

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0054569</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Duquoin Nursing & Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>514 East Jackson St</u> <u>Duquoin</u> <u>62832</u>																									
Number City Zip Code																									
County: <u>Perry</u>																									
Telephone Number: <u>(618) 542-4731</u> Fax # <u>(618) 542-2651</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>																								
Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>																								
	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>																								
	(Telephone) <u>(630) 361-2868</u> Fax # ()																								
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																								
Date of Initial License for Current Owners: <u>41883</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab

0054569 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 4/1/2016

	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	<u>29</u>	Skilled (SNF)	<u>74</u>	<u>22,989</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>45</u>	Intermediate (ICF)		<u>4,095</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,084</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,095</u>	<u>2,095</u>	8
9	SNF/PED					9
10	ICF	<u>11,390</u>	<u>4,235</u>		<u>15,625</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,390</u>	<u>4,235</u>	<u>2,095</u>	<u>17,720</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.43%

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 74 and days of care provided 1,853

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab # 0054569 Report Period Beginning: 1/1/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	112,373	4,819	5,153	122,345		122,345		122,345			1
2	Food Purchase		93,556		93,556		93,556		93,556			2
3	Housekeeping	100,096	9,213		109,309		109,309	2,607	111,916			3
4	Laundry	43,849	6,677		50,526		50,526		50,526			4
5	Heat and Other Utilities			62,556	62,556		62,556	235	62,791			5
6	Maintenance	37,326	19,689	33,307	90,322		90,322	1,908	92,230			6
7	Other (specify):* Waste Rem/RDK/SI Benefits Alloc			1,863	1,863		1,863	1,098	2,961			7
8	TOTAL General Services	293,644	133,954	102,879	530,477		530,477	5,848	536,325			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	750,055	42,330	2,400	794,785		794,785	21,491	816,276			10
10a	Therapy											10a
11	Activities	26,792			26,792		26,792		26,792			11
12	Social Services	33,484	3,086	3,432	40,002		40,002		40,002			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RDK/SI Benefits Alloc							2,865	2,865			15
16	TOTAL Health Care and Programs	810,331	45,416	10,632	866,379		866,379	24,356	890,735			16
	C. General Administration											
17	Administrative	61,242		417,223	478,465		478,465	(206,128)	272,337			17
18	Directors Fees											18
19	Professional Services			37,690	37,690		37,690	(1,317)	36,373			19
20	Dues, Fees, Subscriptions & Promotions			10,017	10,017		10,017	358	10,375			20
21	Clerical & General Office Expenses	29,274	14,302	8,365	51,941		51,941	18,778	70,719			21
22	Employee Benefits & Payroll Taxes			159,978	159,978		159,978		159,978			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,084	2,084		2,084	52	2,136			24
25	Other Admin. Staff Transportation			1,158	1,158		1,158	3,909	5,067			25
26	Insurance-Prop.Liab.Malpractice			48,222	48,222		48,222	905	49,127			26
27	Other (specify):* RDK/SI Benefits Alloc							9,166	9,166			27
28	TOTAL General Administration	90,516	14,302	684,737	789,555		789,555	(174,277)	615,278			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,194,491	193,672	798,248	2,186,411		2,186,411	(144,073)	2,042,338			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			102,043	102,043		102,043	(5,430)	96,613			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,388	80,388		80,388	(96)	80,292			32
33	Real Estate Taxes			20,466	20,466		20,466	127	20,593			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,201	8,201		8,201		8,201			35
36	Other (specify):*			5,310	5,310		5,310		5,310			36
37	TOTAL Ownership			216,408	216,408		216,408	(5,399)	211,009			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,554	156,801	240,355		240,355		240,355			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,821	114,821		114,821		114,821			42
43	Other (specify):* Disallowed Costs			26,391	26,391		26,391	(26,391)				43
44	TOTAL Special Cost Centers		83,554	298,013	381,567		381,567	(26,391)	355,176			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,194,491	277,226	1,312,669	2,784,386		2,784,386	(175,863)	2,608,523			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(6,240)	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	(5,910)	30		9
10	Interest and Other Investment Income	(96)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(686)	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	(54)	43		18
19	Entertainment	(540)	43		19
20	Contributions	(25)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,607)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,388)	43		24
25	Fund Raising, Advertising and Promotional	(13,463)	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	(3,130)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,264)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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 Amount	2 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)	(140,599)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (140,599)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (175,863)		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 Yes	2 No	3 Amount	4 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' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Funeral Expense	\$ (646)	43	1
2	Birthday Expense	(2,043)	43	2
3	Gifts	(306)	43	3
4	Miscellaneous Income offset	(135)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,130)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Duquoin Nursing & Rehab# 0054569

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	2,607	0	0	0	0	0	0	0	0	2,607	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	235	0	0	0	0	0	0	0	0	235	5
6	Maintenance	0	0	1,908	0	0	0	0	0	0	0	0	1,908	6
7	Other (specify):*	0	0	1,098	0	0	0	0	0	0	0	0	1,098	7
8	TOTAL General Services	0	0	5,848	0	0	0	0	0	0	0	0	5,848	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	21,491	0	0	0	0	0	0	0	0	0	21,491	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	2,865	0	0	0	0	0	0	0	0	0	2,865	15
16	TOTAL Health Care and Programs	0	24,356	0	0	0	0	0	0	0	0	0	24,356	16
	C. General Administration													
17	Administrative	0	(69,349)	(136,779)	0	0	0	0	0	0	0	0	(206,128)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,607)	760	530	0	0	0	0	0	0	0	0	(1,317)	19
20	Fees, Subscriptions & Promotions	(125)	421	62	0	0	0	0	0	0	0	0	358	20
21	Clerical & General Office Expenses	(135)	16,984	1,929	0	0	0	0	0	0	0	0	18,778	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	25	27	0	0	0	0	0	0	0	0	52	24
25	Other Admin. Staff Transportation	0	1,941	1,968	0	0	0	0	0	0	0	0	3,909	25
26	Insurance-Prop.Liab.Malpractice	0	377	528	0	0	0	0	0	0	0	0	905	26
27	Other (specify):*	0	7,077	2,089	0	0	0	0	0	0	0	0	9,166	27
28	TOTAL General Administration	(2,867)	(41,764)	(129,646)	0	0	0	0	0	0	0	0	(174,277)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,867)	(17,408)	(123,798)	0	0	0	0	0	0	0	0	(144,073)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Duquoin Nursing & Rehab # 0054569 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(5,910)	480	0	0	0	0	0	0	0	0	0	(5,430)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(96)	0	0	0	0	0	0	0	0	0	0	(96)	32
33	Real Estate Taxes	0	0	127	0	0	0	0	0	0	0	0	127	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	(6,006)	480	127	0	0	0	0	0	0	0	0	(5,399)	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):*	(26,391)	0	0	0	0	0	0	0	0	0	0	(26,391)	43
44	TOTAL Special Cost Centers	(26,391)	0	0	0	0	0	0	0	0	0	0	(26,391)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(35,264)	(16,928)	(123,671)	0	0	0	0	0	0	0	0	(175,863)	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, Inc	Harrisburg	Management Co.
		Saline Care Center	Harrisburg	SI Management Svc, LLC	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%	\$ 21,491	\$ 21,491	1
2	V	15	Health Care and Prog Emp. Ben.		SI Management Services, LLC	100.00%	2,865	2,865	2
3	V	17	Administrative	105,760	SI Management Services, LLC	100.00%	36,411	(69,349)	3
4	V	19	Professional Fees		SI Management Services, LLC	100.00%	760	760	4
5	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	421	421	5
6	V	21	Clerical And General		SI Management Services, LLC	100.00%	16,984	16,984	6
7	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	25	25	7
8	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	1,941	1,941	8
9	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	377	377	9
10	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	7,077	7,077	10
11	V	30	Depreciation				480	480	11
12	V								12
13	V								13
14	Total			\$ 105,760			\$ 88,832	\$ * (16,928)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	\$	RDK Management, Inc.	100.00%	\$ 2,607	\$ 2,607	15
16	V	5	Utilities		RDK Management, Inc.	100.00%	235	235	16
17	V	6	Maintenance		RDK Management, Inc.	100.00%	1,908	1,908	17
18	V	7	General Svcs. Emp. Ben.		RDK Management, Inc.	100.00%	1,098	1,098	18
19	V	17	Administrative	186,463	RDK Management, Inc.	100.00%	49,684	(136,779)	19
20	V	19	Professional Services		RDK Management, Inc.	100.00%	530	530	20
21	V	20	Dues, Fees, Subs & Promotions		RDK Management, Inc.	100.00%	62	62	21
22	V	21	Clerical and General Office		RDK Management, Inc.	100.00%	1,929	1,929	22
23	V	24	Travel and Seminar		RDK Management, Inc.	100.00%	27	27	23
24	V	25	Other Admin. Staff Transport.		RDK Management, Inc.	100.00%	1,968	1,968	24
25	V	26	Insurance-Prop./Liab./Malprac.		RDK Management, Inc.	100.00%	528	528	25
26	V	27	Mgmt. Allocation of Benefits		RDK Management, Inc.	100.00%	2,089	2,089	26
27	V	33	Real Estate Taxes		RDK Management, Inc.	100.00%	127	127	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			\$ 186,463			\$ 62,792	\$ * (123,671)	39

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

SEE ACCOUNTANTS' PREPARATION 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' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab # 0054569 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Stout	Owner	Administrative	22.00	See Att Sch 7A	7.93	13.22	See Sch 7A	\$ 44,406	See Sch 7A	1
2	Steven Herrin	Owner	Administrative	22.00	120,000	-	-	Guar. Pymt	27,500	L18,C3	2
3	Penny Sisk	Owner	Administrative	5.00	See Att Sch 7A	5.28	13.20	See Sch 7A	21,995	See Sch 7A	3
4	Virginia Pierce	Owner	Administrative	6.00	See Att Sch 7A	1.32	13.20	See Sch 7A	10,905	See Sch 7A	4
5	Dr. Roger Herrin	Owner	Administrative	3.00	See Att Sch 7A	7.93	11.66	See Sch 7A	45,570	See Sch 7A	5
6	Jamees Woodward	Owner	Administrative	22.00	None	-	-	Guar. Pymt	27,500	L18,C3	6
7	Ryan Saran	Owner	Administrative	5.00	None	-	-	Guar. Pymt	6,250	L18,C3	7
8	Phillip Saran	Owner	Administrative	6.00	None	-	-	Guar. Pymt	7,500	L18,C3	8
9	Lindsay Saran	Owner	Administrative	5.00	None	-	-	Guar. Pymt	6,250	L18,C3	9
10	Lysa Saran	Owner	Administrative	4.00	None	-	-	Guar. Pymt	5,000	L18,C3	10
11											11
12	Steven Herrin received wages from Stonebridge Senior Living Center										12
13								TOTAL	\$ 202,876		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab # 0054569 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization SI Management Services, LLC
Street Address 607 South Commercial
City / State / Zip Code Harrisburg, Illinois
Phone Number (618) 252-7707
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	10	Nursing Wages	Census	134,154	5	162,702	162,702	17,720	\$ 21,491	1
2	15	Health Care and Prog Emp. Ben.	Census	134,154	5	21,694		17,720	2,865	2
3	17	Administrative	Census	134,154	5	275,658	275,657	17,720	36,411	3
4	19	Professional Fees	Census	134,154	5	5,751		17,720	760	4
5	20	Fees, Subscriptions	Census	134,154	5	3,189		17,720	421	5
6	21	Clerical And General	Census	134,154	5	128,583	126,166	17,720	16,984	6
7	24	Travel and Seminar	Census	134,154	5	191		17,720	25	7
8	25	Admin. Staff Trans.	Census	134,154	5	14,698		17,720	1,941	8
9	26	Insurance-Prop./Liab./Malprac.	Census	134,154	5	2,853		17,720	377	9
10	27	Gen. Admin. Emp. Ben.	Census	134,154	5	53,576		17,720	7,077	10
11	30	Depreciation	Census	134,154	5	3,634		17,720	480	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 672,529	\$ 564,525		\$ 88,832	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab # 0054569 Report Period Beginning: 1/1/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	Housekeeping	Census	134,154	5	19,736	19,736	17,720	\$ 2,607	1
2	5	Utilities	Census	134,154	5	1,783		17,720	235	2
3	6	Maintenance	Census	134,154	5	14,444	11,560	17,720	1,908	3
4	7	General Svcs. Emp. Ben.	Census	134,154	5	8,314		17,720	1,098	4
5	17	Administrative	Census	134,154	5	376,148	59,539	17,720	49,684	5
6	19	Professional Services	Census	134,154	5	4,010		17,720	530	6
7	20	Dues, Fees, Subs & Promotions	Census	134,154	5	471		17,720	62	7
8	21	Clerical and General Office	Census	134,154	5	14,604		17,720	1,929	8
9	24	Travel and Seminar	Census	134,154	5	207		17,720	27	9
10	25	Other Admin. Staff Transport.	Census	134,154	5	14,897		17,720	1,968	10
11	26	Ins.-Prop.Liab.Malpractice	Census	134,154	5	3,999		17,720	528	11
12	27	Mgmt. Allocation of Benefits	Census	134,154	5	15,817		17,720	2,089	12
13	33	Real Estate Taxes	Census	134,154	5	962		17,720	127	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 475,392	\$ 90,835		\$ 62,792	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	Farmers State Bank		X	Facility	\$10,351.19	6/29/2016	\$ 1,592,000	\$ 1,562,474	6/29/2036	4.7500	\$ 38,560	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	28,217	6
7	Farmers State Bank		X	Line of Credit/Construction	Interest Only	11/25/15	370,888		11/25/16	4.7500	9,749	7
8	Farmers State Bank		X	Line of Credit	Interest Only	6/29/2016	300,000	151,821	6/29/2017	4.7500	3,853	8
9	TOTAL Facility Related				\$10,351.19		\$ 3,444,388	\$ 1,714,295			\$ 80,379	9
	B. Non-Facility Related*											
10								Miscellaneous Interest			9	10
11								Interest Income Offset			(96)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (87)	14
15	TOTALS (line 9+line14)						\$ 3,444,388	\$ 1,714,295			\$ 80,292	15

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Duquoin Nursing & Rehab COUNTY Perry

FACILITY IDPH LICENSE NUMBER 0054569

CONTACT PERSON REGARDING THIS REPORT Scott Stout

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 1-61-0270-010	Long Term Care Property	\$ 19,718.64	\$ 19,718.64
2. 06-2-275-02	Home Office Allocation	\$ 963.32	\$ 127.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 20,681.96	\$ 19,845.64

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,703

B. General Construction Type: ExteriorMasonryFrameMasonry & SteelNumber of Stories1

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	125,722	2014	\$ 19,775	1
2					2
3	TOTALS	125,722		\$ 19,775	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	74		2014	1966	\$ 50,000	\$	40	1,250	\$ 1,250	\$ 2,500
5										
6										
7										
8										
	Improvement Type**									
9	Facility Renovation - See attached schedule of work performed			2015	218,505		20	10,925	10,925	16,388
10	Pole Barn			2015	20,840		20	1,042	1,042	1,563
11	Interior Design Development Fee			2015	12,000		20	600	600	900
12	Electric Rerouting & Rewiring throughout Facility			2015	33,941		20	1,697	1,697	2,546
13	Plumbing work - Replace pipings and drains in bathroom:			2015	52,695		20	2,635	2,635	3,952
14	and Replace Water Heater									
15	Install New Phone System			2015	10,215		20	511	511	766
16	Install New Facility Camera Detector System			2015	11,875		20	594	594	891
17	Install New Nurse Call System			2015	17,950		20	898	898	1,347
18	Install 10 New Heat Pumps with Sleeves			2015	9,382		20	469	469	704
19	New Side Entry Therapure Bath			2015	9,201		20	460	460	690
20	Install New Ductwork throughout Facility			2015	5,068		20	253	253	380
21	Strip and Paint Interior Doors			2015	8,528		20	426	426	639
22	New Cabinets and Countertops- Nurse Station, Dining Rm,			2015	75,135		20	3,757	3,757	5,635
23	Beauty Shop, Fitness Rm, Shower Rm, Hospice Rm, Offices									
24	Wall Vinyl-Resident Rms, Lobby, Dining			2015	30,315		20	1,516	1,516	2,274
25	Privacy Tracks/Draperies-Resident Rms, Shower Rms, Fitness Rm			2015	23,202		20	1,160	1,160	1,740
26	Handrails/bumper guards-Hallways, Dining,			2015	9,553		20	478	478	717
27	Flooring/cove base-Res Rms, Dining, Halls, Shower Rms, Offices			2015	40,894		20	2,045	2,045	3,067
28	Windowcoverings-Res Rms, Shower Rms, Offices, Fitness, Dining			2015	21,532		20	1,077	1,077	1,615
29	Light fixtures/sconces-Dining, Res Rms, Shower Rms, Lobby,			2015	18,949		20	947	947	1,421
30	Beauty Shop, Fitness Rm									
31	Carpet-Offices, Conference Rm			2015	5,465		20	273	273	410
32	Ceramic Floor/Wall tile-Shower Rms, Bistro			2015	13,131		20	657	657	985
33	New Doors (Hall A, B & C and Beauty), Closet Doors and Frames			2015	39,582		20	1,979	1,979	2,969
34	New Main Entrance Awning			2015	5,150		20	258	258	387
35	New Room Signs			2015	4,298		20	215	215	322
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 Duquoin Nursing & Rehab

0054569

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Painting/Wallpapering-Hallways & Resident Rms	2015	26,265		20	1,313	\$ 1,313	\$ 1,970	37
38	Excavating/Drainage, Carport and Tree Removal	2015	8,380		20	419	419	629	38
39	Relocate and Replace Sprinkler Lines and Heads	2015	4,485		20	224	224	336	39
40	Concrete Slabs for Maint Bldg, Fuel Tanks & Trench	2015	5,200		20	260	260	390	40
41	Painting / Carpentry /Tile / Flooring Labor & Dumpster Fees	2015	143,789		20	7,189	7,189	10,171	41
42	for Wing A and Completion of Wing C and Offices								42
43	Interior Design Development Fee-South Corridor	2015	4,000		20	200	200	300	43
44	Electric Rewiring & Rerouting, Light Fixtures & Finish work in	2015	26,519		20	1,326	1,326	1,989	44
45	A, B C wings, Nurses Station, Dining, Kitchen, Therapy, Lobby								45
46	Plumbing C wing-Relocate Plumbing Lines / Install Fixtures	2015	13,140		20	657	657	986	46
47	Nurse Call System Installation Additional Charges	2015	575		20	29	29	43	47
48	Balance due on New Facility Camera Detector System	2015	325		20	16	16	159	48
49	Install New Ductwork - Supplies and Returns	2015	4,462		20	223	223	335	49
50	Rewire & Install Phone Lines in C wing, Offices and Reception	2015	9,144		20	457	457	686	50
51	New Entrance Sign	2015	1,890		20	95	95	142	51
52	New Asphalt Driveway	2015	9,800		20	490	490	735	52
53	Crack fill, Seal Cost and Restripe Parking Lot	2015	3,500		20	175	175	263	53
54	Stain and Varnish Wood Doors	2015	2,337		20	117	117	165	54
55	New Generator	2015	53,500		20	2,675	2,675	4,013	55
56	New Landscaping - Bushes, gravel, weed barriers, edging, tile	2015	13,038		20	652	652	978	56
57	Wallcoverings and Wallguards - Conference Room, SS Office,	2015	11,151		20	558	558	837	57
58	Dining Rms, Resident Rooms, Shower Rooms, Public								58
59	Restrooms, Admin Office, Reception Area								59
60	Privacy Drapes, Light Fixtures, Flooring & Windowcoverings in	2015	3,719		20	186	186	279	60
61	Conference Rm, SS Office, Corridor A, Dining Lounge,								61
62	Resident Restrooms, Kitchen								62
63	Painting/Drywall Repairs/Replace and Repair Wallpaper & Instal	2015	48,107		20	2,405	2,405	3,608	63
64	Flooring - Wings A, B & C, Kitchen, Employee Restroom, Admin								64
65	& Business offices, SS Office, Conference Rm & Entryway								65
66	Relocate and Replace Sprinkler heads / Install Door Holders	2015	3,653		20	183	183	274	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,144,385	\$		\$ 55,971	\$ 55,971	\$ 84,096	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Duquoin Nursing & Rehab

0054569

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,144,385	\$		\$ 55,971	\$ 55,971	\$ 84,096	1
2	New door hardware and dumpster fees	2015	716		20	18	18	18	2
3	Complete Electrical Rewiring in Kitchen and Bathroom								3
4	Radiant Ceiling heat, pigtail sockets	2015	1,026		20	26	26	26	4
5	Complete Plumbing Work-Install 6 inch C/O on 8 inch Main	2016	1,579		20	39	39	39	5
6	New Furnace/AC Unit	2016	10,722		20	268	268	268	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27	Financial Statement Depreciation			102,043			(102,043)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,158,428	\$ 102,043		\$ 56,322	\$ (45,721)	\$ 84,447	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 261,603	\$	\$ 39,288	\$ 39,288	5-7 yrs	\$ 75,739	71
72	Current Year Purchases	6,084		523	523	5-7 yrs	523	72
73	Fully Depreciated Assets							73
74	Alloc From Mgmt Co			480	480			74
75	TOTALS	\$ 267,687	\$	\$ 40,291	\$ 40,291		\$ 76,262	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)	\$ 1,445,890	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,043	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,613	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,430)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 160,709	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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: \$ 8,201 Description: Medical Equipment \$6,856 ; Office Equipment \$1,345
(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	N/A		\$	\$	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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	\$			

(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

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	

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

12345678										
	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	\$		\$ 64,122	\$		\$ 64,122	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			20,834			20,834	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			71,845			71,845	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				83,554		83,554	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			\$		\$ 156,801	\$ 83,554		\$ 240,355	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

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	\$ 164,808	\$ 164,808	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,043,317	1,043,317	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	36,543	36,543	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,244,668	\$ 1,244,668	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	697,845	1,108,428	15
16	Equipment, at Historical Cost	348,212	267,687	16
17	Accumulated Depreciation (book methods)	(166,224)	(160,709)	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)	\$ 949,046	\$ 1,285,181	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,193,714	\$ 2,529,849	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 67,075	\$ 67,075	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	151,821	151,821	29
30	Accrued Salaries Payable	39,258	39,258	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,252	1,252	31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,194	20,194	32
33	Accrued Interest Payable	6,362	6,362	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)	\$ 285,962	\$ 285,962	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,562,474	1,562,474	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)	\$ 1,562,474	\$ 1,562,474	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,848,436	\$ 1,848,436	46
47	TOTAL EQUITY(page 18, line 24)	\$ 345,278	\$ 681,413	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,193,714	\$ 2,529,849	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 42,510	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 42,510	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	302,768	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)	\$ 302,768	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)	\$ 345,278	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Duquoin Nursing & Rehab

0054569

Report Period Beginning: 1/1/16

Ending: 12/31/16

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	\$ 3,039,411	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,039,411	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	47,512	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 47,512	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***	96	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 96	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	135	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 135	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,087,154	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	530,477	31
32	Health Care	866,379	32
33	General Administration	789,555	33
	B. Capital Expense		
34	Ownership	216,408	34
	C. Ancillary Expense		
35	Special Cost Centers	266,746	35
36	Provider Participation Fee	114,821	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,784,386	40
41	Income before Income Taxes (line 30 minus line 40)**	302,768	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 302,768	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,584,520	44
45	Private Pay - Net Inpatient Revenue	654,424	45
46	Medicare - Net Inpatient Revenue	681,542	46
47	Other-(specify) <u>Insurance</u>	118,925	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,039,411	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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,928	2,080	\$ 52,085	\$ 25.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,873	6,024	139,710	23.19	3
4	Licensed Practical Nurses	8,834	9,295	168,175	18.09	4
5	CNAs & Orderlies	35,534	36,272	390,085	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,579	2,680	26,792	10.00	10
11	Social Service Workers	2,068	2,249	33,484	14.89	11
12	Dietician					12
13	Food Service Supervisor	1,988	2,169	26,043	12.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,497	9,696	86,330	8.90	15
16	Dishwashers					16
17	Maintenance Workers	1,890	2,106	37,326	17.72	17
18	Housekeepers	10,479	10,757	100,096	9.31	18
19	Laundry	4,550	4,688	43,849	9.35	19
20	Administrator	2,032	2,163	61,242	28.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,941	1,941	29,274	15.08	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)	89,193	92,120	\$ 1,194,491 *	\$ 12.97	34

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	101	\$ 5,153	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	3,432	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	\$ 15,785		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number		Duquoin Nursing & Rehab		STATE OF ILLINOIS	#	0054569	Report Period Beginning:	1/1/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>No</u> <u>N/A</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u> If YES, what is the capacity? <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>5-7 yrs</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>0</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u> If NO, attach a complete explanation.							
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u> If YES, give effective date of lease. <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES <u>NO</u> <u>X</u> 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.			\$ <u>114,821</u> 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?			<u>No</u> If YES, attach an explanation of the allocation.							
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(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?			<u>No</u> 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 benefit on Schedule V.			\$ <u>0</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ <u>0</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u> If YES, attach a complete explanation.							
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% Line 14</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>No</u> Firm Name: <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility?			<u>Yes</u> See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees							

SEE ACCOUNTANTS' PREPARATION REPORT

Duquoin Nursing & Rehab

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

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	262
Fuel and miscellaneous supplies	896
Allocated from Mgmt Co	3,909
	5,067