FOR BHF USE

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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.

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

I. IDPH License ID Number: 0046250

Facility Name: DOUGLAS NURSING REHAB CENTER

Address: 3516 POWELL LANE (Number) MATTOON (City) 61938 (Zip Code)

County: COLES

Telephone Number: (217) 234-6401 **Fax #** (217) 258-3300

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 DOUGLAS NURSING REHAB CENTER # 0046250 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	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	257	67	2,723	3,047	8
9	SNF/PED					9
10	ICF	8,119	3,175		11,294	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,376	3,242	2,723	14,341	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.73%

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)

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 03/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/28/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 79 and days of care provided 2,546

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 DOUGLAS NURSING REHAB CENTER # 0046250 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	115,748	7,835	6,380	129,963		129,963		129,963			1
2	Food Purchase		106,160		106,160	(933)	105,227	(492)	104,735			2
3	Housekeeping	86,881	10,022		96,903		96,903		96,903			3
4	Laundry	32,508	4,690		37,198		37,198		37,198			4
5	Heat and Other Utilities			101,655	101,655		101,655	(8,030)	93,625			5
6	Maintenance	52,564	9,958	36,978	99,500		99,500	1,246	100,746			6
7	Other (specify):* SCAVENGER			14,603	14,603		14,603		14,603			7
8	TOTAL General Services	287,701	138,665	159,616	585,982	(933)	585,049	(7,276)	577,773			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	977,989	87,714	35,690	1,101,393		1,101,393		1,101,393			10
10a	Therapy	25,460			25,460		25,460		25,460			10a
11	Activities	36,609	1,495	3,523	41,627		41,627		41,627			11
12	Social Services	32,522		3,539	36,061		36,061		36,061			12
13	CNA Training											13
14	Program Transportation			1,445	1,445		1,445		1,445			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,072,580	89,209	50,197	1,211,986		1,211,986		1,211,986			16
	C. General Administration											
17	Administrative	63,511			63,511		63,511	83,564	147,075			17
18	Directors Fees											18
19	Professional Services			70,092	70,092		70,092	(2,673)	67,419			19
20	Dues, Fees, Subscriptions & Promotions			28,498	28,498		28,498	(16,224)	12,274			20
21	Clerical & General Office Expenses	37,345	9,628	19,274	66,247		66,247	6,593	72,840			21
22	Employee Benefits & Payroll Taxes			218,961	218,961	933	219,894	20,044	239,938			22
23	Inservice Training & Education			100	100		100		100			23
24	Travel and Seminar			285	285		285	258	543			24
25	Other Admin. Staff Transportation			4,805	4,805		4,805	1,224	6,029			25
26	Insurance-Prop.Liab.Malpractice			31,940	31,940		31,940	586	32,526			26
27	Other (specify):*			(1,818,241)	(1,818,241)		(1,818,241)	1,818,241				27
28	TOTAL General Administration	100,856	9,628	(1,444,286)	(1,333,802)	933	(1,332,869)	1,911,613	578,744			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,461,137	237,502	(1,234,473)	464,166		464,166	1,904,337	2,368,503			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 DOUGLAS NURSING REHAB CENTER #0046250 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			11,755	11,755		11,755	1,786	13,541			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,223	2,223		2,223	1,679	3,902			32
33	Real Estate Taxes			158,557	158,557		158,557	299	158,856			33
34	Rent-Facility & Grounds			595,825	595,825	2,963	598,788		598,788			34
35	Rent-Equipment & Vehicles			59,030	59,030	(2,963)	56,067		56,067			35
36	Other (specify):*											36
37	**TOTAL Ownership**			827,390	827,390		827,390	3,764	831,154			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,817	262,081	405,898		405,898		405,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,836	114,836		114,836		114,836			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		143,817	376,917	520,734		520,734		520,734			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,461,137	381,319	(30,166)	1,812,290		1,812,290	1,908,101	3,720,391			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 DOUGLAS NURSING REHAB CENTER # 0046250 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	(9,655)	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				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	(1,067)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,730)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	1,821,737	27		24
25	Fund Raising, Advertising and Promotional	(3,496)	27		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	(17,554)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 1,785,235		$	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)	122,866		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 122,866		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,908,101		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

DOUGLAS NURSING REHAB CENTER

ID# 0046250

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment Utilities	$ 274	5	1
2	Advertising	(16,884)	20	2
3	Chamber of Commerce (refund)	536	20	3
4	Employee Meal Income	575	2	4
5	Non Includable Real Estate Tax	(2,055)	33	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**	(17,554)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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	(492)	0	0	0	0	0	0	0	0	0	0	(492)	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	(9,381)	1,351	0	0	0	0	0	0	0	0	0	(8,030)	5
6	Maintenance	0	1,246	0	0	0	0	0	0	0	0	0	1,246	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,873)	2,597	0	0	0	0	0	0	0	0	0	(7,276)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	83,564	0	0	0	0	0	0	0	0	0	83,564	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,730)	1,591	466	0	0	0	0	0	0	0	0	(2,673)	19
20	Fees, Subscriptions & Promotions	(16,348)	124	0	0	0	0	0	0	0	0	0	(16,224)	20
21	Clerical & General Office Expenses	0	6,193	400	0	0	0	0	0	0	0	0	6,593	21
22	Employee Benefits & Payroll Taxes	0	20,044	0	0	0	0	0	0	0	0	0	20,044	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	258	0	0	0	0	0	0	0	0	0	258	24
25	Other Admin. Staff Transportation	0	1,224	0	0	0	0	0	0	0	0	0	1,224	25
26	Insurance-Prop.Liab.Malpractice	0	586	0	0	0	0	0	0	0	0	0	586	26
27	Other (specify):*	1,818,241	0	0	0	0	0	0	0	0	0	0	1,818,241	27
28	**TOTAL General Administration**	1,797,163	113,584	866	0	0	0	0	0	0	0	0	1,911,613	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	1,787,290	116,181	866	0	0	0	0	0	0	0	0	1,904,337	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 **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	0	0	1,786	0	0	0	0	0	0	0	0	1,786	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,679	0	0	0	0	0	0	0	0	1,679	32
33	Real Estate Taxes	(2,055)	0	2,354	0	0	0	0	0	0	0	0	299	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	(2,055)	0	5,819	0	0	0	0	0	0	0	0	3,764	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)	1,785,235	116,181	6,685	0	0	0	0	0	0	0	0	1,908,101	45

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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	37.5	SALEM	HI CARE	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	37.5	37.5	EFFINGHAM	MANAGEMENT		
MORRIS ESFORMES	15	15				
SANDRA SEGAL	10	10		H&I PROPERTIES	SPRINGFIELD	REAL ESTATE

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		$	$	1
2	V	6	MAINTENANCE		HI CARE MANAGEMENT		1,246	1,246	2
3	V	5	UTILITIES		HI CARE MANAGEMENT		1,351	1,351	3
4	V	10	NURSING		HI CARE MANAGEMENT				4
5	V	17	ADMINISRATION		HI CARE MANAGEMENT		83,564	83,564	5
6	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		6,193	6,193	6
7	V	19	PROFESSIONAL SVCS		HI CARE MANAGEMENT		1,591	1,591	7
8	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		124	124	8
9	V	24	TRAINING AND EDUCATION		HI CARE MANAGEMENT		258	258	9
10	V	25	TRAVEL		HI CARE MANAGEMENT		1,224	1,224	10
11	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		586	586	11
12	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT		20,044	20,044	12
13	V								13
14	Total			$			$ 116,181	$ * 116,181	14

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

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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)		$ 1,786	$ 1,786	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		1,679	1,679	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		2,354	2,354	17
18	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		400	400	18
19	V	19	PROFESSIONAL SVCS		H&I PROPERTIES (HOME OFFICE)		466	466	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			$			$ 6,685	$ * 6,685	39

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

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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	39,601	8.084	0.20	SALARY	$ 10,030	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	37.50	28,497	8.084	0.20	SALARY	7,218	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	11,527	8.084	0.20	SALARY	2,919	17-7	3
4	DEREK HEDGES	VP OPERATIONS	VP OPERATIONS	0.00	82,597	8.084	0.20	SALARY	20,919	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	$ 41,086		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 NURSING REHAB CENTER # 0046250 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	14,341	$ 1,246	1
2	5	UTILITIES	PER RESIDENT DAY	70,964	3	6,687		14,341	1,351	2
3	10	NURSING	PER RESIDENT DAY	70,964	3			14,341	0	3
4	17	ADMINISTRATION	PER RESIDENT DAY	70,964	3	413,504	413,504	14,341	83,564	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	70,964	3	30,644		14,341	6,193	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	70,964	3	7,872		14,341	1,591	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	70,964	3	614		14,341	124	7
8	24	TRAINING AND EDUCATION	PER RESIDENT DAY	70,964	3	1,279		14,341	258	8
9	25	TRAVEL	PER RESIDENT DAY	70,964	3	6,059		14,341	1,224	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	70,964	3	2,900		14,341	586	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	70,964	3	99,186		14,341	20,044	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		$ 116,181	25

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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) 528-3412

	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	30	DEPRECIATION	PER LICENSE BED	319	3	$ 7,212	$	79	$ 1,786	1
2	32	INTEREST	PER LICENSE BED	319	3	6,778		79	1,679	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	319	3	9,505		79	2,354	3
4	21	OFFICE EXPENSE	PER LICENSE BED	319	3	1,614		79	400	4
5	19	PROFESSIONAL SVCS	PER LICENSE BED	319	3	1,880		79	466	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	$		$ 6,685	25

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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 PROP)		X	MORTGAGE HOME OFFICE		06/29/2005	$	$		0.0425	$ 1,679	1
2												2
3	MEMBER LOAN	X		WORKING CAPITAL	INTEREST	07/18/2003	99,667	299,667	10/01/2023	0.0700	(1,512)	3
4	ALLIANCE LAUNDRY		X	LAUNDRY EQUIPMENT		03/20/2012	32,618	3,627	03/20/2018	0.0862	742	4
5												5
	Working Capital											
6	MB FINANCIAL BANK			WORKING CAPITAL	INTEREST	REVOLV			2/15/2017	PRIME +	2,993	6
7												7
8												8
9	TOTAL Facility Related						$ 132,285	$ 303,294			$ 3,902	9
	B. Non-Facility Related*											
10	Omega Healthcare		X	WORKING CAPITAL		05/01/2013	305,613	283,006	05/01/2020	0.0800		10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 305,613	$ 283,006			$	14
15	TOTALS (line 9+line14)						$ 437,898	$ 586,300			$ 3,902	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 DOUGLAS NURSING REHAB CENTER # 0046250 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.**	$	30,064	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.)	$	99,012	2
3. Under or (over) accrual (line 2 minus line 1).	$	68,948	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	89,908	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.	$	158,856	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	26,409	8
	2013	25,737	9
	2014	26,780	10
	2015	27,432	11
	2016	99,012	12

	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 DOUGLAS NURSING REHAB CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0046250

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

TELEPHONE (217) 528-2244 FAX #: (217) 528-3412

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.	07-1-00300-000	NURSING HOME	$ 96,143.32	$ 96,143.32
2.	07-1-00572-000	NURSING HOME	$ 514.74	$ 514.74
3.	22-03.0-107-017	HOME OFFICE	$ 3,757.50	$ 940.00
4.	22-03.0-107-018	HOME OFFICE	$ 5,653.08	$ 1,414.00
5.	07-1-00300-001	DUPLEX	$ 2,054.98	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 108,123.62	$ 99,012.06

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 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 DOUGLAS NURSING REHAB CENTER # 0046250 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,116 B. General Construction Type: Exterior MASONARY Frame STEEL 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	HOME OFFICE		2005	$ 14,364	1
2					2
3	TOTALS			$ 14,364	3

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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	OFFC BLD		2005		65,106	1,786	39	1,786			8
	Improvement Type**										
9	INSULATION			2004	10,441	380	27.5	380		5,081	9
10	REPLACE HEAT & CHILL LINES			2005	3,245	118	27.5	118		1,421	10
11	COMPRESSOR REPAIR			2006	14,696	534	27.5	534		6,032	11
12	GENERATOR (1 OF 2)			2008	2,670	97	27.5	97		902	12
13	DRAPES			2008	3,962		5			3,962	13
14	PAINTING & WALL VINYL			2008	8,203		5			8,203	14
15	COMPRESSOR REPAIR			2009	19,021	691	27.5	691		5,787	15
16	INSTALL SPRINKLERS IN REST ROOM AND CLOSET			2009	6,877	250	27.5	250		2,095	16
17	ROOF TOP VENTILATING FANS			2009	4,251	155	27.5	155		1,299	17
18	PUMPS			2010	3,461	103	27.5	103		781	18
19	NEW BEARING AND SEALS ON FAN			2010	3,132	126	27.5	126		892	19
20	HOT WATER BOOSTER HEATER			2010	2,853	114	27.5	114		831	20
21	AC CIRCULATION PUMP			2011	3,415	124	27.5	124		823	21
22	WATER HEATER			2011	5,564	202	27.5	202		1,239	22
23											23
24	SEWER LINE REPAIRS			2012	8,350	304	27.5	304		1,531	24
25	THERAPY ROOM ADDITION AND UPGRAGE MECHANICALS			2013	1,237,453						25
26	(PAID BY LANDLORD)										26
27	ROOF REPLACEMENT PAID BY LANDLORD			2014	111,900						27
28	SEWER INSTALL FRONT OF BUILDING			2015	8,550	219	27.5	219		465	28
29	GENERATOR TIMER, CAT GENERATOR			2016	1,240	45	27.5	45		66	29
30	GENERATOR BACKUP PANELS			2017	4,620	45	27.5	45		45	30
31											31
32											32
33											33
34											34
35				2008	25,620						35
36	HOT WATER HEATER (PAID BY LANDLORD)			2008	7,923						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 DOUGLAS NURSING REHAB CENTER # 0046250 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)		$ 1,562,553	$ 5,293		$ 5,293	$	$ 41,455	70

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

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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	$ 118,762	$ 8,248	$ 8,248	$		$ 77,990	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 118,762	$ 8,248	$ 8,248	$		$ 77,990	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)	$ 1,695,679	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,541	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 119,445	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 DOUGLAS NURSING REHAB CENTER # 0046250 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: ELITE MATTOON

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:		79		$ 598,788			3
4	Additions							4
5								5
6								6
7	TOTAL		79		$ 598,788 **			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: $ 42,593 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	$ 816.00	$ 13,474	17
18					18
19					19
20					20
21	TOTAL		$ 816.00	$ 13,474	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 DOUGLAS NURSING REHAB CENTER # 0046250 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 DOUGLAS NURSING REHAB CENTER # 0046250 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 95,697	$		$ 95,697	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			47,109			47,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			119,275			119,275	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				143,817		143,817	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			$		$ 262,081	$ 143,817		$ 405,898	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 NURSING REHAB CENTER **#** 0046250 **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	$ 59,351	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 85,000)	528,842		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,547		6
7	Other Prepaid Expenses	1,688		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 597,428	$	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	102,386		15
16	Equipment, at Historical Cost	130,927		16
17	Accumulated Depreciation (book methods)	(139,949)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	33,237		21
22	Other Long-Term Assets (spe **Insurance**	19,750		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 146,351	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 743,779	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 653,408	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,515		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,782		31
32	Accrued Real Estate Taxes(Sch.IX-B)	98,713		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Advance Billing**	62,098		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 916,516	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	586,300		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Restricted RTF**	7,188		43
44	**Deferred Rent**	250,776		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 844,264	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,760,780	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,017,001)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 743,779	$	48

***(See instructions.)**

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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**	$ (2,244,701)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,244,701)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,227,700	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)**	$ 1,227,700	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,017,001)	24 *

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

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 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	$ 2,973,952	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,973,952	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,010	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 54,010	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***	28	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	12,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,039,990	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	585,049	31
32	Health Care	1,211,986	32
33	General Administration	(1,332,869)	33
	B. Capital Expense		
34	Ownership	827,390	34
	C. Ancillary Expense		
35	Special Cost Centers	405,898	35
36	Provider Participation Fee	114,836	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,812,290	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,227,700	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,227,700	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,190,708	44
45	Private Pay - Net Inpatient Revenue	505,894	45
46	Medicare - Net Inpatient Revenue	1,207,565	46
47	Other-(specify) Insurance	69,785	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,973,952	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 DOUGLAS NURSING REHAB CENTER # 0046250 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	1,968	2,064	$ 58,483	$ 28.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,419	4,481	121,951	27.22	3
4	Licensed Practical Nurses	12,110	12,972	269,986	20.81	4
5	CNAs & Orderlies	32,977	34,195	408,552	11.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,939	1,984	25,460	12.83	8
9	Activity Director	1,692	1,806	21,531	11.92	9
10	Activity Assistants	1,518	1,561	15,078	9.66	10
11	Social Service Workers	1,861	2,089	32,522	15.57	11
12	Dietician					12
13	Food Service Supervisor	2,405	2,484	35,192	14.17	13
14	Head Cook	5,404	5,505	52,729	9.58	14
15	Cook Helpers/Assistants	3,122	3,232	27,827	8.61	15
16	Dishwashers					16
17	Maintenance Workers	3,000	3,483	52,564	15.09	17
18	Housekeepers	8,555	9,072	86,881	9.58	18
19	Laundry	3,467	3,725	32,508	8.73	19
20	Administrator	1,800	1,955	63,511	32.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,859	2,150	37,345	17.37	23
24	Clerical					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	1,850	2,001	39,156	19.57	31
32	Other Health Care(specify)					32
33	Other(specify) MDS, Tranport	3,917	4,099	79,861	19.48	33
34	TOTAL (lines 1 - 33)	93,863	98,858	$ 1,461,137 *	$ 14.78	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	131	$ 6,380	1-3	35
36	Medical Director	76	6,000	9-3	36
37	Medical Records Consultant	24	1,772	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	91	1,392	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	68	8,658	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	81	3,523	11-3	44
45	Social Service Consultant	81	3,534	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	552	$ 31,259		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	24	884	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	24	$ 884		53

Facility Name & ID Number DOUGLAS NURSING REHAB CENTER # 0046250 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brenda Reed	Administrator	0	$ 63,511
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,511

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule		67,419
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 67,419

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,790
Unemployment Compensation Insurance	48,356
FICA Taxes	114,790
Employee Health Insurance	39,964
Employee Meals	933
Illinois Municipal Retirement Fund (IMRF)*	
401k	950
Post Screening	155
TOTAL (agree to Schedule V, line 22, col.8)	$ 239,938

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,151
Advertising: Employee Recruitment	2,126
Health Care Worker Background Check	
(Indicate # of checks performed 16)	776
Patient Background Checks 100	1,666
See Attached Schedule	4,555
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,274

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Seminars	543
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 543

**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. **($869)**

(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? **27.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,750** 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. $ **114,836**
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. $ **933** Has any meal income been offset against related costs? **NO** 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

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	Facility	Allocated	Total
Matrix Care	E-H-R	$ 20,883		$ 20,883
ESOLUTION	AR	$ 2,114		$ 2,114
INOVATICE LTC SOLUTIONS	BILLING	$ 1,679		$ 1,679
SMARTLINX	PAYROLL	$ 5,837		$ 5,837
TALX Corp	Unemployment	$ 598		$ 598
Benefit Planning Consult	401K Third Party Admin	$ -	$ 142	$ 142
WAGE WORKS	SECTION 125 COMP	$ -	$ 37	$ 37
MNS	BILLING Refund	$ (750)		$ (750)
RICHTER HEALTHCARE	BILLING	$ 26,124		$ 26,124
WILLIAM RADKEY	LEGAL	$ 1,628		$ 1,628
GROTEFELD HOFFMAN	LEGAL	$ -		$ -
Sikich	Accounting	$ 7,249	$ 1,878	$ 9,127
TOTALS		$ 65,362	$ 2,057	$ 67,419

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	Facility	Allocated	Total	
IHCA	DUES	$ (869)		$ (869)	Refund
Ability Network	CAREWATCH	$ 4,300	$ 40	$ 4,340	
CLIA Lab	FEES	$ 150		$ 150	
MEDPASS	SUBSCRIPTION	$ -	$ 84	$ 84	
ILLINOIS SECRETARY OF STAT	FEES	$ 455		$ 455	
COLES COUNTY HEALTH DEPT	FOOD PERMIT	$ 300		$ 300	
Illinois State Fire Marshall	Fees	$ 95	$ -	$ 95	
TOTALS		$ 4,431	$ 124	$ 4,555	

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

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

TOTAL FOOD PURCHASE	$ 106,735	
LESS SALES TAX	$ (1,067)	
NET FOOD	$ 105,668	
TOTAL PATIENT CENSUS	14,341	
MEALS PER DAY	3	
TOTAL PATIENT MEALS	43,023	
TOTAL EMPLOYEE MEALS	383	
TOTAL MEALS PER YEAR	43,406	
COST PER MEAL	$ 2.43	
TOTAL EMPLOYEE MEAL COST	$ 933	Reclassified to Employee Benefits

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
Dishwasher	$ 185
POSTAGE MACHINE	$ -
COPIER	$ 6,590
Desktop computers	$ 11,010
IV PUMPS	$ 2,375
Wound Care	$ 6,876
Defibulator	$ 3,000
BEDS/MATTRESS	$ 12,557
TOTAL	$ 42,593

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
COST REPORT PERIOD ENDING 12/31/17

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	Facility	Allocated	Total
TRANSPORT VAN FUEL AND REPAIRS	$ 4,034		$ 4,034
OTHER FACILITY STAFF	$ 529		$ 529
BRENDA REED Administrator	$ 242		$ 242
CORPORATE TRAVEL	$ -	$ 1,224	$ 1,224
Total	$ 4,805	$ 1,224	$ 6,029

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULE VII
C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
REPORT PERIOD ENDING 12/31/2017

FACILITY ID	0046417	0046235	
	EVERGREEN	DOCTORS	TOTAL
NAME	NURSING AND REHAB	NURSING AND REHAB	OTHER
ROBERT HEDGES	$ 19,921	$ 19,680	$ 39,601
WILLIAM IRVINE	$ 14,336	$ 14,162	$ 28,498
MARTHA IRVINE	$ 5,798	$ 5,728	$ 11,526
DEREK HEDGES	$ 41,550	$ 41,047	$ 82,597
	$ 81,605	$ 80,617	$ 162,222

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
Schedule of Reclassification
REPORT PERIOD ENDING 12/31/2017

From	To	Amount	Description
Rent Equipment	Rent Facility	$ 2,963	Reclass facility rent miss-coded