

		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

<p>I. IDPH License ID Number: <u>0046235</u></p> <p>Facility Name: <u>DOCTORS NURSING & REHABILITATION CENTER</u></p> <p>Address: <u>1201 HAWTHORN ROAD</u> <u>SALEM</u> <u>62881</u> Number City Zip Code</p> <p>County: <u>MARION</u></p> <p>Telephone Number: <u>(217) 528-0044</u> Fax # <u>(217) 528-3412</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>05/01/2003</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2010</u> to <u>12/31/2010</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROBERT HEDGES</u></td> <td></td> </tr> <tr> <td>(Title) <u>MEMBER</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>ROBERT HEDGES</u>		(Title) <u>MEMBER</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER

0046235 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	4,881	840	9,628	15,349	8	
9	SNF/PED					9	
10	ICF	15,606	4,174	146	19,926	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	20,487	5,014	9,774	35,275	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.54%

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 05/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/03 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 120 and days of care provided 7,931

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number **DOCTORS NURSING & REHABILITATIO** # **0046235** Report Period Beginning: **01/01/2010** Ending: **12/31/2010**

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	150,465	18,321	11,225	180,011		180,011		180,011		1
2	Food Purchase		170,469		170,469		170,469		170,469		2
3	Housekeeping	97,908	24,123		122,031		122,031		122,031		3
4	Laundry	57,737	21,868		79,605		79,605		79,605		4
5	Heat and Other Utilities			142,231	142,231		142,231		142,231		5
6	Maintenance	49,815	12,357	52,727	114,899		114,899	6,530	121,429		6
7	Other (specify):*			15,594	15,594		15,594		15,594		7
8	TOTAL General Services	355,925	247,138	221,777	824,840		824,840	6,530	831,370		8
	B. Health Care and Programs										
9	Medical Director			23,400	23,400		23,400		23,400		9
10	Nursing and Medical Records	1,724,229	292,906	59,550	2,076,685		2,076,685	13,009	2,089,694		10
10a	Therapy	274,369			274,369		274,369		274,369		10a
11	Activities	41,025	6,666	1,421	49,112		49,112		49,112		11
12	Social Services	42,859		1,421	44,280		44,280		44,280		12
13	CNA Training										13
14	Program Transportation			980	980		980		980		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,082,482	299,572	86,772	2,468,826		2,468,826	13,009	2,481,835		16
	C. General Administration										
17	Administrative	99,435		538,611	638,046		638,046	(450,106)	187,940		17
18	Directors Fees										18
19	Professional Services			185,128	185,128		185,128	(139,878)	45,250		19
20	Dues, Fees, Subscriptions & Promotions			35,464	35,464		35,464	(19,174)	16,290		20
21	Clerical & General Office Expenses	113,327	15,523	144,722	273,572		273,572	(90,372)	183,200		21
22	Employee Benefits & Payroll Taxes			345,841	345,841		345,841		345,841		22
23	Inservice Training & Education			3,136	3,136		3,136		3,136		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			26,387	26,387		26,387		26,387		25
26	Insurance-Prop.Liab.Malpractice			63,253	63,253		63,253		63,253		26
27	Other (specify):*			10,954	10,954		10,954	(495)	10,459		27
28	TOTAL General Administration	212,762	15,523	1,353,496	1,581,781		1,581,781	(700,025)	881,756		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,651,169	562,233	1,662,045	4,875,447		4,875,447	(680,486)	4,194,961		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	11,225
	REPAIRS & MAINTENANCE	0
		0
		11,225
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	47,236
	ELECTRICITY	56,315
	WATER	32,926
	CABLE TV - LOBBY	5,754
		0
		142,231
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,490
	PAINTING & DECORATING	5,061
	BUILDING REPAIRS	17,547
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	16,170
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,655
	FIRE SERVICE	5,804
		0
		0
		0
		0
		52,727
7	OTHER	
	SCAVENGER	15,594
	SECURITY SERVICE	0
		0
		0
		15,594
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	23,400
		23,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	48,428
	PURCHASED SERVICES	5,860
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,049
	PHARMACY CONSULTANT XVIII B 39-2	3,213
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		59,550
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,421
		0
		1,421
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,421
		0
		1,421
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	980
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	538,611
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	14,804
	ADMINISTRATIVE CONSULTANTS XIX C	83,628
	PROFESSIONAL FEES XIX C	86,696
		0
		185,128
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	17,187
	EMPLOYEE WANT ADS XIX F	148
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,256
	LICENSES & PERMITS XIX F	1,254
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,987
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	880
	PATIENT BACKGROUND CHECKS XIX F	2,752
		35,464
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	12,287
	EQUIPMENT REPAIR & MAINTENANCE	171
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	121,500
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,764
	MESSENGER SERVICE	0
		0
		144,722

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	200,470
	UNEMPLOYMENT COMPENSATION XIX D	20,069
	WORKERS COMPENSATION INSURANC XIX D	73,448
	HOSPITALIZATION INSURANCE XIX D	31,115
	EMPLOYEE BENEFITS - OTHER XIX D	9,340
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	11,399
	CHICAGO HEAD TAX XIX D	0
		0
		345,841
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,136
		3,136
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	26,387
		26,387
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	63,253
		63,253
27	OTHER	
	BAD DEBTS VI 24	10,954
		10,954

GRAND TOTAL COLUMN 3 OTHER

1,662,045

**DOCTORS NURSING & REHABILITATION CENTER
SCHEDULES
12/31/2010**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	170,469
LESS SALES TAX	<u>0</u>
NET FOOD	170,469

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5???

TOTAL PATIENT CENSUS	35,275
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	105,825

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	105,825
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	105,825

NET FOOD	170,469
DIVIDE TOTAL MEALS/YEAR	<u>105,825</u>

COST PER MEAL	1.61
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER #0046235 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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			32,036	32,036		32,036	(8,997)	23,039			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,915	12,915		12,915	(11,500)	1,415			32
33	Real Estate Taxes			67,318	67,318		67,318	1,186	68,504			33
34	Rent-Facility & Grounds			806,457	806,457		806,457		806,457			34
35	Rent-Equipment & Vehicles			146,508	146,508		146,508		146,508			35
36	Other (specify):*											36
37	TOTAL Ownership			1,065,234	1,065,234		1,065,234	(19,311)	1,045,923			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		360,203	639,480	999,683		999,683		999,683			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		360,203	705,180	1,065,383		1,065,383		1,065,383			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,651,169	922,436	3,432,459	7,006,064		7,006,064	(699,797)	6,306,267			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	(9,996)	30		9
10	Interest and Other Investment Income	(13,086)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(828)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,987)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,954)	27		24
25	Fund Raising, Advertising and Promotional	(17,187)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(76,696)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,734)		\$	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)	(569,063)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (569,063)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (699,797)		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

DOCTORS NURSING & REHABILITATION CENTER

ID# 0046235

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	MARKETING SALARY	(20,446)	21	2
3	HEALTHCARE HORIZONS - OTHER PROF	(41,250)	19	3
4	OTHER PROFESSIONAL FEES	(15,000)	19	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	(76,696)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER# 0046235

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	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	6,530	0	0	0	0	0	0	0	0	0	6,530	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	6,530	0	0	0	0	0	0	0	0	0	6,530	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	13,009	0	0	0	0	0	0	0	0	0	13,009	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	13,009	0	0	0	0	0	0	0	0	0	13,009	16
	C. General Administration													
17	Administrative	0	(450,106)	0	0	0	0	0	0	0	0	0	(450,106)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(56,250)	(83,628)	0	0	0	0	0	0	0	0	0	(139,878)	19
20	Fees, Subscriptions & Promotions	(19,174)	0	0	0	0	0	0	0	0	0	0	(19,174)	20
21	Clerical & General Office Expenses	(20,446)	(69,926)	0	0	0	0	0	0	0	0	0	(90,372)	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):*	(10,954)	10,459	0	0	0	0	0	0	0	0	0	(495)	27
28	TOTAL General Administration	(106,824)	(593,201)	0	0	0	0	0	0	0	0	0	(700,025)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,824)	(573,662)	0	0	0	0	0	0	0	0	0	(680,486)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER# 0046235

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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	(9,996)	0	999	0	0	0	0	0	0	0	0	(8,997)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,914)	0	2,414	0	0	0	0	0	0	0	0	(11,500)	32
33	Real Estate Taxes	0	0	1,186	0	0	0	0	0	0	0	0	1,186	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	(23,910)	0	4,599	0	0	0	0	0	0	0	0	(19,311)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(130,734)	(573,662)	4,599	0	0	0	0	0	0	0	0	(699,797)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT HEDGES				HI CARE MGMT.	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE						
MORRIS ESFORMES				H&I PROPERTIES	SPRINGFIELD	REAL ESTATE
SANDRA SEGAL						
				HEALTHCARE		
				HORIZONS	SPRINGFIELD	NURSE CONSULT

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	17	MANAGEMENT FEES	\$ 538,611	HI CARE MANAGEMENT		\$	(538,611)	1
2	V	21	HOME OFFICE EXPENSE	121,500	" " "			(121,500)	2
3	V	19	ADMINISTRATIVE CON	83,628	" " "			(83,628)	3
4	V	6	MAINTENANCE		" " "			6,530	4
5	V	10	NURSING		" " "			13,009	5
6	V	17	ADMINISTRATIVE		" " "			88,505	6
7	V	21	OFFICE EXPENSE		" " "			51,574	7
8	V	27	PAYROLL TAXES & GRP INS		" " "			10,459	8
9	V				" " "				9
10	V				" " "				10
11	V				" " "				11
12	V				" " "				12
13	V				" " "				13
14	Total		\$ 743,739				\$	170,077	\$ * (573,662) 14

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

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	30 DEPRECIATION	\$	H & I PROPERTIES (HOME OFFICE)		\$ 999	\$ 999	15
16	V	32 INTEREST		" "		2,414	2,414	16
17	V	33 REAL ESTATE		" "		1,186	1,186	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 4,599	\$ * 4,599	39

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

Facility Name & ID Number **DOCTORS NURSING & REHABILITATION** # **0046235** Report Period Beginning: **01/01/2010** Ending: **12/31/2010**

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	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.					SALARY	\$ 33,087	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.		SEE			SALARY	31,736	17-7	4
5					ATTACHED						5
6					SCHEDULE						6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	2,473	21-7	7
8											8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	14,267	17-7	10
11											11
12											12
13								TOTAL	\$ 81,563		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 DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 HI CARE MANAGEMENT
 Street Address 1625 SOUTH SIXTH STREET
 City / State / Zip Code SPRINGFIELD IL. 62703
 Phone Number (217)528-0044
 Fax Number (217)528-3412

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	6	MAINTENANCE	PER RESIDENT DAY	206,077	8	\$ 38,149	\$ 38,149	35,275	\$ 6,530	1
2	10	NURSING	PER RESIDENT DAY	206,077	8	76,000	76,000	35,275	13,009	2
3	17	OFFICER SALARY- IRVINE	PER RESIDENT DAY	206,077	8	185,400	185,400	35,275	31,736	3
4	17	OFFICER SALARY- HEDGES	PER RESIDENT DAY	206,077	8	193,296	193,296	35,275	33,087	4
5	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	206,077	8	55,000	55,000	35,275	9,415	5
6	17	SPECIAL PROJ MNGR- HEDGE	PER RESIDENT DAY	206,077	8	83,349	83,349	35,275	14,267	6
7	21	OFFICE EXPENSE	PER RESIDENT DAY	206,077	8	301,295	301,295	35,275	51,574	7
8	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	206,077	8	61,099		35,275	10,459	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					\$ 993,588	\$ 932,489		\$ 170,077	25

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER # 0046235 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 H & I PROPERTIES - HOME OFFICE
 Street Address 1625 S SIXTH STREET
 City / State / Zip Code SPRINGFIELD IL 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0412

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	30	DEPRECIATION	PER LICENSE BED	810	8	\$ 6,741	\$ 120	\$ 999	1
2	32	INTEREST	PER LICENSE BED	810	8	16,292	120	2,414	2
3	33	REAL ESTATE	PER LICENSE BED	810	8	8,006	120	1,186	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					\$ 31,039	\$	\$ 4,599	25

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										1										
2	US BANK (HI PROP)	X	MORTGAGE (OFFICE)		6/29/05		36,769	6/29/12	0.0635	2,414										
3										3										
4										4										
5										5										
Working Capital																				
6		X	WORKING CAPITAL	INTEREST	REVOLV		242,000	REVOLV	PRIME +	5,087										
7	MEMBER LOAN	X	WORKING CAPITAL			100,000	100,000			7,000										
8										8										
9	TOTAL Facility Related					\$ 100,000	\$ 378,769			\$ 14,501										
B. Non-Facility Related*																				
10			BED TAX							828										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$			\$ 828										
15	TOTALS (line 9+line14)					\$ 100,000	\$ 378,769			\$ 15,329										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

* 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.)

Facility Name & ID Number **DOCTORS NURSING & REHABILITATION CENTER**# **0046235** Report Period Beginning: **01/01/2010** Ending: **12/31/2010****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2009 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	71,978	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.)		\$	69,648			2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,330)			3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	69,648			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.		\$	67,318			7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2005	<u>40,502</u>	8	FOR BHF USE ONLY	
		2006	<u>42,007</u>	9	13	FROM R. E. TAX STATEMENT FOR 2009 \$ 13
		2007	<u>68,461</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2008	<u>71,978</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
		2009	<u>69,648</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED						
ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL						
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.						

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOCTORS NURSING & REHABILITATION CENTER COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0046235

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(A)	(B)	(C)	(D) <u>Tax Applicable to Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-03-000-004</u>	<u>NURSING HOME</u>	\$ <u>69,338.28</u>	\$ <u>69,338.28</u>
2. <u>11-03-400-003</u>	<u>NURSING HOME</u>	\$ <u>177.78</u>	\$ <u>177.78</u>
3. <u>11-03-400-004</u>	<u>NURSING HOME</u>	\$ <u>131.82</u>	\$ <u>131.82</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>69,647.88</u></u>	\$ <u><u>69,647.88</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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: _____ B. General Construction Type: Exterior BRICK Frame METAL 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	<u>OFFICE BUILDING</u>		<u>2005</u>	<u>\$ 15,080</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 15,080	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6	H&I								
7	Properties								
8	office bldg		2005	38,909	999	39	999		
	Improvement Type**								
9	WATER HEATER		2003	6,135	223	27.5	223		1,626
10	WATER HEATER		2004	8,145	296	27.5	296		2,014
11	TILING		2005	4,980	181	27.5	181		1,003
12	SIDEWALK		2005	6,300	420	15	420		1,680
13	WALL HEAT & A/C UNIT		2006	1,075	39	27.5	39		167
14	DOORS		2007	2,828	103	27.5	103		365
15	CARPETING		2007	23,768	2,738	5	4,754	2,016	19,016
16	ROOF (1 OF 2)		2008	2,475	90	27.5	90		229
17	FENCE		2008	3,964	264	15	264		594
18	THERAPY ROOM ADDITION		2009	157,255	5,718	27.5	5,718		8,658
19	WATER HEATER		2010	14,133	133	27.5	133		133
20									
21									
22									
23									
24									
25									
26									
27	ROOF (2 OF 2) THIS PORTION PAID BY LANDLORD		2008	122,006					
28	WINDOWS (PAID BY LANDLORD)		2008	86,718					
29	A/C CORRIDORS EXISTING BUILDING (PAID BY LANDLORD)		2008	44,160					
30	SPRINKLER SYSTEM (PAID BY LANDLORD)		2009	93,600					
31	THERAPY ROOM ADDITION (PAID BY LANDLORD)		2009	553,516					
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,169,967	\$ 11,204		\$ 13,220	\$ 2,016	\$ 35,485	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 92,941	\$ 11,324	\$ 9,294	\$ (2,030)		\$ 28,072	71
72	Current Year Purchases	10,507	10,507	525	(9,982)		525	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 103,448	\$ 21,831	\$ 9,819	\$ (12,012)		\$ 28,597	75

D. Vehicle Depreciation (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	FACILITY	2001 CHEVY EXPRESS BUS	2004	\$ 23,000	\$	\$	\$		\$ 23,000	76
77										77
78										78
79										79
80	TOTALS			\$ 23,000	\$	\$	\$		\$ 23,000	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)	\$ 1,311,495	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,035	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,039	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,996)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 87,082	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SALEM ASSOCIATES, LLC

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:		120		\$ 806,457			3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 806,457			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: \$ 145,852 Description: SEE SCHEDULE ATTACHED

(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				656	18
19					19
20					20
21	TOTAL		\$	\$ 656	21

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.	<u>/2011</u>	\$ _____
13.	<u>/2012</u>	\$ _____
14.	<u>/2013</u>	\$ _____

* 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>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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 262,517	\$		\$ 262,517	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			83,325			83,325	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			293,638			293,638	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				360,203		360,203	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			\$		\$ 639,480	\$ 360,203		\$ 999,683	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.

Facility Name & ID Number **DOCTORS NURSING & REHABILITATION CENTER** # **0046235** Report Period Beginning: **01/01/2010** Ending: **12/31/2010**
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2010** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 686,280	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100,000))	1,110,545		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,131		6
7	Other Prepaid Expenses	1,964		7
8	Accounts Receivable (owners or related parties)	673,208		8
9	Other(specify): <u>real estate escrow dept.</u>	45,754		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,583,882	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	231,058		15
16	Equipment, at Historical Cost	126,448		16
17	Accumulated Depreciation (book methods)	(148,166)		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)	\$ 209,340	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,793,222	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 768,944	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	242,000		29
30	Accrued Salaries Payable	93,715		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,831		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,648		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,209,138	\$	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		100,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,309,138	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,484,084	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,793,222	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,632,145	1
2	Restatements (describe):		2
3	POST CLOSING	(112,244)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,519,901	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	732,965	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	(768,782)	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)	\$ (35,817)	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)	\$ 1,484,084	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **DOCTORS NURSING & REHABILITATION CEN # 0046235** Report Period Beginning: **01/01/2010**Ending: **12/31/2010****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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,564,627	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,564,627	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,233	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 167,233	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	3,575	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)	\$ 3,575	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,086	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,086	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,748,521	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	824,840	31
32	Health Care	2,468,826	32
33	General Administration	1,581,781	33
B. Capital Expense			
34	Ownership	1,065,234	34
C. Ancillary Expense			
35	Special Cost Centers	999,683	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,006,064	40
41	Income before Income Taxes (line 30 minus line 40)**	742,457	41
42	Income Taxes	(9,492)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 732,965	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** 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 **DOCTORS NURSING & REHABILITATION CENTER**

0046235

Report Period Beginning: **01/01/2010**

Ending:

12/31/2010

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	1,813	1,845	\$ 75,291	\$ 40.81	1
2	Assistant Director of Nursing	3,283	3,731	82,199	22.03	2
3	Registered Nurses	12,595	14,372	281,670	19.60	3
4	Licensed Practical Nurses	24,734	27,421	470,704	17.17	4
5	CNAs & Orderlies	59,588	65,073	664,047	10.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,999	15,987	274,369	17.16	8
9	Activity Director	1,756	1,969	20,188	10.25	9
10	Activity Assistants	2,227	2,563	20,837	8.13	10
11	Social Service Workers	3,477	3,818	42,859	11.23	11
12	Dietician					12
13	Food Service Supervisor	1,838	1,993	25,282	12.69	13
14	Head Cook	6,175	7,097	59,692	8.41	14
15	Cook Helpers/Assistants	7,312	8,144	65,491	8.04	15
16	Dishwashers					16
17	Maintenance Workers	3,689	3,925	49,815	12.69	17
18	Housekeepers	10,870	11,680	97,908	8.38	18
19	Laundry	6,064	7,065	57,737	8.17	19
20	Administrator	1,760	2,072	99,435	47.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,809	2,117	38,852	18.35	23
24	Clerical	4,920	5,314	74,475	14.01	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	945	1,061	9,080	8.56	31
32	Other Health Care central supp, MDS	6,334	7,031	141,238	20.09	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,188	194,278	\$ 2,651,169 *	\$ 13.65	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	231	\$ 11,225	1-3	35
36	Medical Director	36	23,400	9-3	36
37	Medical Records Consultant	30	2,049	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		3,213	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	22	1,421	11-3	44
45	Social Service Consultant	22	1,421	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	341	\$ 42,729		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
KYLE MOORE	ADMINISTRATOR	0	\$ 99,435	Workers' Compensation Insurance	\$ 73,448	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	20,069	Advertising: Employee Recruitment	148	
	OTHER ADMIN		0	FICA Taxes	200,470	Health Care Worker Background Check	880	
				Employee Health Insurance	31,115	(Indicate # of checks performed <u>55</u>)		
				Employee Meals	0	Patient Background Checks	172 2,752	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,987	
				EMPLOYEE BENEFITS - OTHER	9,340	MARKETING/ADV/PROMO	17,187	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	12,510	
				PENSION/PROFIT SHARING PLANS	11,399	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,987)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(17,187)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,435	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 538,611	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
B. Administrative - Other			Amount	Description	Line #	Amount	Description	Amount
Description			Amount					
HI CARE MANAGEMENT			\$ 538,611				Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 185,128	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER

0046235

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTHCARE ASSOC. \$4637
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,202 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES _____ 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. \$ 65,700
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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.