

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	79	Skilled (SNF)	79	28,835	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,835	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	114	31	1,800	1,945	8
9	SNF/PED					9
10	ICF	15,675	4,702		20,377	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,789	4,733	1,800	22,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.41%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 03/01/03

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 79 and days of care provided 1,800

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **DOUGLAS REHABILITATION & CARE C** # **0046250** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	121,526	5,552	4,347	131,425		131,425	0	131,425		1
2	Food Purchase		87,797		87,797	(7,008)	80,789	(296)	80,493		2
3	Housekeeping	53,680	10,694	0	64,374		64,374	0	64,374		3
4	Laundry	25,052	6,399	42	31,493	0	31,493	0	31,493		4
5	Heat and Other Utilities			112,499	112,499		112,499	959	113,458		5
6	Maintenance	53,871	1,685	20,533	76,089		76,089	5,164	81,253		6
7	Other (specify):*			13,790	13,790		13,790	0	13,790		7
8	TOTAL General Services	254,129	112,127	151,211	517,467	(7,008)	510,459	5,827	516,286		8
	B. Health Care and Programs										
9	Medical Director	0		330	330		330	0	330		9
10	Nursing and Medical Records	1,013,622	59,281	6,742	1,079,645		1,079,645	0	1,079,645		10
10a	Therapy	19,624		0	19,624		19,624	0	19,624		10a
11	Activities	73,176	1,104	0	74,280		74,280	0	74,280		11
12	Social Services	29,340		3,695	33,035		33,035	0	33,035		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			3,477	3,477		3,477	0	3,477		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,135,762	60,385	14,244	1,210,391	0	1,210,391	0	1,210,391		16
	C. General Administration										
17	Administrative	58,078		149,253	207,331		207,331	(87,382)	119,949		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			68,371	68,371		68,371	(23,332)	45,039		19
20	Dues, Fees, Subscriptions & Promotions			15,938	15,938		15,938	(6,762)	9,176		20
21	Clerical & General Office Expenses	77,716	8,375	79,676	165,767		165,767	(61,237)	104,530		21
22	Employee Benefits & Payroll Taxes			195,841	195,841	7,008	202,849	0	202,849		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			2,793	2,793		2,793	500	3,293		24
25	Other Admin. Staff Transportation			6,020	6,020		6,020	(1,430)	4,590		25
26	Insurance-Prop.Liab.Malpractice			47,019	47,019		47,019	1,837	48,856		26
27	Other (specify):*			9,896	9,896		9,896	5,073	14,969		27
28	TOTAL General Administration	135,794	8,375	574,807	718,976	7,008	725,984	(172,733)	553,251		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,525,685	180,887	740,262	2,446,834	0	2,446,834	(166,906)	2,279,928		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,347
	REPAIRS & MAINTENANCE	0
		0
		4,347
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	42
		0
		42
5	HEAT & OTHER UTILITIES	
	GAS HEAT	41,057
	ELECTRICITY	31,614
	WATER	33,267
	CABLE TV - LOBBY	6,561
		0
		112,499
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,449
	PAINTING & DECORATING	718
	BUILDING REPAIRS	5,874
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	7,342
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,958
	FIRE SERVICE	3,192
		0
		0
		0
		0
		20,533
7	OTHER	
	SCAVENGER	13,790
	SECURITY SERVICE	0
		0
		0
		13,790
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	330
		330

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	4,394
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,348
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		6,742
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	271
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,424
		0
		3,695
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	3,477
		3,477
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	149,253
		149,253
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,708
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	60,663
		0
		68,371
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,274
	EMPLOYEE WANT ADS XIX F	1,256
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	6,036
	LICENSES & PERMITS XIX F	250
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	736
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	554
	PATIENT BACKGROUND CHECKS XIX F	832
		15,938
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,630
	EQUIPMENT REPAIR & MAINTENANCE	121
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,461
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,464
	MESSENGER SERVICE	0
		0
		79,676

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	115,859
	UNEMPLOYMENT COMPENSATION XIX D	21,214
	WORKERS COMPENSATION INSURANC XIX D	40,899
	HOSPITALIZATION INSURANCE XIX D	10,549
	EMPLOYEE BENEFITS - OTHER XIX D	2,091
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,229
	CHICAGO HEAD TAX XIX D	0
		0
		195,841
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	2,793
	TRAVEL XIX G	0
		2,793
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	6,020
		6,020
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	47,019
		47,019
27	OTHER	
	BAD DEBTS VI 24	9,896
		9,896

GRAND TOTAL COLUMN 3 OTHER

740,262

DOUGLAS REHABILITATION & CARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	87,797	PATIENT MEALS	66966
LESS SALES TAX	(296)	ADD EMPLOYEE MEALS	5840
	-----		-----
NET FOOD	87,501	TOTAL MEALS/YEAR	72806
TOTAL PATIENT CENSUS	22,322	NET FOOD	87501
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	72806

TOTAL PATIENT MEALS	66966	COST PER MEAL	1.2
		TIME EMPLOYEE MEALS	5840
ADD # EMPLOYEE MEALS/DAY	16		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	7008
	-----		=====
TOTAL EMPLOYEE MEALS	5840		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			3,033	3,033		3,033	(330)	2,703		30
31	Amortization of Pre-Op. & Org.			1,400	1,400		1,400	0	1,400		31
32	Interest			33,168	33,168		33,168	(644)	32,524		32
33	Real Estate Taxes			35,200	35,200		35,200	534	35,734		33
34	Rent-Facility & Grounds			367,647	367,647		367,647	0	367,647		34
35	Rent-Equipment & Vehicles			14,344	14,344		14,344	0	14,344		35
36	Other (specify):* amort software			1,286	1,286		1,286	0	1,286		36
37	TOTAL Ownership			456,078	456,078	0	456,078	(440)	455,638		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		50,644	177,740	228,384		228,384	0	228,384		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			43,253	43,253		43,253	0	43,253		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	50,644	220,993	271,637	0	271,637	0	271,637		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,525,685	231,531	1,417,333	3,174,549	0	3,174,549	(167,346)	3,007,203		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,163)	30		9
10	Interest and Other Investment Income	(2,842)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(296)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(1,461)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,896)	27		24
25	Fund Raising, Advertising and Promotional	(6,274)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(736)	20		28
29	Other-Attach Schedule	(46,364)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,032)		\$ 0	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(98,314)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,314)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (167,346)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

STATE OF ILLINOIS
DOUGLAS REHABILITATION & CARE CENTER

ID# 0046250

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING TRAVEL	\$ (2,668)	25	1
2	MARKETING SALARIES	(12,260)	21	2
3	BANK CHARGES	(5,630)	21	3
4	HEALTHCARE HORIZONS	(21,000)	19	4
5	ELITE CORP	(4,806)	19	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	(46,364)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(296)	0	0	0	0	0	0	0	0	0	0	(296)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	959	0	0	0	0	0	0	0	0	0	959	5
6	Maintenance	0	5,164	0	0	0	0	0	0	0	0	0	5,164	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(296)	6,123	0	5,827	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	(87,382)	0	0	0	0	0	0	0	0	0	(87,382)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25,806)	2,474	0	0	0	0	0	0	0	0	0	(23,332)	19
20	Fees, Subscriptions & Promotions	(7,010)	248	0	0	0	0	0	0	0	0	0	(6,762)	20
21	Clerical & General Office Expenses	(19,351)	(41,886)	0	0	0	0	0	0	0	0	0	(61,237)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	500	0	0	0	0	0	0	0	0	0	500	24
25	Other Admin. Staff Transportation	(2,668)	1,238	0	0	0	0	0	0	0	0	0	(1,430)	25
26	Insurance-Prop.Liab.Malpractice	0	1,837	0	0	0	0	0	0	0	0	0	1,837	26
27	Other (specify):*	(9,896)	14,969	0	0	0	0	0	0	0	0	0	5,073	27
28	TOTAL General Administration	(64,731)	(108,002)	0	(172,733)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(65,027)	(101,879)	0	(166,906)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(1,163)	0	833	0	0	0	0	0	0	0	0	(330)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,842)	0	2,198	0	0	0	0	0	0	0	0	(644)	32
33	Real Estate Taxes	0	0	534	0	0	0	0	0	0	0	0	534	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	(4,005)	0	3,565	0	(440)	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)	(69,032)	(101,879)	3,565	0	(167,346)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				HI CARE		
				MANAGEMENT	SPRINGFIELD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				HI CARE	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 149,253	HI CARE MANAGEMENT		\$	\$ (149,253)	1
2	V	21 HOME OFFICE EXPENSE	60,000				(60,000)	2
3	V	5 UTILITIES				959	959	3
4	V	6 MAINTENANCE				5,164	5,164	4
5	V	17 ADMINISTRATIVE				61,871	61,871	5
6	V	19 PROFESSIONAL FEES				2,474	2,474	6
7	V	20 DUES & SUBSCRIPTION				248	248	7
8	V	21 OFFICE EXPENSE				18,114	18,114	8
9	V	24 TRAVEL SEMINARS				500	500	9
10	V	25 TRANSPORTATION				1,238	1,238	10
11	V	26 INSURANCE				1,837	1,837	11
12	V	27 PAYROLL TAXES & GRP INS				14,969	14,969	12
13	V							13
14	Total		\$ 209,253			\$ 107,374	\$ * (101,879)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 DEPRECIATION	\$	H & I PROPERTIES (HOME OFFICE)		\$ 833	\$ 833	15
16	V	32 INTEREST				2,198	2,198	16
17	V	33 REAL ESTATE				534	534	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 3,565	\$ * 3,565	39

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

Facility Name & ID Number **DOUGLAS REHABILITATION & CARE C** # **0046250** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.					SALARY	\$ 20,523	17-7	1
2	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										2
3											3
4	WILLIAM IRVINE	VICE-PRESIDENT	OFFICE MGMT.					SALARY	20,523	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	1,040	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$8,615										8
9	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	3,259	17-7	9
10	TOTAL SALARY RECEIVED FROM HI CARE \$27,000										10
11											11
12											12
13								TOTAL	\$ 45,345		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER # 0046250 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PER RESIDENT DAY	184,904	7	\$ 7,946	22,322	\$ 959	1	
2	6	MAINTENANCE	PER RESIDENT DAY	184,904	7	42,775	36,113	22,322	5,164	2
3	17	OFFICER SALARY	PER RESIDENT DAY	184,904	7	340,000	340,000	22,322	41,046	3
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	184,904	7	68,050	68,050	22,322	8,215	4
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	184,904	7	77,460	77,460	22,322	9,351	5
6	17	SPECIAL PROJECTS MNGR	PER RESIDENT DAY	184,904	7	27,000	27,000	22,322	3,259	6
7	19	PROFESSIONAL FEES	PER RESIDENT DAY	184,904	7	20,492		22,322	2,474	7
8	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	184,904	7	2,057		22,322	248	8
9	21	OFFICE EXPENSE	PER RESIDENT DAY	184,904	7	150,049	112,536	22,322	18,114	9
10	24	TRAVEL &SEMINARS	PER RESIDENT DAY	184,904	7	4,140		22,322	500	10
11	25	TRANSPORTATION	PER RESIDENT DAY	184,904	7	10,252		22,322	1,238	11
12	26	INSURANCE	PER RESIDENT DAY	184,904	7	15,218		22,322	1,837	12
13	27	PAYROLL TAXES &GRP INS	PER RESIDENT DAY	184,904	7	123,996		22,322	14,969	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					\$ 889,435	\$ 661,159		\$ 107,374	25

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER # 0046250 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	639	7	\$ 6,741	\$ 0	79	\$ 833	1
2	32	INTEREST	639	7	17,780	0	79	2,198	2
3	33	REAL ESTATE	639	7	4,317	0	79	534	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 28,838	\$		\$ 3,565	25

Facility Name & ID Number

DOUGLAS REHABILITATION & CARE C

0046250

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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 -(HI - PROP)		X	MORTGAGE (OFFICE)		6/29/05	\$	\$	6/29/12	0.0635	\$ 2,198	1								
2												2								
3												3								
4												4								
5	MEMBER LOANS	X		WORKING CAPITAL	INTEREST		100,000	100,000	DEMAND		7,000	5								
Working Capital																				
6	ILLINI BANK		X	WORKING CAPITAL	INTEREST	REVOLV		176,060	REVOLV	PRIME +	22,438	6								
7	ILLINI BANK		X	WORKING CAPITAL	1580 + INT	9/25/03	75,000	37,601	9/25/08	0.0964	3,730	7								
8												8								
9	TOTAL Facility Related						\$ 175,000	\$ 313,661			\$ 35,366	9								
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES								10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14								
15	TOTALS (line 9+line14)						\$ 175,000	\$ 313,661			\$ 35,366	15								

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	\$	32,670	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.)	\$	33,434	2
3. Under or (over) accrual (line 2 minus line 1).	\$	764	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	34,436	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.	\$	35,200	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001		8
	2002	35,123	9
	2003	30,417	10
	2004	32,669	11
	2005	33,434	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOUGLAS REHABILITATION & CARE CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0046250

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-1-00300-000</u>	<u>NURSING HOME</u>	\$ <u>31,051.98</u>	\$ <u>31,051.98</u>
2. <u>07-1-00300-001</u>	<u>NURSING HOME</u>	\$ <u>2,017.64</u>	\$ <u>2,017.64</u>
3. <u>07-1-00572-000</u>	<u>NURSING HOME</u>	\$ <u>364.02</u>	\$ <u>364.02</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>33,433.64</u>	\$ <u>33,433.64</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: 7,000 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 1,400 4. Dates Incurred: 03/01/03

Nature of Costs: LEGAL 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	<u>OFFICE BUILDING</u>			\$ <u>7,192</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ <u>7,192</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	INSULATION		2004	10,441	380	27.5	380		903
10	REPLACE HEAT & CHILL LINES		2005	3,245	118	27.5	118		123
11	COMPRESSOR		2006	14,696	156	27.5	156		156
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23	H & I PROPERTIES - OFFICE BUILDING		2005	32,513	833	39	833		1,479
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			60,895		1,487		0	2,661

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 11,287	\$ 2,031	\$ 1,129	\$ (902)		\$ 2,399	71
72	Current Year Purchases	1,738	348	87	(261)		87	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 13,025	\$ 2,379	\$ 1,216	\$ (1,163)		\$ 2,486	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 81,112	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,866	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,703	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,163)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,147	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ELITE MATTOON LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		79	2/28/03	\$ 367,647	10		3
4	Additions							4
5								5
6								6
7	TOTAL		79		\$ 367,647			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,344 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning 2/28/03

Ending 2/28/13

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2007 \$ 367,647

13. /2008 \$ 367,647

14. /2009 \$ 367,647

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 66,596	\$		\$ 66,596	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			24,833			24,833	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			86,311			86,311	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				50,644		50,644	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 177,740	\$ 50,644		\$ 228,384	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 32,075	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (35,000))	526,323		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,118		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	20,000		8
9	Other(specify): <u>R/E ESCROW DEPOSIT</u>	36,901		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 663,417	\$ 0	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	28,382		15
16	Equipment, at Historical Cost	36,170		16
17	Accumulated Depreciation (book methods)	(32,917)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,367)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 33,268	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 696,685	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 555,423	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	249,739		29
30	Accrued Salaries Payable	53,588		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,009		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,436		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 917,195	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	100,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,017,195	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (320,510)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 696,685	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (184,790)	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (184,789)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(135,721)	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)	\$ (135,721)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (320,510)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,887,307	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,887,307	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	133,940	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 133,940	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	8,886	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)	\$ 8,886	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,842	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,842	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	LAWSUIT SETTLEMENT	(4,588)	28
28a	adjust prior year expense	10,441	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,853	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,038,828	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	517,467	31
32	Health Care	1,210,391	32
33	General Administration	718,976	33
B. Capital Expense			
34	Ownership	456,078	34
C. Ancillary Expense			
35	Special Cost Centers	228,384	35
36	Provider Participation Fee	43,253	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,174,549	40
41	Income before Income Taxes (line 30 minus line 40)**	(135,721)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (135,721)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,055	2,493	\$ 68,291	\$ 27.39	1
2	Assistant Director of Nursing	1,821	2,356	58,763	24.94	2
3	Registered Nurses	2,164	2,263	45,306	20.02	3
4	Licensed Practical Nurses	15,854	17,478	279,285	15.98	4
5	CNAs & Orderlies	42,561	46,397	490,704	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,577	1,734	19,624	11.32	8
9	Activity Director	1,692	1,928	20,632	10.70	9
10	Activity Assistants	4,941	5,463	52,544	9.62	10
11	Social Service Workers	1,707	1,948	29,340	15.06	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,080	30,239	14.54	13
14	Head Cook	5,164	5,619	44,912	7.99	14
15	Cook Helpers/Assistants	5,879	6,270	46,375	7.40	15
16	Dishwashers					16
17	Maintenance Workers	3,542	4,036	53,871	13.35	17
18	Housekeepers	6,754	7,489	53,680	7.17	18
19	Laundry	3,530	3,702	25,052	6.77	19
20	Administrator	1,824	2,080	58,078	27.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,080	36,602	17.60	23
24	Clerical	3,259	3,533	41,114	11.64	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	814	814	8,265	10.15	31
32	Other Health C: <u>central sup, mds</u>	3,352	3,915	63,008	16.09	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,466	123,678	\$ 1,525,685 *	\$ 12.34	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	115	\$ 4,347	1-3	35
36	Medical Director	2	330	9-3	36
37	Medical Records Consultant	45	2,348	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	44	3,424	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	206	\$ 10,449		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DIANNA SPENCE	ADMINISTRATOR	0.00%	\$ 58,078	Workers' Compensation Insurance	\$ 40,899	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	21,214	Advertising: Employee Recruitment	1,256	
				FICA Taxes	115,859	Health Care Worker Background Check	554	
				Employee Health Insurance	10,549	(Indicate # of checks performed <u>33</u>)		
				Employee Meals	7,008	Patient Background Checks	52	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	2,091	MARKETING/ADV/PROMO	7,010	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	6,286	
				PENSION/PROFIT SHARING PLANS	5,229	MGMT CO ALLOC	248	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(6,274)	
						Yellow page advertising	(736)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,078	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 202,849		\$ 9,176		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
HI CARE MANAGEMENT			\$ 149,253			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 149,253				Seminar Expense	2,793
							MGMT ALLOC	500
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount	\$			()	
ACHIEVE SOFTWARE	DATA PROCESSING		\$ 7,354				(agree to Sch. V, line 24, col. 8)	
IVANS	DATA PROCESSING		354				TOTAL	
KBKB	ACCOUNTING		17,750				\$ 3,293	
RICHARD PEELO	MEDICARE CONSULTANT		3,000					
STRATTON GIGANTIST	LEGAL		2,244					
PERSONNEL PLANNERS	U/C ONSULTANT		90					
HEALTHCARE HORIZONS	MEDICARE / MEDICAID		21,000					
SYSTEMATIC MANAGEMENT	MED B BILLING		11,773					
ELITE CARE CORP	ENVIRONMENTAL CONSULTI		4,806					
SEE SCHEDULE ATTACHED								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 68,371					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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?
If YES, give association name and amount. IL HEALTH CARE ASSOC \$4,334
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO 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. \$ 43,253
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 7,008 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees