

		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><b>I. IDPH License ID Number:</b> <u>0046250</u></p> <p><b>Facility Name:</b> <u>DOUGLAS REHABILITATION &amp; CARE CENTER</u></p> <p><b>Address:</b> <u>3516 POWELL LANE</u> <u>MATTOON</u> <u>61938</u>          Number City Zip Code</p> <p><b>County:</b> <u>COLES</u></p> <p><b>Telephone Number:</b> <u>( 217 ) 528-0044</u> <b>Fax #</b> <u>( 217 ) 528-3412</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>05/01/2003</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></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="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # <b>(217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____		(Title) <u>MEMBER</u>	<b>Paid Preparer</b>	(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 &amp; 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 DOUGLAS REHABILITATION & CARE CENTER

# 0046250 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	79	Skilled (SNF)	79	28,835	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	79	TOTALS	79	28,835	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF		272	2,643	2,915	8
9	SNF/PED					9
10	ICF	10,137	2,737		12,874	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,137	3,009	2,643	15,789	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.76%

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 03/01/03

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/28/03 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 79 and days of care provided 2,643

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 **DOUGLAS REHABILITATION & CARE C** # **0046250** 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
	<b>A. General Services</b>										
1	Dietary	107,339	7,817	4,748	119,904		119,904		119,904		1
2	Food Purchase		82,703		82,703	(11,498)	71,205	(33)	71,172		2
3	Housekeeping	56,983	9,605		66,588		66,588		66,588		3
4	Laundry	26,192	8,326		34,518		34,518		34,518		4
5	Heat and Other Utilities			180,196	180,196		180,196	(2,321)	177,875		5
6	Maintenance	34,309	4,099	33,338	71,746		71,746	2,923	74,669		6
7	Other (specify):*			16,944	16,944		16,944		16,944		7
8	<b>TOTAL General Services</b>	224,823	112,550	235,226	572,599	(11,498)	561,101	569	561,670		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	857,984	67,371	21,655	947,010		947,010	5,823	952,833		10
10a	Therapy	10,989		3,775	14,764		14,764		14,764		10a
11	Activities	48,191	1,523	1,695	51,409		51,409		51,409		11
12	Social Services	28,323		1,695	30,018		30,018		30,018		12
13	CNA Training										13
14	Program Transportation			932	932		932		932		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	945,487	68,894	35,752	1,050,133		1,050,133	5,823	1,055,956		16
	<b>C. General Administration</b>										
17	Administrative	83,959		120,380	204,339		204,339	(80,765)	123,574		17
18	Directors Fees										18
19	Professional Services			52,322	52,322		52,322	(18,500)	33,822		19
20	Dues, Fees, Subscriptions & Promotions			30,876	30,876		30,876	(18,264)	12,612		20
21	Clerical & General Office Expenses	83,348	8,174	83,787	175,309		175,309	(58,514)	116,795		21
22	Employee Benefits & Payroll Taxes			188,603	188,603	11,498	200,101		200,101		22
23	Inservice Training & Education			2,533	2,533		2,533		2,533		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			11,559	11,559		11,559	(3,441)	8,118		25
26	Insurance-Prop.Liab.Malpractice			42,507	42,507		42,507		42,507		26
27	Other (specify):*			13,185	13,185		13,185	(8,504)	4,681		27
28	<b>TOTAL General Administration</b>	167,307	8,174	545,752	721,233	11,498	732,731	(187,988)	544,743		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,337,617	189,618	816,730	2,343,965		2,343,965	(181,596)	2,162,369		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	4,748
	REPAIRS & MAINTENANCE	0
		4,748
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	58,809
	ELECTRICITY	51,097
	WATER	61,132
	CABLE TV - LOBBY	9,158
		0
		180,196
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	7,838
	PAINTING & DECORATING	428
	BUILDING REPAIRS	11,893
	MAINTENANCE TRAVEL	5,927
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,392
	FIRE SERVICE	5,860
		0
		0
		0
		0
		33,338
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	16,944
	SECURITY SERVICE	0
		0
		0
		16,944
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	11,848
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,522
	PHARMACY CONSULTANT XVIII B 39-2	1,581
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	5,704
		0
		21,655
<b>10a</b>	<b>THERAPY</b>	
	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	3,775
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,775
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,695
		0
		1,695
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,695
		0
		1,695
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	932
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	120,380
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	9,739
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	42,583
		0
		52,322
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,287
	EMPLOYEE WANT ADS XIX F	3,505
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	4,077
	LICENSES & PERMITS XIX F	1,515
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,669
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,308
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,952
	PATIENT BACKGROUND CHECKS XIX F	1,563
		30,876
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	11,263
	EQUIPMENT REPAIR & MAINTENANCE	264
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,260
	MESSENGER SERVICE	0
		0
		83,787

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	101,449
	UNEMPLOYMENT COMPENSATION XIX D	30,193
	WORKERS COMPENSATION INSURANC XIX D	46,192
	HOSPITALIZATION INSURANCE XIX D	8,509
	EMPLOYEE BENEFITS - OTHER XIX D	1,310
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	950
	CHICAGO HEAD TAX XIX D	0
		0
		188,603
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	2,533
		2,533
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	11,559
		11,559
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	42,507
		42,507
27	<b>OTHER</b>	
	BAD DEBTS VI 24	13,185
		13,185

GRAND TOTAL COLUMN 3 OTHER

816,730

**DOUGLAS REHABILITATION & CARE CENTER**  
**SCHEDULES**  
**12/31/2010**

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

TOTAL FOOD PURCHASE	82,703
LESS SALES TAX	<u>(33)</u>
NET FOOD	82,670

TOTAL PATIENT CENSUS	15,789
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	47,367

ADD # EMPLOYEE MEALS/DAY	21
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	7,665

PATIENT MEALS	47,367
ADD EMPLOYEE MEALS	<u>7,665</u>
TOTAL MEALS/YEAR	55,032

NET FOOD	82,670
DIVIDE TOTAL MEALS/YEAR	<u>55,032</u>

COST PER MEAL	1.50
TIME EMPLOYEE MEALS	<u>7,665</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>11,498</b>

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			13,782	13,782		13,782	(4,811)	8,971			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,851	17,851		17,851	(7,191)	10,660			32
33	Real Estate Taxes			25,729	25,729		25,729	781	26,510			33
34	Rent-Facility & Grounds			396,504	396,504		396,504		396,504			34
35	Rent-Equipment & Vehicles			40,955	40,955		40,955		40,955			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			494,821	494,821		494,821	(11,221)	483,600			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,708	355,236	454,944		454,944		454,944			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,253	43,253		43,253		43,253			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		99,708	398,489	498,197		498,197		498,197			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,337,617	289,326	1,710,040	3,336,983		3,336,983	(192,817)	3,144,166			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(5,468)	30		9
10	Interest and Other Investment Income	(7,690)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	2		13
14	Non-Care Related Interest	(1,090)	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	(1,308)	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	(13,185)	27		24
25	Fund Raising, Advertising and Promotional	(15,287)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,669)	20		28
29	Other-Attach Schedule	(45,860)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (91,590)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(101,227)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (101,227)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (192,817)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52



**DOUGLAS REHABILITATION & CARE CENTER**

**ID# 0046250**

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

**Ending: 12/31/2010**

Sch. V Line

**NON-ALLOWABLE EXPENSES**

**Amount**

**Reference**

1	DEFERRED MAINTENANCE	\$	6	1
2	MARKETING SALARY	(21,598)	21	2
3	MARKETING TRAVEL	(3,441)	25	3
4	HEALTHCARE HORIZONS	(18,500)	19	4
5	APARTMENT UTILITIES	(2,321)	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	<b>Total</b>	(45,860)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER# 0046250

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	(33)	0	0	0	0	0	0	0	0	0	0	(33)	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	(2,321)	0	0	0	0	0	0	0	0	0	0	(2,321)	5
6	Maintenance	0	2,923	0	0	0	0	0	0	0	0	0	2,923	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,354)</b>	<b>2,923</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>569</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,823	0	0	0	0	0	0	0	0	0	5,823	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>5,823</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,823</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(80,765)	0	0	0	0	0	0	0	0	0	(80,765)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,500)	0	0	0	0	0	0	0	0	0	0	(18,500)	19
20	Fees, Subscriptions & Promotions	(18,264)	0	0	0	0	0	0	0	0	0	0	(18,264)	20
21	Clerical & General Office Expenses	(21,598)	(36,916)	0	0	0	0	0	0	0	0	0	(58,514)	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	(3,441)	0	0	0	0	0	0	0	0	0	0	(3,441)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(13,185)	4,681	0	0	0	0	0	0	0	0	0	(8,504)	27
28	<b>TOTAL General Administration</b>	<b>(74,988)</b>	<b>(113,000)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(187,988)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(77,342)</b>	<b>(104,254)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(181,596)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER# 0046250

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)	
	<b>D. Ownership</b>													
30	Depreciation	(5,468)	0	657	0	0	0	0	0	0	0	0	(4,811)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,780)	0	1,589	0	0	0	0	0	0	0	0	(7,191)	32
33	Real Estate Taxes	0	0	781	0	0	0	0	0	0	0	0	781	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	<b>TOTAL Ownership</b>	<b>(14,248)</b>	<b>0</b>	<b>3,027</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,221)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(91,590)	(104,254)	3,027	0	0	0	0	0	0	0	0	(192,817)	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	37.5			HI CARE	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	37.5			MANAGEMENT		
MORRIS ESFORMES	15					
SANDRA SEGAL	10			HI CARE	SPRINGFIELD	REAL ESTATE
				HEALTHCARE	SPRINGFIELD	NURSE CONSULT
				HORIZONS		

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	\$ 120,380	HI CARE MANAGEMENT		\$	\$ (120,380)	1
2	V	21 HOME OFFICE EXPENSE	60,000	" " "			(60,000)	2
3	V	6 MAINTENANCE		" " "		2,923	2,923	3
4	V	10 NURSING		" " "		5,823	5,823	4
5	V	17 ADMINISTRATIVE		" " "		39,615	39,615	5
6	V	21 OFFICE EXPENSE		" " "		23,084	23,084	6
7	V	27 PAYROLL TAXES & GRP INS		" " "		4,681	4,681	7
8	V			" " "				8
9	V			" " "				9
10	V			" " "				10
11	V			" " "				11
12	V			" " "				12
13	V			" " "				13
14	Total		\$ 180,380			\$ 76,126	\$ * (104,254)	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)		\$ 657	\$ 657	15
16	V	32 INTEREST		" " "		1,589	1,589	16
17	V	33 REAL ESTATE		" " "		781	781	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		\$			\$ 3,027	\$ * 3,027	39

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

Facility Name & ID Number **DOUGLAS REHABILITATION & CARE C** # **0046250** 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	\$ 14,810	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.		SEE			SALARY	14,205	17-7	4
5					ATTACHED						5
6					SCHEDULE						6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	1,107	21-7	7
8											8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	6,386	17-7	10
11											11
12											12
13								TOTAL	\$ 36,508		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 DOUGLAS REHABILITATION & CARE CENTER # 0046250 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PER RESIDENT DAY	206,077	8	\$ 38,149	\$ 15,789	\$ 2,923	1
2	10	NURSING	PER RESIDENT DAY	206,077	8	76,000	15,789	5,823	2
3	17	OFFICER SALARY- IRVINE	PER RESIDENT DAY	206,077	8	185,400	15,789	14,205	3
4	17	OFFICER SALARY- HEDGES	PER RESIDENT DAY	206,077	8	193,296	15,789	14,810	4
5	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	206,077	8	55,000	15,789	4,214	5
6	17	SPECIAL PROJ MNGR- HEDGE	PER RESIDENT DAY	206,077	8	83,349	15,789	6,386	6
7	21	OFFICE EXPENSE	PER RESIDENT DAY	206,077	8	301,295	15,789	23,084	7
8	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	206,077	8	61,099	15,789	4,681	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	\$ 76,126	25

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER # 0046250 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 )528-0044

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	\$ 79	\$ 657	1
2	32	INTEREST	PER LICENSE BED	810	8	16,292	79	1,589	2
3	33	REAL ESTATE	PER LICENSE BED	810	8	8,006	79	781	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	\$	\$ 3,027	25



Facility Name & ID Number

DOUGLAS REHABILITATION & CARE CI

# 0046250

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1										1									
2	US BANK (HI PROP)	X	MORTGAGE ( OFFICE)		6/29/05		24,347	6/29/12	0.0635	1,589									
3										3									
4										4									
5	MEMBER LOAN			INTEREST		100,000	100,000			7,000									
<b>Working Capital</b>																			
6		X	WORKING CAPITAL	INTEREST	REVOL		329,381	revolv	prime +	9,761									
7										7									
8										8									
9	TOTAL Facility Related					\$ 100,000	\$ 453,728			\$ 18,350									
<b>B. Non-Facility Related*</b>																			
10			BED TAX							1,090									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related					\$	\$			\$ 1,090									
15	TOTALS (line 9+line14)					\$ 100,000	\$ 453,728			\$ 19,440									

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.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.		\$	<b>26,043</b>		<b>1</b>
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.)		\$	<b>25,886</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(157)</b>		<b>3</b>
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>25,886</b>		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>25,729</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<b>33,434</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2006	<b>32,544</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009 \$ <b>13</b>
	2007	<b>32,517</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2008	<b>26,042</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
	2009	<b>25,886</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>					
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.</b>					

**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 DOUGLAS REHABILITATION & CARE CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0046250

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 Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>07-1-00300-000</u>	<u>NURSING HOME</u>	\$ <u>23,489.24</u>	\$ <u>23,489.24</u>
2. <u>07-1-00300-001</u>	<u>NURSING HOME</u>	\$ <u>2,033.68</u>	\$ <u>2,033.68</u>
3. <u>07-1-00572-000</u>	<u>NURSING HOME</u>	\$ <u>363.34</u>	\$ <u>363.34</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>25,886.26</u></u>	\$ <u><u>25,886.26</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.**

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

# 0046250 Report Period Beginning:

01/01/2010 Ending:

12/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 27,000 B. General Construction Type: Exterior MASONRY FACE BR Frame STEEL & 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).

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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>\$ 9,976</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 9,976</b>	<b>3</b>

**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	25,764	657	39	657		
	Improvement Type**								
9	INSULATION		2004	10,441	380	27.5	380		2,423
10	REPLACE HEAT & CHILL LINES		2005	3,245	118	27.5	118		595
11	COMPRESSOR		2006	14,696	534	27.5	534		2,292
12	GENERATOR (1 OF 2)		2008	2,670	97	27.5	97		222
13	DRAPES		2008	3,962	380	5	792	412	1,980
14	PAINTING & WALL VINYL		2008	8,203	788	5	1,641	853	4,102
15	COMPRESSOR REPAIR		2009	19,021	691	27.5	691		950
16	INSTALL SPRINKLERS IN RESTROOMS AND CLOSETS		2009	6,877	250	27.5	250		344
17	ROOF TOP VENTILATING FANS		2009	4,251	155	27.5	155		213
18	PUMPS		2010	3,461	37	27.5	37		37
19	NEW BEARINGD AND SEALS ON FAN		2010	3,132	33	27.5	33		33
20	HOT WATER BOOSTER HEATER		2010	2,853	30	27.5	30		30
21									
22									
23	GENERATOR (2 OF 2) THIS PORTION PAID BY LANDLORD		2008	25,620					
24	HOT WATER HEATER (PAID BY LANDLORD)		2008	7,923					
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70	
			142,119		4,150		5,415	1,265	13,221

\*\*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	\$ 28,950	\$ 2,359	\$ 2,895	\$ 536	10 YRS	\$ 12,229	71
72	Current Year Purchases	13,216	7,930	661	(7,269)	10 YRS	661	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 42,166	\$ 10,289	\$ 3,556	\$ (6,733)		\$ 12,890	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 194,261	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,439	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 8,971	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,468)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 26,111	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: ELITE MATTON, 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:				\$ <u>396,504</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ <u>396,504</u>			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: \$ 40,955 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					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 160,000	\$		\$ 160,000	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,171			11,171	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			184,065			184,065	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				99,708		99,708	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	<b>TOTAL</b>			\$		\$ 355,236	\$ 99,708		\$ 454,944	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 **DOUGLAS REHABILITATION & CARE CENTER**

# **0046250**

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 433,367	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (35,000) )	246,507		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,490		6
7	Other Prepaid Expenses	63,557		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>refund due fr IDR</b>	4,034		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 788,955	\$	10
<b>B. Long-Term Assets</b>				
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	82,812		15
16	Equipment, at Historical Cost	42,166		16
17	Accumulated Depreciation (book methods)	(51,461)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 73,517	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 862,472	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,131,678	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	329,381		29
30	Accrued Salaries Payable	45,832		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,469		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,886		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37	<b>INTER-COMPANY PAY</b>	21,500		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,577,746	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44		100,000		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 100,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,677,746	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (815,274)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 862,472	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(496,737)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>POST CLOSING</b>	<b>(24,607)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(521,344)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(293,930)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(293,930)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(815,274)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number **DOUGLAS REHABILITATION & CARE CENTE # 0046250** 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,829,323	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,829,323	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	197,910	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 197,910	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,690	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,690	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Rent Apartments</u>	9,596	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,596	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,044,519	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	572,599	31
32	Health Care	1,050,133	32
33	General Administration	721,233	33
<b>B. Capital Expense</b>			
34	Ownership	494,821	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	454,944	35
36	Provider Participation Fee	43,253	36
<b>D. Other Expenses (specify):</b>			
37	<u>OUT-OF-PERIOD EXPENSES</u>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,336,983	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(292,464)	41
42	<b>Income Taxes</b>	(1,466)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (293,930)	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 **DOUGLAS REHABILITATION & CARE CENTER**

# **0046250**

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	1,913	2,113	\$ 61,895	\$ 29.29	1
2	Assistant Director of Nursing	262	302	6,796	22.50	2
3	Registered Nurses	5,413	5,647	116,739	20.67	3
4	Licensed Practical Nurses	10,397	11,185	208,207	18.61	4
5	CNAs & Orderlies	35,736	38,320	403,795	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,000	1,114	10,989	9.86	8
9	Activity Director	1,567	2,672	21,218	7.94	9
10	Activity Assistants	2,865	3,253	26,973	8.29	10
11	Social Service Workers	1,585	1,779	28,323	15.92	11
12	Dietician					12
13	Food Service Supervisor	1,822	2,072	32,727	15.79	13
14	Head Cook	5,078	5,458	46,154	8.46	14
15	Cook Helpers/Assistants	3,266	3,453	28,458	8.24	15
16	Dishwashers					16
17	Maintenance Workers	1,971	2,111	34,309	16.25	17
18	Housekeepers	5,948	6,534	56,983	8.72	18
19	Laundry	3,081	3,191	26,192	8.21	19
20	Administrator	2,093	2,648	83,959	31.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,925	2,125	40,016	18.83	23
24	Clerical	1,862	2,436	43,332	17.79	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	682	682	6,127	8.98	31
32	Other Health Care(specify)	2,991	3,223	54,425	16.89	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,457	100,318	\$ 1,337,617 *	\$ 13.33	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	109	\$ 4,748	1-3	35
36	Medical Director	MONTHLY	6,000	9-3	36
37	Medical Records Consultant	35	2,522	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	1,581	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	11	3,775	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	24	1,695	11-3	44
45	Social Service Consultant	24	1,695	12-3	45
46	Other(specify) <u>program consultant</u>		5,704	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	203	\$ 27,720		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DIANA SPENCE	ADMINISTRATOR	0	\$ 66,728	Workers' Compensation Insurance	\$ 46,192	IDPH License Fee	\$	
LESTER ROBERTSON	ADMINISTRATOR	0	17,231	Unemployment Compensation Insurance	30,193	Advertising: Employee Recruitment	3,505	
	OTHER ADMIN		0	FICA Taxes	101,449	Health Care Worker Background Check	1,952	
				Employee Health Insurance	8,509	(Indicate # of checks performed 122)		
				Employee Meals	11,498	Patient Background Checks	73	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,308	
				EMPLOYEE BENEFITS - OTHER	1,310	MARKETING/ADV/PROMO	16,956	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	5,592	
				PENSION/PROFIT SHARING PLANS	950	MGMT CO ALLOC		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 83,959	CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,308)	
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
HI CARE MANAGEMENT			\$ 120,380				Out-of-State Travel	\$
							In-State Travel	
								0
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 120,380				Seminar Expense	
(Attach a copy of any management service agreement)								0
<b>C. Professional Services</b>				<b>TOTAL</b>				
Vendor/Payee	Type		Amount			\$	Entertainment Expense	( )
							(agree to Sch. V,	
							line 24, col. 8)	
							TOTAL	\$
SEE SCHEDULE ATTACHED			52,322					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 52,322					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* 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? YES  
If YES, give association name and amount. IL HEALTHCARE ASSOC. \$4361
- (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? \_\_\_\_\_
- (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. \$ 3,697 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? X YES \_\_\_\_\_ NO \_\_\_\_\_
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO \_\_\_\_\_ 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. \$ 43,253  
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. \$ 11,498 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.