

Facility Name & ID Number DOCTORS NURSING & REHAB CENTER

0046235 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	8,101	1,352	7,810	17,263	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD	18,028	4,099		22,127	11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	26,129	5,451	7,810	39,390	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.93%

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

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/01/93

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 120 and days of care provided 7,482

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **DOCTORS NURSING & REHAB CENTER** # **0046235** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	149,051	18,045	11,649	178,745		178,745		178,745		1
2	Food Purchase		155,800		155,800		155,800	(259)	155,541		2
3	Housekeeping	77,042	23,382		100,424		100,424		100,424		3
4	Laundry	55,883	16,830		72,713		72,713		72,713		4
5	Heat and Other Utilities			143,493	143,493		143,493	1,851	145,344		5
6	Maintenance	40,394	15,422	26,743	82,559		82,559	8,815	91,374		6
7	Other (specify):*			13,761	13,761		13,761		13,761		7
8	TOTAL General Services	322,370	229,479	195,646	747,495		747,495	10,407	757,902		8
	B. Health Care and Programs										
9	Medical Director			23,400	23,400		23,400		23,400		9
10	Nursing and Medical Records	1,730,662	213,749	66,071	2,010,482		2,010,482		2,010,482		10
10a	Therapy	195,119			195,119		195,119		195,119		10a
11	Activities	42,790	7,599		50,389		50,389		50,389		11
12	Social Services	43,850		5,024	48,874		48,874		48,874		12
13	CNA Training										13
14	Program Transportation			41,414	41,414		41,414		41,414		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,012,421	221,348	135,909	2,369,678		2,369,678		2,369,678		16
	C. General Administration										
17	Administrative	89,264		411,903	501,167		501,167	(295,306)	205,861		17
18	Directors Fees										18
19	Professional Services			153,791	153,791		153,791	(118,985)	34,806		19
20	Dues, Fees, Subscriptions & Promotions			29,342	29,342		29,342	(11,428)	17,914		20
21	Clerical & General Office Expenses	112,688	14,438	141,071	268,197		268,197	(97,086)	171,111		21
22	Employee Benefits & Payroll Taxes			367,997	367,997		367,997		367,997		22
23	Inservice Training & Education			2,076	2,076		2,076		2,076		23
24	Travel and Seminar							1,269	1,269		24
25	Other Admin. Staff Transportation			14,635	14,635		14,635	(6,008)	8,627		25
26	Insurance-Prop.Liab.Malpractice			73,346	73,346		73,346	3,409	76,755		26
27	Other (specify):*			28,184	28,184		28,184	(178)	28,006		27
28	TOTAL General Administration	201,952	14,438	1,222,345	1,438,735		1,438,735	(524,313)	914,422		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,536,743	465,265	1,553,900	4,555,908		4,555,908	(513,906)	4,042,002		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	11,649
	REPAIRS & MAINTENANCE	0
		0
		11,649
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	45,294
	ELECTRICITY	58,010
	WATER	34,867
	CABLE TV - LOBBY	5,322
		0
		143,493
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,455
	PAINTING & DECORATING	173
	BUILDING REPAIRS	10,130
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,404
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,560
	FIRE SERVICE	2,021
		0
		0
		0
		0
		26,743
7	OTHER	
	SCAVENGER	13,761
	SECURITY SERVICE	0
		0
		0
		13,761
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	23,400
		23,400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	52,373
	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	2,046
	PHARMACY CONSULTANT XVIII B 39-2	4,392
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	7,260
		0
		0
		66,071
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 CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	5,024
		0
		5,024
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	41,414
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	411,903
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	9,469
	ADMINISTRATIVE CONSULTANTS XIX C	72,960
	PROFESSIONAL FEES XIX C	71,362
		0
		153,791
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	11,779
	EMPLOYEE WANT ADS XIX F	576
	CONTRIBUTIONS VI 20 XIX F	525
	DUES & SUBSCRIPTIONS XIX F	10,936
	LICENSES & PERMITS XIX F	2,518
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,216
	PATIENT BACKGROUND CHECKS XIX F	1,792
		29,342
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,612
	EQUIPMENT REPAIR & MAINTENANCE	263
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	957
	HOME OFFICE EXPENSE	120,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,239
	MESSENGER SERVICE	0
		0
		141,071

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	193,510
	UNEMPLOYMENT COMPENSATION XIX D	37,859
	WORKERS COMPENSATION INSURANC XIX D	109,625
	HOSPITALIZATION INSURANCE XIX D	7,670
	EMPLOYEE BENEFITS - OTHER XIX D	7,354
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	11,979
	CHICAGO HEAD TAX XIX D	0
		0
		367,997
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,076
		2,076
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	14,635
		14,635
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	73,346
		73,346
27	OTHER	
	BAD DEBTS VI 24	28,184
		28,184

GRAND TOTAL COLUMN 3 OTHER

1,553,900

**DOCTORS NURSING & REHAB CENTER
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	155,800
LESS SALES TAX	<u>(259)</u>
NET FOOD	155,541

TOTAL PATIENT CENSUS	39,390
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	118,170

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

PATIENT MEALS	118,170
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	118,170

NET FOOD	155,541
DIVIDE TOTAL MEALS/YEAR	<u>118,170</u>

COST PER MEAL	1.32
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number **DOCTORS NURSING & REHAB CENTER**

#0046235

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			19,071	19,071		19,071	(3,786)	15,285			30
31	Amortization of Pre-Op. & Org.			1,400	1,400		1,400		1,400			31
32	Interest			16,226	16,226		16,226	(11,457)	4,769			32
33	Real Estate Taxes			42,297	42,297		42,297	1,448	43,745			33
34	Rent-Facility & Grounds			445,300	445,300		445,300		445,300			34
35	Rent-Equipment & Vehicles			129,696	129,696		129,696		129,696			35
36	Other (specify):*											36
37	TOTAL Ownership			653,990	653,990		653,990	(13,795)	640,195			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		374,567	575,602	950,169		950,169		950,169			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		374,567	641,302	1,015,869		1,015,869		1,015,869			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,536,743	839,832	2,849,192	6,225,767		6,225,767	(527,701)	5,698,066			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,052)	30		9
10	Interest and Other Investment Income	(13,071)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(259)	2		13
14	Non-Care Related Interest	(1,638)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(957)	21		18
19	Entertainment		20		19
20	Contributions	(525)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,772)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,184)	27		24
25	Fund Raising, Advertising and Promotional	(11,779)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(73,207)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (136,444)		\$	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)	(391,257)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (391,257)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (527,701)		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
DOCTORS NURSING & REHAB CENTER

ID# 0046235

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	STAFF TRANSPORTATION MARKETING	\$ (8,437)	25	1
2				2
3	MARKETING - SALARY	(19,770)	21	3
4	PROF FEES - HEALTHCARE HORIZONS	(45,000)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(73,207)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(259)	0	0	0	0	0	0	0	0	0	0	(259)	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	1,851	0	0	0	0	0	0	0	0	0	1,851	5
6	Maintenance	0	8,815	0	0	0	0	0	0	0	0	0	8,815	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(259)	10,666	0	10,407	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	(295,306)	0	0	0	0	0	0	0	0	0	(295,306)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(46,772)	(72,213)	0	0	0	0	0	0	0	0	0	(118,985)	19
20	Fees, Subscriptions & Promotions	(12,304)	876	0	0	0	0	0	0	0	0	0	(11,428)	20
21	Clerical & General Office Expenses	(20,727)	(76,359)	0	0	0	0	0	0	0	0	0	(97,086)	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	1,269	0	0	0	0	0	0	0	0	0	1,269	24
25	Other Admin. Staff Transportation	(8,437)	2,429	0	0	0	0	0	0	0	0	0	(6,008)	25
26	Insurance-Prop.Liab.Malpractice	0	3,409	0	0	0	0	0	0	0	0	0	3,409	26
27	Other (specify):*	(28,184)	28,006	0	0	0	0	0	0	0	0	0	(178)	27
28	TOTAL General Administration	(116,424)	(407,889)	0	(524,313)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(116,683)	(397,223)	0	(513,906)	29								

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(5,052)	0	1,266	0	0	0	0	0	0	0	0	(3,786)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,709)	0	3,252	0	0	0	0	0	0	0	0	(11,457)	32
33	Real Estate Taxes	0	0	1,448	0	0	0	0	0	0	0	0	1,448	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	(19,761)	0	5,966	0	(13,795)	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)	(136,444)	(397,223)	5,966	0	(527,701)	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				
				H & I PROPERTIES	SPRINGFIELD	REAL ESTATE
				HEALTHCARE	SPRINGFIELD	NURSE
				HORIZONS		CONSULTANT

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	\$ 411,903	HI CARE MANAGEMENT		\$	\$ (411,903)	1
2	V	19 ADMINISTRATIVE CONS	72,960				(72,960)	2
3	V	21 HOME OFFICE EXPENSE	120,000				(120,000)	3
4	V	5 UTILITIES				1,851	1,851	4
5	V	6 MAINTENANCE				8,815	8,815	5
6	V	17 ADMINISTRATIVE				116,597	116,597	6
7	V	19 PROFESSIONAL FEES				747	747	7
8	V	20 DUES & SUBSCRIPTION				876	876	8
9	V	21 OFFICE EXPENSE				43,641	43,641	9
10	V	24 TRAVEL & SEMINARS				1,269	1,269	10
11	V	25 TRANSPORTATION				2,429	2,429	11
12	V	26 INSURANCE				3,409	3,409	12
13	V	27 PAYROLL TAXES & GRP INS				28,006	28,006	13
14	Total		\$ 604,863			\$ 207,640	\$ * (397,223)	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)		\$ 1,266	\$ 1,266	15
16	V	32 INTEREST				3,252	3,252	16
17	V	33 REAL ESTATE				1,448	1,448	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		\$			\$ 5,966	\$ * 5,966	39

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

Facility Name & ID Number **DOCTORS NURSING & REHAB CENTER** # **0046235** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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.	37.50		SEE	ATTACHED	SALARY	\$ 35,215	17-7	1
2	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$165,000										2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	37.50		SEE	ATTACHED	SALARY	35,215	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$165,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING				SEE	ATTACHED	SALARY	3,083	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$14,446										8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR				SEE	ATTACHED	SALARY	15,540	17-7	10
11	TOTAL SALARY RECEIVED FROM HI CARE \$72,810										11
12											12
13								TOTAL	\$ 89,053		13

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

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

Facility Name & ID Number **DOCTORS NURSING & REHAB CENTER**

0046235

Report Period Beginning:

01/01/2007

Ending: **2/31/2007**

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	184,560	7	\$ 8,675	\$ 39,390	\$ 1,851	1
2	6	MAINTENANCE	PER RESIDENT DAY	184,560	7	41,300	37,474	39,390	8,815
3	17	OFFICER SALARY-B HEDGES	PER RESIDENT DAY	184,560	7	165,000	165,000	39,390	35,215
4	17	OFFICER SALARY-B. IRVINE	PER RESIDENT DAY	184,560	7	165,000	165,000	39,390	35,215
5	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	184,560	7	69,647	69,647	39,390	14,865
6	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	184,560	7	73,854	73,854	39,390	15,762
7	17	SPECIAL PROJ MNGR-DEREK	PER RESIDENT DAY	184,560	7	72,810	72,810	39,390	15,540
8	19	PROFESSIONAL FEES	PER RESIDENT DAY	184,560	7	3,500		39,390	747
9	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	184,560	7	4,105		39,390	876
10	21	OFFICE EXPENSE	PER RESIDENT DAY	184,560	7	204,479	141,575	39,390	43,641
11	24	TRAVEL & SEMINARS	PER RESIDENT DAY	184,560	7	5,945		39,390	1,269
12	25	TRANSPORTATION	PER RESIDENT DAY	184,560	7	11,383		39,390	2,429
13	26	INSURANCE	PER RESIDENT DAY	184,560	7	15,972		39,390	3,409
14	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	184,560	7	131,223		39,390	28,006
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 972,893	\$ 725,360	\$ 207,640	25

Facility Name & ID Number **DOCTORS NURSING & REHAB CENTER**

0046235

Report Period Beginning:

01/01/2007

Ending: **2/31/2007**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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	639	7	\$ 6,741	\$ 120	\$ 1,266	1
2	32	INTEREST	PER LICENSE BED	639	7	17,316	120	3,252	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	639	7	7,709	120	1,448	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 31,766	\$	\$ 5,966	25

Facility Name & ID Number **DOCTORS NURSING & REHAB CENTER**

0046235

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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																				
2																				
3	US BANK (HI PROP)		X	MORTGAGE (office)		6/29/05			6/29/12	0.0635	3,252									
4																				
5	MEMBER LOAN	X		WORKING CAPITAL			100,000	100,000			7,000									
Working Capital																				
6	ILLINI BANK		x	WORKING CAPITAL	\$2,017.00	9/25/03	100,000	17,982	9/25/08	0.0950	2,940									
7	MARINE BANK		x	BUS	\$594.00	5/19/04	19,500		6/19/07		48									
8	ILLINI BANK		X	WORKING CAPITAL	INTEREST	REVOLV		343,000	REVOLV	PRIME +	4,600									
9	TOTAL Facility Related				\$2,611.00		\$ 219,500	\$ 460,982			\$ 17,840									
B. Non-Facility Related*																				
10											1,638									
11																				
12																				
13																				
14	TOTAL Non-Facility Related						\$	\$			\$ 1,638									
15	TOTALS (line 9+line14)						\$ 219,500	\$ 460,982			\$ 19,478									

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 2006 report.	\$	41,717	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.)	\$	42,007	2
3. Under or (over) accrual (line 2 minus line 1).	\$	290	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	42,007	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.	\$	42,297	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	36,986	8
	2003	36,893	9
	2004	39,221	10
	2005	40,502	11
	2006	42,007	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOCTORS NURSING & REHAB CENTER COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0046235

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>11-03-000-004</u>	<u>NURSING HOME</u>	\$ <u>41,709.74</u>	\$ <u>41,709.74</u>
2. <u>11-03-400-003</u>	<u>NURSING HOME</u>	\$ <u>170.62</u>	\$ <u>170.62</u>
3. <u>11-03-400-004</u>	<u>NURSING HOME</u>	\$ <u>126.56</u>	\$ <u>126.56</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>42,006.92</u>	\$ <u>42,006.92</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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: _____

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				\$	1
2	OFFICE BUILDING		2005	10,904	2
3	TOTALS			\$ 10,904	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	WATER HEATER		2003	6,135	223	27.5	223		957
10	WATER HEATER		2004	8,145	296	27.5	296		1,126
11	TILING		2005	4,980	181	27.5	181		460
12	SIDEWALK		2005	6,300	420	15	210	(210)	630
13	WALL HEAT & A/C UNIT		2006	1,075	39	27.5	39		50
14	DOORS		2007	2,828	56	27.5	56		56
15	CARPETING		2007	23,768	4,754	5	4,754		4,754
16									
17									
18									
19									
20									
21									
22									
23	H & I PROPERTIES - OFFICE BUILDING		2005	49,376	1,266	39	1,266		3,513
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

**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	\$ 23,056	\$ 5,031	\$ 2,305	\$ (2,726)	10 YRS	\$ 5,254	71
72	Current Year Purchases	27,104	5,421	1,355	(4,066)	10 YRS	1,355	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 50,160	\$ 10,452	\$ 3,660	\$ (6,792)		\$ 6,609	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 CHEVY EXPRESS BUS	2004	\$ 23,000	\$ 2,650	\$ 4,600	\$ 1,950	5 YRS	\$ 18,400	76
77										77
78										78
79										79
80	TOTALS			\$ 23,000	\$ 2,650	\$ 4,600	\$ 1,950		\$ 18,400	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)	\$ 186,671	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,337	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,285	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,052)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 36,555	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SALEM ASSOCIATES

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>120</u>	<u>2/28/03</u>	\$ <u>445,300</u>	<u>10</u>		<u>3</u>
4	Additions							<u>4</u>
5								<u>5</u>
6								<u>6</u>
7	TOTAL		<u>120</u>		\$ <u>445,300</u>			<u>7</u>

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: \$ 129,696 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			\$ _____	\$ _____	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	TOTAL		\$ _____	\$ _____	<u>21</u>

10. Effective dates of current rental agreement:

Beginning 4/01/03

Ending 2/28/13

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

Fiscal Year Ending Annual Rent

12. /2008 \$ 445,300

13. /2009 \$ 445,300

14. /2010 \$ 445,300

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 199,759	\$		\$ 199,759	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			137,176			137,176	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			238,667			238,667	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				306,103		306,103	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						68,464		68,464	13
14	TOTAL			\$		\$ 575,602	\$ 374,567		\$ 950,169	14

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

Facility Name & ID Number DOCTORS NURSING & REHAB CENTER

0046235

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 270,383	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	1,117,921		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,534		6
7	Other Prepaid Expenses	45,456		7
8	Accounts Receivable (owners or related parties)	437,700		8
9	Other(specify): <u>Due from prior owner</u>	24,365		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,983,359	\$	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	53,231		15
16	Equipment, at Historical Cost	73,160		16
17	Accumulated Depreciation (book methods)	(75,996)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,767)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Comp Soft</u>)	27,592		22
23	Other(specify): <u>deposit on fixed asset</u>	27,560		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 105,780	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,089,139	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 390,990	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	360,981		29
30	Accrued Salaries Payable	84,677		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,687		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,007		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)	\$ 914,342	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>MEMBER LOANS</u>	100,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,014,342	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,074,797	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,089,139	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 847,427	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 847,432	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	396,154	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	(168,789)	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)	\$ 227,365	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)	\$ 1,074,797	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	\$ 6,376,316	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,376,316	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	239,985	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 239,985	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***	13,071	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,071	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,629,372	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	747,495	31
32	Health Care	2,369,678	32
33	General Administration	1,438,735	33
	B. Capital Expense		
34	Ownership	653,990	34
	C. Ancillary Expense		
35	Special Cost Centers	950,169	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,225,767	40
41	Income before Income Taxes (line 30 minus line 40)**	403,605	41
42	Income Taxes	(7,451)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 396,154	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number DOCTORS NURSING & REHAB CENTER

0046235

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	2,008	2,080	\$ 68,252	\$ 32.81	1
2	Assistant Director of Nursing	3,657	4,123	86,265	20.92	2
3	Registered Nurses	12,402	13,466	254,672	18.91	3
4	Licensed Practical Nurses	27,754	30,782	500,144	16.25	4
5	CNAs & Orderlies	64,478	69,017	631,750	9.15	5
6	CNA Trainees					6
7	Licensed Therapist	10,581	11,609	195,119	16.81	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,745	2,048	23,038	11.25	9
10	Activity Assistants	2,506	2,782	19,752	7.10	10
11	Social Service Workers	3,068	3,321	43,850	13.20	11
12	Dietician					12
13	Food Service Supervisor	1,794	2,026	24,952	12.32	13
14	Head Cook	5,282	5,920	45,957	7.76	14
15	Cook Helpers/Assistants	10,235	11,047	78,142	7.07	15
16	Dishwashers					16
17	Maintenance Workers	3,021	3,245	40,394	12.45	17
18	Housekeepers	9,371	10,042	77,042	7.67	18
19	Laundry	6,391	7,537	55,883	7.41	19
20	Administrator	1,824	2,080	89,264	42.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,833	2,100	36,824	17.54	23
24	Clerical	5,184	5,910	75,864	12.84	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)	3,489	4,100	43,677	10.65	30
31	Medical Records	867	1,009	10,117	10.03	31
32	Other Health C: Unit Aide	77	82	754	9.20	32
33	Other(specify) <u>MDS,Central sup.</u>	5,867	6,788	135,031	19.89	33
34	TOTAL (lines 1 - 33)	183,434	201,114	\$ 2,536,743 *	\$ 12.61	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	282	\$ 11,649	1-3	35
36	Medical Director	monthly	23,400	9-3	36
37	Medical Records Consultant	31	2,046	10-3	37
38	Nurse Consultant		7,260	10-3	38
39	Pharmacist Consultant	monthly	4,392	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	76	5,024	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	389	\$ 53,771		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		
KYLE MOORE	ADMINISTRATOR	0	\$ 89,264	Workers' Compensation Insurance	\$ 109,625	IDPH License Fee	\$		
				Unemployment Compensation Insurance	37,859	Advertising: Employee Recruitment	576		
				FICA Taxes	193,510	Health Care Worker Background Check	1,216		
				Employee Health Insurance	7,670	(Indicate # of checks performed <u>76</u>)			
				Employee Meals	0	Patient Background Checks	1,792		
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	525		
				EMPLOYEE BENEFITS - OTHER	7,354	MARKETING/ADV/PROMO	11,779		
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	13,454		
				PENSION/PROFIT SHARING PLANS	11,979	MGMT CO ALLOC	876		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(525)		
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)		
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(11,779)		
						Yellow page advertising	(0)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 89,264	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,914	
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			\$ 411,903				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)			\$ 411,903				Seminar Expense	0	
C. Professional Services							MGMT ALLOC		1,269
Vendor/Payee	Type		Amount				Entertainment Expense		()
ACHIEVE HEALTHCARE	DATA PROCESSING		\$ 9,469				(agree to Sch. V, line 24, col. 8)		
KRUPNICK BOKOR KAGDA	ACCOUNTING		15,400				TOTAL		\$ 1,269
RICHARD PEELO & ASSOC.	MEDICARE ACCOUNTING		3,000						
BRANSON,JONES & STEDELIN	LEGAL		848						
STRATTON,GIGANTI,STONE	LEGAL		924						
HEALTHCARE HORIZON			45,000						
SYSTEMATIC MANAGEMENT	MEDICARE BILLING		6,190						
HICARE MANAGEMENT	ADMINISTRATIVE CONSUL		72,960						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 153,791	TOTAL				

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DOCTORS NURSING & REHAB CENTER

0046235

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTHCARE ASSOCIATION \$7176
- (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. \$ 13,445 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. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees