FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

I. IDPH License ID Number: 0046235

Facility Name: DOCTORS NURSING & REHAB CTR

Address: 1201 HAWTHORN ROAD (Number) SALEM (City) 62881 (Zip Code)

County: MARION

Telephone Number: (618) 548-4884 **Fax #** (618) 548-5007

HFS ID Number:

Date of Initial License for Current Owners: 05/01/2003

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BILL WEEAKS **Telephone Number:** (217) 528-2244
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Robert Hedges
(Title) Member

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,847	462	4,939	11,248	8
9	SNF/PED					9
10	ICF	13,343	3,548		16,891	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,190	4,010	4,939	28,139	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.24%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient therapy

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 4,422

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	163,367	16,425	10,209	190,001		190,001		190,001			1
2	Food Purchase		198,228		198,228		198,228	(1,963)	196,265			2
3	Housekeeping	101,577	21,173		122,750		122,750		122,750			3
4	Laundry	51,630	13,491		65,121		65,121		65,121			4
5	Heat and Other Utilities			109,083	109,083		109,083	(1,575)	107,508			5
6	Maintenance	27,383	12,510	27,250	67,143		67,143	2,445	69,588			6
7	Other (specify):* Scavenger			18,417	18,417		18,417		18,417			7
8	TOTAL General Services	343,957	261,827	164,959	770,743		770,743	(1,093)	769,650			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	1,613,832	350,885	127,268	2,091,985	685	2,092,670		2,092,670			10
10a	Therapy	290,445			290,445		290,445		290,445			10a
11	Activities	41,571	6,926	1,482	49,979		49,979		49,979			11
12	Social Services	35,999		1,482	37,481		37,481		37,481			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,981,847	357,811	166,232	2,505,890	685	2,506,575		2,506,575			16
	C. General Administration											
17	Administrative	121,147		133,000	254,147		254,147	(12,021)	242,126			17
18	Directors Fees											18
19	Professional Services			260,361	260,361	(685)	259,676	(107,923)	151,753			19
20	Dues, Fees, Subscriptions & Promotions			32,499	32,499		32,499	(11,283)	21,216			20
21	Clerical & General Office Expenses	71,331	16,140	66,310	153,781		153,781	(52,423)	101,358			21
22	Employee Benefits & Payroll Taxes			342,227	342,227		342,227	39,330	381,557			22
23	Inservice Training & Education			220	220		220	507	727			23
24	Travel and Seminar			2,162	2,162		2,162		2,162			24
25	Other Admin. Staff Transportation			15,844	15,844		15,844	(1,039)	14,805			25
26	Insurance-Prop.Liab.Malpractice			65,958	65,958		65,958	1,150	67,108			26
27	Other (specify):*			847,649	847,649		847,649	(847,620)	29			27
28	TOTAL General Administration	192,478	16,140	1,766,230	1,974,848	(685)	1,974,163	(991,322)	982,841			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,518,282	635,778	2,097,421	5,251,481		5,251,481	(992,415)	4,259,066			29

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR #0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			21,333	21,333		21,333	6,390	27,723			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,768	46,768		46,768	(15,448)	31,320			32
33	Real Estate Taxes			113,896	113,896		113,896	3,576	117,472			33
34	Rent-Facility & Grounds			749,287	749,287		749,287		749,287			34
35	Rent-Equipment & Vehicles			193,032	193,032		193,032		193,032			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,124,316	1,124,316		1,124,316	(5,482)	1,118,834			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		276,148	556,574	832,722		832,722		832,722			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			209,761	209,761		209,761		209,761			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		276,148	766,335	1,042,483		1,042,483		1,042,483			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,518,282	911,926	3,988,072	7,418,280		7,418,280	(997,897)	6,420,383			45

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,227)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,677	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,963)	2		13
14	Non-Care Related Interest	(17,998)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,111)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(847,620)	27		24
25	Fund Raising, Advertising and Promotional	(10,145)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(83,346)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (987,733)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(10,164)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,164)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (997,897)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		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

DOCTORS NURSING & REHAB CTR

ID# 0046235

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (35,181)	21	1
2	Administrative Salary	(42,986)	17	2
3	Marketing Consultant	(356)	19	3
4	Chamber of Commerce	(1,381)	20	4
5	Marketing Travel	(3,442)	25	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**	(83,346)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,963)	0	0	0	0	0	0	0	0	0	0	(1,963)	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	(4,227)	2,652	0	0	0	0	0	0	0	0	0	(1,575)	5
6	Maintenance	0	2,445	0	0	0	0	0	0	0	0	0	2,445	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,190)	5,097	0	0	0	0	0	0	0	0	0	(1,093)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(42,986)	30,965	0	0	0	0	0	0	0	0	0	(12,021)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,467)	(82,163)	707	0	0	0	0	0	0	0	0	(107,923)	19
20	Fees, Subscriptions & Promotions	(11,526)	243	0	0	0	0	0	0	0	0	0	(11,283)	20
21	Clerical & General Office Expenses	(35,181)	(17,849)	607	0	0	0	0	0	0	0	0	(52,423)	21
22	Employee Benefits & Payroll Taxes	0	39,330	0	0	0	0	0	0	0	0	0	39,330	22
23	Inservice Training & Education	0	507	0	0	0	0	0	0	0	0	0	507	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(3,442)	2,403	0	0	0	0	0	0	0	0	0	(1,039)	25
26	Insurance-Prop.Liab.Malpractice	0	1,150	0	0	0	0	0	0	0	0	0	1,150	26
27	Other (specify):*	(847,620)	0	0	0	0	0	0	0	0	0	0	(847,620)	27
28	**TOTAL General Administration**	(967,222)	(25,414)	1,314	0	0	0	0	0	0	0	0	(991,322)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(973,412)	(20,317)	1,314	0	0	0	0	0	0	0	0	(992,415)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,677	0	2,713	0	0	0	0	0	0	0	0	6,390	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,998)	0	2,550	0	0	0	0	0	0	0	0	(15,448)	32
33	Real Estate Taxes	0	0	3,576	0	0	0	0	0	0	0	0	3,576	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**	(14,321)	0	8,839	0	0	0	0	0	0	0	0	(5,482)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(987,733)	(20,317)	10,153	0	0	0	0	0	0	0	0	(997,897)	45

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT HEDGES	37.5	EVERGREEN NURSING	EFFINGHAM	HI CARE MGMT	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	37.5	DOUGLAS NURSING	MATTOON	H&I PROPERTIES	SPRINGFIELD	REAL ESTATE
MORRIS ESFORMES	15					
SANDRA SEGAL	10					

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$	HI CARE MANAGEMENT		$ (133,000)	$ (133,000)	1
2	V	21	HOME OFFICE EXPENSE		HI CARE MANAGEMENT		(30,000)	(30,000)	2
3	V	19	ADMINISTRATIVE CONSULT		HI CARE MANAGEMENT		(85,284)	(85,284)	3
4	V	6	MAINTENANCE		HI CARE MANAGEMENT			2,445	4
5	V	5	UTILITIES		HI CARE MANAGEMENT			2,652	5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT			163,965	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT			12,151	7
8	V	19	PROFESSIONAL SVCS		HI CARE MANAGEMENT			3,121	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT			243	9
10	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT			507	10
11	V	25	TRAVEL		HI CARE MANAGEMENT			2,403	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT			1,150	12
13	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT			39,330	13
14	Total			$			$ (248,284)	$ * (20,317)	14

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES (HOME OFFICE)		$ 2,713	$ 2,713	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		2,550	2,550	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		3,576	3,576	17
18	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		607	607	18
19	V	19	PROFESSIONAL SVCS		H&I PROPERTIES HOME OFFICE		707	707	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			$			$ 10,153	$ * 10,153	39

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	37.50	29,951	15.861	0.40	SALARY	$ 19,680	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	37.50	21,553	15.861	0.40	SALARY	14,162	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	8,718	15.861	0.40	SALARY	5,728	17-7	3
4	DEREK HEDGES	COO	OFFICE MGMT	0.00	62,469	15.861	0.40	SALARY	41,047	17-7	4
5	MORRIS ESFORMES			15.00							5
6	SANDRA SEGAL			10.00							6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 80,617		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 & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 [X] NO [ ]

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

Name of Related Organization: HI CARE MANAGEMENT
Street Address: 1625 S 6TH ST
City / State / Zip Code: SPRINGFIELD, IL 62703
Phone Number: ((217)528-0044
Fax Number: ((217)528-3412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PER RESIDENT DAY	70,964	3	$ 6,165	$ 1,731	28,139	$ 2,445	1
2	5	UTILITIES	PER RESIDENT DAY	70,964	3	6,687		28,139	2,652	2
3	10	NURSING	PER RESIDENT DAY	70,964	3			28,139	0	3
4	17	ADMINISTRATION	PER RESIDENT DAY	70,964	3	413,504	413,504	28,139	163,965	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	70,964	3	30,644		28,139	12,151	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	70,964	3	7,872		28,139	3,121	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	70,964	3	614		28,139	243	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	70,964	3	1,279		28,139	507	8
9	25	TRAVEL	PER RESIDENT DAY	70,964	3	6,059		28,139	2,403	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	70,964	3	2,900		28,139	1,150	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	70,964	3	99,186		28,139	39,330	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					$ 574,910	$ 415,235		$ 227,967	25

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 [X] 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 6TH ST
City / State / Zip Code: SPRINGFIELD, IL 62703
Phone Number: ((217)528-0044
Fax Number: ((217)528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	PER LICENSE BED	319	3	$ 7,212	$	120	$ 2,713	1
2	32	INTEREST	PER LICENSE BED	319	3	6,778		120	2,550	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	319	3	9,505		120	3,576	3
4	21	OFFICE EXPENSE	PER LICENSE BED	319	3	1,614		120	607	4
5	19	PROFESSIONAL SVCS	PER LICENSE BED	319	3	1,880		120	707	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					$ 26,989	$		$ 10,153	25

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	US BANK H&I PROPERTIES		X	MORTGAGE OFFICE		06/29/05	$	$ 56,085	06/29/2022	0.0425	$ 2,550	1
2	MEMBER LOANS	X				7/1/17		1,325				2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL BANK		X	WORKING CAPITAL	INTEREST	REVOLV		275,000	05/31/2018	PRIME +	28,770	6
7												7
8												8
9	TOTAL Facility Related						$	$ 332,410			$ 31,320	9
	B. Non-Facility Related*											
10	OMEGA HEALTHCARE		X	WORKING CAPITAL		05/31/2013	305,613	31,997		0.0800	17,998	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 305,613	$ 31,997			$ 17,998	14
15	TOTALS (line 9+line14)						$ 305,613	$ 364,407			$ 49,318	15

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

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

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 107,800	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.)		$ 112,524	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,724	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 112,748	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.		$ 117,472	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	144,448	8
	2013	147,713	9
	2014	108,154	10
	2015	107,511	11
	2016	112,524	12
Prior Yr			

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOCTORS NURSING & REHAB CTR COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0046235

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

TELEPHONE (217) 528-2244 FAX #: (217) 528-4115

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-03-400-012	NURSING HOME	$ 108,947.70	$ 108,947.70
2.	22-03.0-107-018	HOME OFFICE	$ 5,653.08	$ 2,148.00
3.	22-03.0-107-017	HOME OFFICE	$ 3,757.50	$ 1,428.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,358.28	$ 112,523.70

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 _____ 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. [X] (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. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2005	$ 21,818	1
2					2
3	TOTALS			$ 21,818	3

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6	H&I										6
7	PROP										7
8	OFC BLD		2005		98,895	2,713	39	2,713			8
	Improvement Type**										
9	WATER HEATER			2003	6,135	223	27.5	223		3,188	9
10	WATER HEATER			2004	8,145	296	27.5	296		4,083	10
11	TILING			2005	4,980	181	27.5	181		2,271	11
12	SIDEWALK			2005	6,300	420	15	420		5,250	12
13	WALL HEAT & A/C UNIT			2006	1,075	39	27.5	39		441	13
14	DOORS			2007	2,828	103	27.5	103		1,085	14
15	CARPETING			2007	23,768		5			23,768	15
16	ROOF (1 OF 2)			2008	2,475	90	27.5	90		859	16
17	FENCE			2008	3,964	264	15	264		2,510	17
18	THERAPY ROOM			2009	157,255	5,718	27.5	5,718		48,840	18
19	WATER HEATER			2010	14,133	514	27.5	514		3,730	19
20	AC UNIT			2011	2,690		27.5	98	98	657	20
21	FREEZER			2012	4,291	188	7	613	425	3,601	21
22	AC UNIT			2012	2,950	107	27.5	107		549	22
23	ROOF FLASHING			2013	3,350	86	27.5	86		398	23
24	ELECTRICAL BREAKER			2013	2,109	54	27.5	54		245	24
25	FLOORING IN ALL HALLWAYS (NORTH,WEST,SW,PHOENIX)			2014	19,144	491	27.5	491		1,493	25
26	ISLANDAIRE HVAC ON PHOENIX WING ROOM 110			2015	6,299	162	27.5	162		385	26
27	5 TON AC UNIT KITCHEN			2015	2,989	76	27.5	76		169	27
28	CALL LIGHT SYSTEM SOUTH WING			2017	4,456	100	27.5	100		100	28
29	GENERATOR TRANSFER SWITCH BACK EQUIPMENT ROOM			2017	3,500	11	27.5	11		11	29
30											30
31											31
32	ROOF (2 OF2) THIS PORTION PAID BY LANDLORD			2008	122,006						32
33	WINDOWS (PAID BY LANDLORD)			2008	86,718						33
34	A/C CORRIDORS EXISTING BUILDING(PAID BY LANDLORD)			2008	44,160						34
35	SPRINKLER SYSTEM (PAID BY LANDLORD)			2009	93,600						35
36	THERAPY ROOM ADDITION (PAID BY LANDLORD)			2009	553,516						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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		$ 1,281,731	$ 11,836		$ 12,359	$ 523	$ 103,633	70

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 212,903	$ 11,917	$ 15,071	$ 3,154	5-10 YRS	$ 139,159	71
72	Current Year Purchases	8,211	293	293		5-10 YRS	293	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 221,114	$ 12,210	$ 15,364	$ 3,154		$ 139,452	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,524,663	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 24,046	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,723	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,677	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 243,085	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. [X] 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		$ 749,287			3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 749,287 **			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 [X] NO Terms: *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 172,659 Description: SEE ATTACHED SCHEDULE
(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	PATIENT TRANSPORT	2011 FORD BRAUN	$ #######	$ 20,373	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 20,373	21

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

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	1	2	3	4	5	6	7	8	
	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	$		$ 201,918	$		$ 201,918	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			105,622			105,622	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			249,034			249,034	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				276,148		276,148	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			$		$ 556,574	$ 276,148		$ 832,722	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 & REHAB CTR **#** 0046235 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 29,939	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 119,000)	1,310,592		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,336		6
7	Other Prepaid Expenses	5,220		7
8	Accounts Receivable (owners or related parties)	198,798		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,559,885	$	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	259,068		15
16	Equipment, at Historical Cost	244,882		16
17	Accumulated Depreciation (book methods)	(293,550)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	32,611		21
22	Other Long-Term Assets (spe **Deposits**	60,000		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 303,011	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,862,896	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 497,463	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	275,000		29
30	Accrued Salaries Payable	108,514		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,420		31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,952		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Advance Billing**	93,159		36
37	**RTF**	12,569		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,108,077	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	33,322		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Deferred Rent**	327,325		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 360,647	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,468,724	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 394,172	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,862,896	$	48

***(See instructions.)**

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,243,237	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,243,237	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(849,065)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (849,065)	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)**	$ 394,172	24 *

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,239,929	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,239,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,641	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 328,641	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	645	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 645	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)**	$ 6,569,215	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	770,743	31
32	Health Care	2,506,575	32
33	General Administration	1,974,163	33
	B. Capital Expense		
34	Ownership	1,124,316	34
	C. Ancillary Expense		
35	Special Cost Centers	832,722	35
36	Provider Participation Fee	209,761	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,418,280	40
41	**Income before Income Taxes (line 30 minus line 40)****	(849,065)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (849,065)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,500,589	44
45	Private Pay - Net Inpatient Revenue	545,723	45
46	Medicare - Net Inpatient Revenue	1,934,383	46
47	Other-(specify) Insurance	259,234	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,239,929	49

* **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 is 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 & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,288	1,346	$ 45,090	$ 33.50	1
2	Assistant Director of Nursing	1,989	2,223	56,001	25.19	2
3	Registered Nurses	8,537	9,735	228,026	23.42	3
4	Licensed Practical Nurses	23,010	25,436	501,388	19.71	4
5	CNAs & Orderlies	54,231	58,059	616,424	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,206	15,417	311,636	20.21	8
9	Activity Director	1,819	2,082	24,417	11.73	9
10	Activity Assistants	1,878	2,019	17,154	8.50	10
11	Social Service Workers	2,412	2,693	35,999	13.37	11
12	Dietician					12
13	Food Service Supervisor	1,875	2,125	32,955	15.51	13
14	Head Cook	3,408	4,020	38,026	9.46	14
15	Cook Helpers/Assistants	9,786	10,567	92,386	8.74	15
16	Dishwashers					16
17	Maintenance Workers	1,950	2,063	27,383	13.27	17
18	Housekeepers	10,672	11,381	101,577	8.93	18
19	Laundry	5,618	6,028	51,630	8.57	19
20	Administrator	2,000	2,080	78,161	37.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,959	2,130	36,025	16.91	23
24	Clerical	14	14	125	8.93	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	25	25	1,227	49.08	31
32	Other Health C: Central supply, MI	6,286	7,097	144,485	20.36	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,963	166,540	$ 2,440,115 *	$ 14.65	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	206	$ 10,209	1-3	35
36	Medical Director	78	36,000	9-3	36
37	Medical Records Consultant	33	2,803	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	40	3,525	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	1,482	11-3	44
45	Social Service Consultant	42	1,482	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	441	$ 55,501		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,719	$ 75,672	10-3	50
51	Licensed Practical Nurses	134	7,022	10-3	51
52	Certified Nurse Assistants/Aides	329	7,845	10-3	52
53	TOTAL (lines 50 - 52)	2,182	$ 90,539		53

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Baker	Administrator	0	$ 66,238
Kyle Moore	Administrator	0	11,923
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 78,161

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 133,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 133,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 151,753
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 151,753

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,245
Unemployment Compensation Insurance	21,889
FICA Taxes	200,487
Employee Health Insurance	77,211
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	10,523
Post Screening	4,202
TOTAL (agree to Schedule V, line 22, col.8)	$ 381,557

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,323
Advertising: Employee Recruitment	1,477
Health Care Worker Background Check (Indicate # of checks performed 32)	747
Patient Background Checks 116	1,961
See attached schedule	15,708
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,216

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
IHCA	1,777
INHA	125
Seminar	260
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,162

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. **$7,920**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,395** 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 **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **209,761**
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? **YES** 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? **25%**
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? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. $

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	Facility	Allocated	Total
TALX	Unemployment Services	$ 5,700		$ 5,700
COMPASS CFO SERVICES	ACCOUNTING	$ 73,946		$ 73,946
SIKICH	ACCOUNTING	$ 14,400	$ 3,477	$ 17,877
SMARTLINX	PAYROLL	$ 8,683		$ 8,683
MATRIX CARE	BILLING/MDS	$ 32,787		$ 32,787
BPC	401K Third Party Admin	$ 848	$ 278	$ 1,126
ESOLUTONS	BILLING	$ 2,991		$ 2,991
INNOVATIVE LTC SOLUTIONS	BILLING	$ 6,839		$ 6,839
MB Financial	Legal	$ 1,731		$ 1,731
WILLIAM RADKEY	LEGAL	$ -		$ -
WAGE WORKS	PAYROLL	$ -	$ 73	$ 73
TOTAL		$ 147,925	$ 3,828	$ 151,753

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	AMOUNT	Allocated	Total
ALLSCRIPTS	SUBSCRIPTIONS	$ 3,000		$ 3,000
Illinois NHA	DUES	$ -	$ 79	$ 79
Ability Network	ANNUAL SUBSCRIPTION	$ 4,108		$ 4,108
IHCA	DUES	$ 7,920		$ 7,920
CLIA	FEES	$ -		$ -
ILLINOIS SECRETARY OF STAT	FEES	$ 437		$ 437
MEDPASS	SUBSCRIPTIONS	$ -	$ 164	$ 164
		$ 15,465	$ 243	$ 15,708

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE XIX (G) TRAVEL AND SEMINAR

SEMINARS	AMOUNT

OMITTED

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE OF RENTAL EQUIPMENT

Item		Amount
CONCENTRATORS	$	81,691
BEDS	$	52,383
IV PUMPS	$	4,793
ICE MACHINE	$	2,701
WASHING MACHINE	$	2,700
COPIERS	$	11,310
POSTAGE EQUIPMENT	$	964
COMPUTERS	$	14,617
STORAGE UNIT	$	1,500
TOTAL RENTALS	$	172,659

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SALES TAX EXCLUSION

TOTAL FOOD PURCHASES WITH TAX	$	198,228
TOTAL FOOD PURCHASES WITHOUT TAX	$	196,265
TOTAL SALES TAX	$	1,963

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	Facility	Allocated	Total
TRANSPORT VAN FUEL AND REPAIRS	$ 3,964		$ 3,964
Administrator	$ 7,828		$ 7,828
Other Employee Travel	$ 610		$ 610
Corporate Staff Travel	$ -	$ 2,403	$ 2,403
TOTALS	$ 12,402	$ 2,403	$ 14,805

SCHEDULE VII
C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
REPORT PERIOD ENDING 12/31/2017

FACILITY ID	0046417	0046250	
	EVERGREEN	DOUGLAS	TOTAL
NAME	NURSING AND REHAB	NURSING AND REHAB	OTHER
ROBERT HEDGES	$ 19,921	$ 10,030	$ 29,951
WILLIAM IRVINE	$ 14,336	$ 7,218	$ 21,554
MARTHA IRVINE	$ 5,798	$ 2,919	$ 8,717
DEREK HEDGES	$ 41,550	$ 20,919	$ 62,469
	$ 81,605	$ 41,086	$ 122,691

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

Reclassification

From	Line	To	Line	Amount	Description
Professional Services	19	Nursing	10	$ 685	Marion Eye Center cost miss-coded