

		FOR BHF USE				

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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>0020628</u> Facility Name: <u>Eldorado Rehab & Healthcare</u> Address: <u>1001 A Jefferson St</u> <u>Eldorado</u> <u>62930</u> Number City Zip Code County: <u>Saline</u> Telephone Number: <u>(618) 273-3353</u> Fax # <u>(618) 273-4800</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>08/17/1976</u> Type of Ownership: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width: 33%; vertical-align: top;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> In the event there are further questions about this report, please contact: Name: <u>Billy L. Jones</u> Telephone Number: <u>(618) 273-3353</u> Email Address: _____	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2015</u> to <u>6/30/2016</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. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____ (Type or Print Name) <u>Lori Pritchard</u> (Title) <u>Administrator</u></td> </tr> <tr> <td style="width: 20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800 St. Louis MO 63101</u> (Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u></td> </tr> </table> 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) _____ (Date) _____ (Type or Print Name) <u>Lori Pritchard</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800 St. Louis MO 63101</u> (Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Lori Pritchard</u> (Title) <u>Administrator</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800 St. Louis MO 63101</u> (Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>							

Facility Name & ID Number Eldorado Rehab & Healthcare

0020628 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

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 3/9/2015

	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	36	Skilled (SNF)	36	13,176	1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	23,058	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,737	3,411	3,251	8,399	8
9	SNF/PED					9
10	ICF	13,908	6,218		20,126	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,645	9,629	3,251	28,525	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.72%

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

0 (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

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 08/17/1976

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 36 and days of care provided 3,251

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Eldorado Rehab & Healthcare # 0020628 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

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	151,703	11,566	8,169	171,438		171,438		171,438		1
2	Food Purchase		177,712		177,712		177,712	(599)	177,113		2
3	Housekeeping	115,477	11,295		126,772		126,772		126,772		3
4	Laundry	56,283	8,017		64,300		64,300		64,300		4
5	Heat and Other Utilities			75,653	75,653		75,653		75,653		5
6	Maintenance	58,790		109,968	168,758		168,758		168,758		6
7	Other (specify):*										7
8	TOTAL General Services	382,253	208,590	193,790	784,633		784,633	(599)	784,034		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,305,165	48,355	3,247	1,356,767		1,356,767		1,356,767		10
10a	Therapy										10a
11	Activities	61,041	2,371	2,497	65,909		65,909		65,909		11
12	Social Services	49,122		2,498	51,620		51,620		51,620		12
13	CNA Training										13
14	Program Transportation			4,333	4,333		4,333		4,333		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,415,328	50,726	12,575	1,478,629		1,478,629		1,478,629		16
	C. General Administration										
17	Administrative	113,827			113,827		113,827		113,827		17
18	Directors Fees			15,300	15,300		15,300		15,300		18
19	Professional Services			67,134	67,134		67,134		67,134		19
20	Dues, Fees, Subscriptions & Promotions			7,129	7,129		7,129	(349)	6,780		20
21	Clerical & General Office Expenses	37,262	17,383	47,646	102,291		102,291	(20,547)	81,744		21
22	Employee Benefits & Payroll Taxes			342,466	342,466		342,466		342,466		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,018	5,018		5,018		5,018		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,667	40,667		40,667		40,667		26
27	Other (specify):*										27
28	TOTAL General Administration	151,089	17,383	525,360	693,832		693,832	(20,896)	672,936		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,948,670	276,699	731,725	2,957,094		2,957,094	(21,495)	2,935,599		29

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

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

Eldorado Rehab & Healthcare

#0020628

Report Period Beginning:

07/01/2015

Ending:

6/30/2016

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			91,006	91,006		91,006		91,006			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			44,027	44,027		44,027		44,027			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			135,033	135,033		135,033		135,033			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		115,302	395,967	511,269		511,269		511,269			39
40	Barber and Beauty Shops		1,504		1,504		1,504		1,504			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			249,448	249,448		249,448		249,448			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		116,806	645,415	762,221		762,221		762,221			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,948,670	393,505	1,512,173	3,854,348		3,854,348	(21,495)	3,832,853			45

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

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
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(599)	2		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				17
18	Fines and Penalties	(161)	21		18
19	Entertainment				19
20	Contributions	(565)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,284)	21		24
25	Fund Raising, Advertising and Promotional	(2,556)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,981)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(349)	20		28
29	Other-Attach Schedule See Pg %A				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,495)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (21,495)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Eldorado Rehab & Healthcare

ID# 0020628

Report Period Beginning: 07/01/2015

Ending: 6/30/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eldorado Rehab & Healthcare# 0020628

Report Period Beginning:

07/01/2015

Ending:

6/30/2016

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	(599)	0	0	0	0	0	0	0	0	0	0	(599)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(599)	0	0	0	0	0	0	0	0	0	0	(599)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(349)	0	0	0	0	0	0	0	0	0	0	(349)	20
21	Clerical & General Office Expenses	(20,547)	0	0	0	0	0	0	0	0	0	0	(20,547)	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,896)	0	0	0	0	0	0	0	0	0	0	(20,896)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,495)	0	0	0	0	0	0	0	0	0	0	(21,495)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eldorado Rehab & Healthcare

0020628

Report Period Beginning:

07/01/2015 Ending:

6/30/2016

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(21,495)	0	0	0	0	0	0	0	0	0	0	(21,495)	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
Albert Bledig	47%					
Billy L. Jones	29%					
Everett Knight	13%					
Mark Knight	11%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Eldorado Rehab & Healthcare

0020628

Report Period Beginning:

07/01/2015

Ending:

6/30/2016

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	Albert Bledig	President	Exec Board	47.00	None	2		Dir Fees	\$ 4,200	18-3	1
2	Billy L. Jones	Sec/Treasurer	Exec Board	29.00	None	2		Dir Fees	4,200	18-3	2
3	Billy L. Jones	Business Manager	Manage Facility	29.00	None	12		Bus. Mgr	30,900	19-3	3
4	Everett Knight	Director	Exec Board	13.00	None	2		Dir Fees	3,450	18-3	4
5	Mark W. Knight	Vice President	Exec Board	11.00	None	2		Dir Fees	3,450	18-3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 46,200		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

Facility Name & ID Number Eldorado Rehab & Healthcare

0020628

Report Period Beginning:

07/01/2015

Ending: 5/30/2016

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Eldorado Rehab & Healthcare

0020628

Report Period Beginning:

07/01/2015

Ending:

6/30/2016

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		7	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							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

** 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 2015 report.		\$	58,256	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.)		\$	38,666	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(19,590)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	63,617	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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	44,027	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	39,087	8	
	2012	38,837	9	
	2013	37,250	10	
	2014	38,665	11	
	2015	40,956	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eldorado Rehab & Healthcare COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0020628

CONTACT PERSON REGARDING THIS REPORT Billy L. Jones

TELEPHONE 618-273-4800 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>04-1-159-14</u>	<u>Facility 4.98 Acres</u>	\$ <u>40,846.62</u>	\$ <u>40,846.62</u>
2. <u>04-2-095-06</u>	<u>Facility Additional Lot</u>	\$ <u>109.14</u>	\$ <u>109.14</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>40,955.76</u></u>	\$ <u><u>40,955.76</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,659 B. General Construction Type: Exterior Masonry Frame 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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	205,512	1976	\$ 20,287	1
2	Facility	5,000	2006	646	2
3	TOTALS	210,512		\$ 20,933	3

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	99	1976	1976	\$ 844,244	\$		\$	\$	\$ 844,244	4
5	12	1983	1983	273,457					273,457	5
6		1993	1993	159,083	3,182	50	3,182		73,449	6
7		1998	1998	17,723	354	50	354		6,255	7
8										8
Improvement Type**										
9	1983 Fixed Assets		1983	20,565		VAR			20,565	9
10	1985 Fixed Assets		1985	4,671		VAR			4,671	10
11	1988 Fixed Assets		1988	6,953		VAR			6,953	11
12	1989 Fixed Assets		1989	11,286		VAR			11,286	12
13	1990 Fixed Assets		1990	852		VAR			852	13
14	1991 Fixed Assets		1991	15,503		VAR			15,503	14
15	1992 Fixed Assets		1992	14,808		VAR			14,808	15
16	1993 Fixed Assets		1993	45,469		VAR			45,469	16
17	1994 Fixed Assets		1994	12,728		VAR			12,728	17
18	1995 Fixed Assets		1995	5,723		VAR			5,723	18
19	1996 Fixed Assets		1996	4,050		VAR			4,050	19
20	1997 Fixed Assets		1997	20,514	1,026	VAR	1,026		19,579	20
21	1998 Fixed Assets		1998	39,310		VAR			39,310	21
22	1999 Fixed Assets		1999	50,144	985	VAR	985		21,201	22
23	2000 Fixed Assets		2000	62,285	5,213	VAR	5,213		51,349	23
24	2001 Fixed Assets		2001	9,045	125	VAR	125		9,045	24
25	2002 Fixed Assets		2002	73,324	3,734	VAR	3,734		55,338	25
26	2003 Fixed Assets		2003	3,470	174	VAR	174		2,349	26
27	2004 Fixed Assets		2004	42,520	1,964	VAR	1,964		27,898	27
28	2005 Fixed Assets		2005	67,405	2,758	VAR	2,758		45,119	28
29	2006 Fixed Assets		2006	17,875	1,192	VAR	1,192		12,789	29
30	2009 Fixed Assets		2009	6,427	428	VAR	428		3,317	30
31	2012 Fixed Assets		2012	137,546	3,771	VAR	3,771		17,995	31
32	2013 Fixed Assets		2013	486,221	35,989	VAR	35,989		134,068	32
33	Landscaping		2014	8,573	572	15	572		1,716	33
34	HAC Unit		2014	6,350	423	15	423		1,199	34
35	HAC Unit		2016	6,650	333	15	333		333	35
36	Rounding								(2)	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

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	\$ 356,870	\$ 25,671	\$ 25,671	\$	VAR	\$ 253,696	71
72	Current Year Purchases	14,803	698	698		VAR	698	72
73	Fully Depreciated Assets	336,319				VAR	336,319	73
74								74
75	TOTALS	\$ 707,992	\$ 26,369	\$ 26,369	\$		\$ 590,713	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	Transport Residents	98 Ford Van	1999	\$ 26,198	\$	\$	\$	10	\$ 26,198	76
77	Transport Residents	2000 Ford Van	2009	8,002				5	8,002	77
78	Transport Residents	2008 Ford Van	2010	34,803	2,414	2,414		6	34,803	78
79										79
80	TOTALS			\$ 69,003	\$ 2,414	\$ 2,414	\$		\$ 69,003	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)	\$ 3,272,702	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,006	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,006	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,442,332	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.

Facility Name & ID Number Eldorado Rehab & Healthcare

0020628

Report Period Beginning: 07/01/2015

Ending: 6/30/2016

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

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

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

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Fountainview only hires trained CNAs.</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	39-3	hrs	\$	2,609	\$ 167,928				2,609	\$ 167,928					1
2	Licensed Speech and Language Development Therapist	39-3	hrs		327	20,782				327	20,782					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39-3	hrs		2,668	170,672				2,668	170,672					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Lax & X-Ray</u>	39-3				36,536					36,536					12
13	Other (specify): <u>Drugs & Med Supply</u>	39-2								111,730					111,730	13
14	TOTAL			\$	5,604	\$ 395,918	\$	111,730	\$	5,604	\$ 507,648					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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2016

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 402,911	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,276)	1,115,556		3
4	Supply Inventory (priced at Cost)	16,179		4
5	Short-Term Investments			5
6	Prepaid Insurance	39,205		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,573,851	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,933		13
14	Buildings, at Historical Cost	2,474,774		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	776,995		16
17	Accumulated Depreciation (book methods)	(2,442,332)		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)	\$ 830,370	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,404,221	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 112,541	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,663		30
31	Accrued Taxes Payable (excluding real estate taxes)	80,325		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,617		32
33	Accrued Interest Payable			33
34	Deferred Compensation	5,872		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)	\$ 355,018	\$	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)	\$ 355,018	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,049,203	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,404,221	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,878,358	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,878,357	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	570,846	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	(400,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 170,846	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)	\$ 2,049,203	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eldorado Rehab & Healthcare

0020628

Report Period Beginning: 07/01/2015

Ending: 6/30/2016

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	\$ 3,597,724	1
2	Discounts and Allowances for all Levels	(46,548)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,551,176	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	714,760	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 714,760	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	98,387	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,708	19
20	Radiology and X-Ray	4,860	20
21	Other Medical Services	4,407	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 146,362	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,239	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,239	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	2,915	28
28a	<u>Miscellaneous Income</u>	8,742	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,657	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,425,194	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	784,633	31
32	Health Care	1,478,629	32
33	General Administration	693,832	33
B. Capital Expense			
34	Ownership	135,033	34
C. Ancillary Expense			
35	Special Cost Centers	512,773	35
36	Provider Participation Fee	249,448	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,854,348	40
41	Income before Income Taxes (line 30 minus line 40)**	570,846	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 570,846	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,680,830	44
45	Private Pay - Net Inpatient Revenue	1,223,143	45
46	Medicare - Net Inpatient Revenue	647,203	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,551,176	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

Facility Name & ID Number Eldorado Rehab & Healthcare

0020628

Report Period Beginning: 07/01/2015

Ending: 6/30/2016

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	2,080	2,080	\$ 75,604	\$ 36.35	1
2	Assistant Director of Nursing	2,080	2,180	53,816	24.69	2
3	Registered Nurses	9,120	9,415	215,778	22.92	3
4	Licensed Practical Nurses	19,925	21,231	363,113	17.10	4
5	CNAs & Orderlies	49,238	50,851	528,386	10.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,554	3,838	42,923	11.18	8
9	Activity Director	1,977	2,056	20,326	9.89	9
10	Activity Assistants	3,941	4,315	40,715	9.44	10
11	Social Service Workers	3,986	4,091	49,122	12.01	11
12	Dietician					12
13	Food Service Supervisor	2,092	2,284	28,835	12.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,594	14,194	122,869	8.66	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	58,790	28.26	17
18	Housekeepers	11,409	12,249	115,477	9.43	18
19	Laundry	5,558	5,859	56,283	9.61	19
20	Administrator	2,080	2,380	65,124	27.36	20
21	Assistant Administrator	1,400	1,400	48,703	34.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,128	2,225	37,262	16.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,008	2,143	25,544	11.92	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)	138,250	144,871	\$ 1,948,670 *	\$ 13.45	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	132	\$ 8,169	01-3	35
36	Medical Director				36
37	Medical Records Consultant	40	2,047	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,497	11-3	44
45	Social Service Consultant	36	2,498	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	256	\$ 16,411		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
<u>RHONDA TRAVELSTEAD</u>	<u>ADMINISTRATOR</u>		\$ <u>39,606</u>	<u>Workers' Compensation Insurance</u>	\$ <u>123,156</u>	<u>IDPH License Fee</u>	\$ <u>3,980</u>		
<u>LORI PRITCHARD</u>	<u>ADMINISTRATOR</u>		25,518	<u>Unemployment Compensation Insurance</u>	22,695	<u>Advertising: Employee Recruitment</u>	1,024		
<u>LORI PRITCHARD</u>	<u>ASST ADMINISTRATOR</u>		48,703	<u>FICA Taxes</u>	145,639	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	25,026	(Indicate # of checks performed)			
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>111</u>	1,480	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Licenses</u>		645	
				<u>LIFE INSURANCE</u>	1,256				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 113,827	<u>RETIREMENT</u>	17,085				
(List each licensed administrator separately.)				<u>UNIFORM ALLOWANCE</u>	2,834				
				<u>EMPLOYEE INCENTIVES</u>	4,775				
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 342,466				
							Less: Public Relations Expense		
							Non-allowable advertising		
							Yellow page advertising	(349)	
							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,780	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	<u>Out-of-State Travel</u>	(\$)	
							<u>In-State Travel</u>		
							<u>Seminar Expense</u>	5,018	
							<u>Entertainment Expense</u>	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(Attach a copy of any management service agreement)							TOTAL	\$ 5,018	
C. Professional Services									
Vendor/Payee	Type								
<u>JAMES H SMITH PC</u>	<u>LEGAL</u>	\$	4,185						
<u>BILLY L JONES</u>	<u>MANAGEMENT</u>		30,900						
<u>LISA BERRY</u>	<u>CORP. MINUTES</u>		441						
<u>CLIFTONLARSONALLEN, LLP</u>	<u>COST REPORT PREP</u>		6,000						
<u>JAMES HENSON</u>	<u>ACCOUNTING</u>		10,608						
<u>BKD, LLP</u>	<u>ACCOUNTING</u>		15,000						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 67,134						
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,552 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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. \$ 249,448
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.

- (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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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
 - 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? Yes
 - 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees