Ancillary Expense			
35	Special Cost Centers	73,341	35
36	Provider Participation Fee	114,928	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,572,649	40
41	Income before Income Taxes (line 30 minus line 40)**	(5,239)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (5,239)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,086,153	44
45	Private Pay - Net Inpatient Revenue	502,020	45
46	Medicare - Net Inpatient Revenue	811,655	46
47	Other-(specify) <u>Insurance</u>	65,910	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,465,738	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab

0052928

Report Period Beginning:

1/1/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,072	\$ 49,416	\$ 23.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,084	5,241	113,355	21.63	3
4	Licensed Practical Nurses	8,140	8,265	132,974	16.09	4
5	CNAs & Orderlies	28,966	29,401	292,650	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	156	156	1,248	8.00	9
10	Activity Assistants	1,787	1,813	19,723	10.88	10
11	Social Service Workers	1,998	2,050	28,055	13.69	11
12	Dietician					12
13	Food Service Supervisor	2,070	2,239	22,885	10.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,702	7,887	74,430	9.44	15
16	Dishwashers					16
17	Maintenance Workers	3,047	3,103	50,126	16.15	17
18	Housekeepers	9,406	9,694	91,553	9.44	18
19	Laundry	2,910	2,985	28,807	9.65	19
20	Administrator	2,032	2,248	67,014	29.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,401	2,461	35,429	14.40	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)	77,699	79,615	\$ 1,007,665 *	\$ 12.66	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	109	\$ 5,479	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	53	3,525	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	162	\$ 16,204		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' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Duquoin Nursing and Rehab

0052928

Report Period Beginning:

1/1/15

Ending:

12/31/15

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (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? _____
- (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? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 114,928
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Duquoin Nursing and Rehab

Period Beginning **1/1/15**
Period End **12/31/15**

ATTACHED SCHEDULE I

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	2,621
Fuel and miscellaneous supplies	5,386
Allocated from Mgmt Co	1,487
	<u>9,494</u>