

Facility Name & ID Number DOUGLAS REHAB & CARE CENTER

0046250 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	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	155	52	3,096	3,303	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	15,372	5,171		20,543	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,527	5,223	3,096	23,846	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.70%

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

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

NONE

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 79 and days of care provided 3,096

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **DOUGLAS REHAB & CARE CENTER** # **0046250** 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	126,610	9,489	5,172	141,271		141,271		141,271		1
2	Food Purchase		92,200		92,200	(9,986)	82,214	(262)	81,952		2
3	Housekeeping	78,556	9,760		88,316		88,316		88,316		3
4	Laundry	29,483	10,429	1,445	41,357		41,357		41,357		4
5	Heat and Other Utilities			133,175	133,175		133,175	1,121	134,296		5
6	Maintenance	37,153	1,580	21,529	60,262		60,262	5,336	65,598		6
7	Other (specify):*			15,148	15,148		15,148		15,148		7
8	TOTAL General Services	271,802	123,458	176,469	571,729	(9,986)	561,743	6,195	567,938		8
	B. Health Care and Programs										
9	Medical Director			330	330		330		330		9
10	Nursing and Medical Records	1,075,128	68,163	26,685	1,169,976		1,169,976		1,169,976		10
10a	Therapy										10a
11	Activities	80,410	1,143		81,553		81,553		81,553		11
12	Social Services	27,973		3,786	31,759		31,759		31,759		12
13	CNA Training										13
14	Program Transportation			5,917	5,917		5,917		5,917		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,183,511	69,306	36,718	1,289,535		1,289,535		1,289,535		16
	C. General Administration										
17	Administrative	61,121		145,491	206,612		206,612	(74,905)	131,707		17
18	Directors Fees										18
19	Professional Services			55,725	55,725		55,725	(20,548)	35,177		19
20	Dues, Fees, Subscriptions & Promotions			22,146	22,146		22,146	(9,019)	13,127		20
21	Clerical & General Office Expenses	94,740	10,841	82,910	188,491		188,491	(56,976)	131,515		21
22	Employee Benefits & Payroll Taxes			233,380	233,380	9,986	243,366		243,366		22
23	Inservice Training & Education			2,030	2,030		2,030		2,030		23
24	Travel and Seminar							768	768		24
25	Other Admin. Staff Transportation			10,120	10,120		10,120	(1,508)	8,612		25
26	Insurance-Prop.Liab.Malpractice			48,487	48,487		48,487	2,064	50,551		26
27	Other (specify):*			18,928	18,928		18,928	(1,973)	16,955		27
28	TOTAL General Administration	155,861	10,841	619,217	785,919	9,986	795,905	(162,097)	633,808		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,611,174	203,605	832,404	2,647,183		2,647,183	(155,902)	2,491,281		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	5,172
	REPAIRS & MAINTENANCE	0
		0
		5,172
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,445
		0
		1,445
5	HEAT & OTHER UTILITIES	
	GAS HEAT	40,734
	ELECTRICITY	49,290
	WATER	36,080
	CABLE TV - LOBBY	7,071
		0
		133,175
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,252
	PAINTING & DECORATING	932
	BUILDING REPAIRS	6,943
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,042
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,532
	FIRE SERVICE	2,828
		0
		0
		0
		0
		21,529
7	OTHER	
	SCAVENGER	15,148
	SECURITY SERVICE	0
		0
		0
		15,148
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	14,505
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	3,300
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	2,235
	PHARMACY CONSULTANT XVIII B 39-2	2,355
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	PROGRAM CONSULTANT	4,290
		0
		26,685
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	271
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,515
		0
		3,786
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	5,917
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	145,491
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	8,603
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	47,122
		0
		55,725
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,655
	EMPLOYEE WANT ADS XIX F	1,041
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	7,599
	LICENSES & PERMITS XIX F	2,067
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	894
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,104
	PATIENT BACKGROUND CHECKS XIX F	786
		22,146
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,380
	EQUIPMENT REPAIR & MAINTENANCE	300
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	4,598
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,632
	MESSENGER SERVICE	0
		0
		82,910

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	122,385
	UNEMPLOYMENT COMPENSATION XIX D	22,987
	WORKERS COMPENSATION INSURANC XIX D	74,334
	HOSPITALIZATION INSURANCE XIX D	7,622
	EMPLOYEE BENEFITS - OTHER XIX D	2,499
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	3,553
	CHICAGO HEAD TAX XIX D	0
		0
		233,380
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,030
		2,030
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,120
		10,120
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	48,487
		48,487
27	OTHER	
	BAD DEBTS VI 24	18,928
		18,928

GRAND TOTAL COLUMN 3 OTHER

832,404

**DOUGLAS REHAB & CARE CENTER
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	92,200
LESS SALES TAX	<u>(262)</u>
NET FOOD	91,938

TOTAL PATIENT CENSUS	23,846
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	71,538

ADD # EMPLOYEE MEALS/DAY	24
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	8,760

PATIENT MEALS	71,538
ADD EMPLOYEE MEALS	<u>8,760</u>
TOTAL MEALS/YEAR	80,298

NET FOOD	91,938
DIVIDE TOTAL MEALS/YEAR	<u>80,298</u>

COST PER MEAL	1.14
TIME EMPLOYEE MEALS	<u>8,760</u>
EMPLOYEE MEAL RECLASSIFICATION	9,986

=====

Facility Name & ID Number **DOUGLAS REHAB & CARE CENTER**

#0046250

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			4,934	4,934		4,934	2,243	7,177		30
31	Amortization of Pre-Op. & Org.			1,400	1,400		1,400		1,400		31
32	Interest			19,788	19,788		19,788	(1,806)	17,982		32
33	Real Estate Taxes			30,652	30,652		30,652	953	31,605		33
34	Rent-Facility & Grounds			374,856	374,856		374,856		374,856		34
35	Rent-Equipment & Vehicles			19,263	19,263		19,263		19,263		35
36	Other (specify):*										36
37	TOTAL Ownership			450,893	450,893		450,893	1,390	452,283		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		91,525	353,144	444,669		444,669		444,669		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			43,253	43,253		43,253		43,253		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		91,525	396,397	487,922		487,922		487,922		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,611,174	295,130	1,679,694	3,585,998		3,585,998	(154,512)	3,431,486		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	1,410	30		9
10	Interest and Other Investment Income	(2,868)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(262)	2		13
14	Non-Care Related Interest	(1,079)	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	(4,598)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,928)	27		24
25	Fund Raising, Advertising and Promotional	(8,655)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(894)	20		28
29	Other-Attach Schedule	(42,777)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,651)		\$	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)	(75,861)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (75,861)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (154,512)		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

DOUGLAS REHAB & CARE CENTER

ID# 0046250

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	STAFF TRANSPORTATION MARKETING	\$ (2,979)	25	1
2				2
3	MARKETING SALARY	(18,798)	21	3
4	PROF. FEES - HEALTHCARE HORIZONS	(21,000)	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	(42,777)		49

STATE OF ILLINOIS

Summary A

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

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	(262)	0	0	0	0	0	0	0	0	0	0	(262)	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	1,121	0	0	0	0	0	0	0	0	0	1,121	5
6	Maintenance	0	5,336	0	0	0	0	0	0	0	0	0	5,336	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(262)	6,457	0	6,195	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	(74,905)	0	0	0	0	0	0	0	0	0	(74,905)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,000)	452	0	0	0	0	0	0	0	0	0	(20,548)	19
20	Fees, Subscriptions & Promotions	(9,549)	530	0	0	0	0	0	0	0	0	0	(9,019)	20
21	Clerical & General Office Expenses	(23,396)	(33,580)	0	0	0	0	0	0	0	0	0	(56,976)	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	768	0	0	0	0	0	0	0	0	0	768	24
25	Other Admin. Staff Transportation	(2,979)	1,471	0	0	0	0	0	0	0	0	0	(1,508)	25
26	Insurance-Prop.Liab.Malpractice	0	2,064	0	0	0	0	0	0	0	0	0	2,064	26
27	Other (specify):*	(18,928)	16,955	0	0	0	0	0	0	0	0	0	(1,973)	27
28	TOTAL General Administration	(75,852)	(86,245)	0	(162,097)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(76,114)	(79,788)	0	(155,902)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOUGLAS REHAB & CARE CENTER

0046250

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,410	0	833	0	0	0	0	0	0	0	0	2,243	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,947)	0	2,141	0	0	0	0	0	0	0	0	(1,806)	32
33	Real Estate Taxes	0	0	953	0	0	0	0	0	0	0	0	953	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,537)	0	3,927	0	1,390	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)	(78,651)	(79,788)	3,927	0	(154,512)	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
				HEALTH CARE	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	\$ 145,491	HI CARE MANAGEMENT		\$	\$ (145,491)	1
2	V	21 HOME OFFICE EXPENSE	60,000				(60,000)	2
3	V	5 UTILITIES				1,121	1,121	3
4	V	6 MAINTENANCE				5,336	5,336	4
5	V	17 ADMINISTRATIVE				70,586	70,586	5
6	V	19 PROFESSIONAL FEES				452	452	6
7	V	20 DUES & SUBSCRIPTION				530	530	7
8	V	21 OFFICE EXPENSE				26,420	26,420	8
9	V	24 TRAVEL & SEMINARS				768	768	9
10	V	25 TRANSPORTATION				1,471	1,471	10
11	V	26 INSURANCE				2,064	2,064	11
12	V	27 PAYROLL TAXES & GRP INS				16,955	16,955	12
13	V							13
14	Total		\$ 205,491			\$ 125,703	\$ * (79,788)	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				2,141	2,141	16
17	V	33 REAL ESTATE				953	953	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		\$			\$ 3,927	\$ * 3,927	39

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

Facility Name & ID Number **DOUGLAS REHAB & CARE CENTER** # **0046250** 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	\$ 21,319	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	21,319	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$165,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING				SEE	ATTACHED	SALARY	1,866	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$14,446										8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR				SEE	ATTACHED	SALARY	9,407	17-7	10
11	TOTAL SALARY RECEIVED FROM HI CARE \$72,810										11
12											12
13								TOTAL	\$ 53,911		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 REHAB & CARE CENTER

0046250 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 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	5	UTILITIES	PER RESIDENT DAY	184,560	7	\$ 8,675	\$ 23,846	\$ 1,121	1	
2	6	MAINTENANCE	PER RESIDENT DAY	184,560	7	41,300	37,474	23,846	5,336	2
3	17	OFFICER SALARY-B HEDGES	PER RESIDENT DAY	184,560	7	165,000	165,000	23,846	21,319	3
4	17	OFFICER SALARY-B. IRVINE	PER RESIDENT DAY	184,560	7	165,000	165,000	23,846	21,319	4
5	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	184,560	7	69,647	69,647	23,846	8,999	5
6	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	184,560	7	73,854	73,854	23,846	9,542	6
7	17	SPECIAL PROJ MNGR-DEREK	PER RESIDENT DAY	184,560	7	72,810	72,810	23,846	9,407	7
8	19	PROFESSIONAL FEES	PER RESIDENT DAY	184,560	7	3,500		23,846	452	8
9	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	184,560	7	4,105		23,846	530	9
10	21	OFFICE EXPENSE	PER RESIDENT DAY	184,560	7	204,479	141,575	23,846	26,420	10
11	24	TRAVEL & SEMINARS	PER RESIDENT DAY	184,560	7	5,945		23,846	768	11
12	25	TRANSPORTATION	PER RESIDENT DAY	184,560	7	11,383		23,846	1,471	12
13	26	INSURANCE	PER RESIDENT DAY	184,560	7	15,972		23,846	2,064	13
14	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	184,560	7	131,223		23,846	16,955	14
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		\$ 125,703	25

Facility Name & ID Number **DOUGLAS REHAB & CARE CENTER**

0046250 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)528-0044

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	\$	79	\$ 833	1
2	32	INTEREST	639	7	17,316		79	2,141	2
3	33	REAL ESTATE	639	7	7,709		79	953	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	\$		\$ 3,927	25

Facility Name & ID Number

DOUGLAS REHAB & CARE CENTER

0046250

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	US BANK (HI PROP)		X	MORTGAGE (office)		6/29/05			6/29/12	0.0635	2,141	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		272,083	REVOLV	PRIME +	9,559	6								
7	ILLINI BANK		X	WORKING CAPITAL	1580 + INT	9/25/03	75,000	13,481	9/25/08	0.0964	2,150	7								
8											8									
9	TOTAL Facility Related						\$ 175,000	\$ 385,564			\$ 20,850	9								
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES							1,079	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 1,079	14								
15	TOTALS (line 9+line14)						\$ 175,000	\$ 385,564			\$ 21,929	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 2006 report.

\$ **34,436** 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.)

\$ **32,544** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **(1,892)** 3

4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **32,544** 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.

\$ **30,652** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	35,123	8
	2003	30,417	9
	2004	32,669	10
	2005	33,434	11
	2006	32,544	12

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

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.

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:** 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 DOUGLAS REHAB & 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 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>07-1-00300-000</u>	<u>NURSING HOME</u>	\$ <u>30,225.06</u>	\$ <u>30,225.06</u>
2. <u>07-1-00300-001</u>	<u>NURSING HOME</u>	\$ <u>1,963.88</u>	\$ <u>1,963.88</u>
3. <u>07-1-00572-000</u>	<u>NURSING HOME</u>	\$ <u>354.64</u>	\$ <u>354.64</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>32,543.58</u>	\$ <u>32,543.58</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.

Facility Name & ID Number DOUGLAS REHAB & CARE CENTER

0046250 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 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	<u>OFFICE BUILDING</u>		<u>2005</u>	<u>7,192</u>	2
3	TOTALS			\$ <u>7,192</u>	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	INSULATION		2004	10,441	380	27.5	380		1,283
10	REPLACE HEAT & CHILL LINES		2005	3,245	118	27.5	118		241
11	COMPRESSOR		2006	14,696	534	27.5	534		690
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23	H & I PROPERTIES - OFFICE BUILDING		2005	32,513	833	39	833		2,312
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)	\$ 60,895	\$ 1,865		\$ 1,865	\$	\$ 4,526	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	\$ 13,025	\$ 1,775	\$ 1,303	\$ (472)		\$ 3,789	71
72	Current Year Purchases	8,178	1,227	409	(818)		409	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 21,203	\$ 3,002	\$ 1,712	\$ (1,290)		\$ 4,198	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				\$ 18,000	\$ 900	\$ 3,600	\$ 2,700	5 YRS	\$ 3,600	76
77										77
78										78
79										79
80	TOTALS			\$ 18,000	\$ 900	\$ 3,600	\$ 2,700		\$ 3,600	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)	\$ 107,290	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,767	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 7,177	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,410	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,324	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:		<u>79</u>	<u>2/28/03</u>	\$ <u>374,856</u>	<u>10</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>79</u>		\$ <u>374,856</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 19,263 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. /2008 \$ _____

13. /2009 \$ _____

14. /2010 \$ _____

* 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	\$		\$ 117,112	\$		\$ 117,112	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			55,170			55,170	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			180,862			180,862	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 prescripts				91,525		91,525	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			\$		\$ 353,144	\$ 91,525		\$ 444,669	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 REHAB & CARE CENTER

0046250

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	\$ 71,701	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 35,000)	478,478		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,482		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>	87,278		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 703,939	\$	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	62,348		16
17	Accumulated Depreciation (book methods)	(37,851)		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 (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 53,112	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 757,051	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 460,364	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	329,811		29
30	Accrued Salaries Payable	55,282		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,280		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,544		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)	\$ 902,281	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	111,000		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)	\$ 111,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,013,281	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (256,230)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 757,051	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (320,510)	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)	\$ (320,509)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	64,279	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)	\$ 64,279	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)	\$ (256,230)	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	\$ 3,393,450	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,393,450	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	244,215	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 244,215	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	9,744	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)	\$ 9,744	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,868	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,868	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)	\$ 3,650,277	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	571,729	31
32	Health Care	1,289,535	32
33	General Administration	785,919	33
	B. Capital Expense		
34	Ownership	450,893	34
	C. Ancillary Expense		
35	Special Cost Centers	444,669	35
36	Provider Participation Fee	43,253	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,585,998	40
41	Income before Income Taxes (line 30 minus line 40)**	64,279	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 64,279	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 REHAB & CARE CENTER

0046250

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	2,032	2,080	\$ 57,168	\$ 27.48	1
2	Assistant Director of Nursing	1,567	1,711	37,289	21.79	2
3	Registered Nurses	4,998	5,177	107,856	20.83	3
4	Licensed Practical Nurses	14,617	15,799	278,797	17.65	4
5	CNAs & Orderlies	43,715	47,609	501,819	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,832	1,992	24,189	12.14	9
10	Activity Assistants	5,233	5,521	56,221	10.18	10
11	Social Service Workers	1,748	1,860	27,973	15.04	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	30,842	14.83	13
14	Head Cook	5,316	5,840	46,302	7.93	14
15	Cook Helpers/Assistants	6,031	6,461	49,466	7.66	15
16	Dishwashers					16
17	Maintenance Workers	2,161	2,193	37,153	16.94	17
18	Housekeepers	8,946	9,743	78,556	8.06	18
19	Laundry	3,856	4,094	29,483	7.20	19
20	Administrator	1,744	2,080	61,121	29.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,820	2,082	37,373	17.95	23
24	Clerical	3,975	4,308	57,367	13.32	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)	1,639	1,837	20,730	11.28	30
31	Medical Records	910	910	9,568	10.51	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS</u>	3,394	3,686	61,901	16.79	33
34	TOTAL (lines 1 - 33)	117,486	127,063	\$ 1,611,174 *	\$ 12.68	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	126	\$ 5,172	1-3	35
36	Medical Director	2	330	9-3	36
37	Medical Records Consultant	27	2,235	10-3	37
38	Nurse Consultant	11	3,300	10-3	38
39	Pharmacist Consultant	MONTHLY	2,355	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	48	3,515	12-3	45
46	Other(specify) <u>Program consultant</u>		4,290	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	214	\$ 21,197		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

Facility Name & ID Number DOUGLAS REHAB & CARE CENTER

0046250

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 HEALTH CARE ASSOC \$4724
- (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. \$ 7,441 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. \$ 9,986 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