

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	13	132	2,600	2,745	8
9	SNF/PED					9
10	ICF	12,667	3,941		16,608	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,680	4,073	2,600	19,353	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.12%

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 2/28/03 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 2,600

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number **DOUGLAS REHABILITATION & CARE C** # **0046250** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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	115,408	9,242	4,955	129,605		129,605		129,605		1
2	Food Purchase		85,490		85,490	(10,830)	74,660	(39)	74,621		2
3	Housekeeping	72,064	10,194		82,258		82,258		82,258		3
4	Laundry	28,185	7,654		35,839		35,839		35,839		4
5	Heat and Other Utilities			139,501	139,501		139,501	1,034	140,535		5
6	Maintenance	31,208	2,508	26,965	60,681		60,681	6,136	66,817		6
7	Other (specify):*			12,423	12,423		12,423	161	12,584		7
8	TOTAL General Services	246,865	115,088	183,844	545,797	(10,830)	534,967	7,292	542,259		8
	B. Health Care and Programs										
9	Medical Director			330	330		330		330		9
10	Nursing and Medical Records	1,004,685	54,562	8,924	1,068,171		1,068,171		1,068,171		10
10a	Therapy	13,666		4,338	18,004		18,004		18,004		10a
11	Activities	51,621	4,330		55,951		55,951		55,951		11
12	Social Services	27,273		3,534	30,807		30,807		30,807		12
13	CNA Training										13
14	Program Transportation			3,739	3,739		3,739		3,739		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,097,245	58,892	20,865	1,177,002		1,177,002		1,177,002		16
	C. General Administration										
17	Administrative	65,624		119,004	184,628		184,628	(39,852)	144,776		17
18	Directors Fees										18
19	Professional Services			57,976	57,976		57,976	(18,286)	39,690		19
20	Dues, Fees, Subscriptions & Promotions			27,824	27,824		27,824	(15,551)	12,273		20
21	Clerical & General Office Expenses	91,824	8,535	81,595	181,954		181,954	(39,276)	142,678		21
22	Employee Benefits & Payroll Taxes			204,084	204,084	10,830	214,914		214,914		22
23	Inservice Training & Education			2,449	2,449		2,449		2,449		23
24	Travel and Seminar							748	748		24
25	Other Admin. Staff Transportation			11,360	11,360		11,360	(1,982)	9,378		25
26	Insurance-Prop.Liab.Malpractice			45,761	45,761		45,761	2,604	48,365		26
27	Other (specify):*			11,332	11,332		11,332	10,816	22,148		27
28	TOTAL General Administration	157,448	8,535	561,385	727,368	10,830	738,198	(100,779)	637,419		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,501,558	182,515	766,094	2,450,167		2,450,167	(93,487)	2,356,680		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,955
	REPAIRS & MAINTENANCE	0
		0
		4,955
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	38,593
	ELECTRICITY	41,501
	WATER	50,812
	CABLE TV - LOBBY	8,595
		0
		139,501
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,822
	PAINTING & DECORATING	365
	BUILDING REPAIRS	9,831
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,097
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,392
	FIRE SERVICE	1,458
		0
		0
		0
		0
		26,965
7	OTHER	
	SCAVENGER	12,423
	SECURITY SERVICE	0
		0
		0
		12,423
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	0
	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	2,314
	PHARMACY CONSULTANT XVIII B 39-2	1,930
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	4,680
		0
		0
		8,924
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	4,338
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		4,338
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,534
		0
		3,534
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	3,739
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	119,004
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,016
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	47,960
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,858
	EMPLOYEE WANT ADS XIX F	2,818
	CONTRIBUTIONS VI 20 XIX F	50
	DUES & SUBSCRIPTIONS XIX F	5,907
	LICENSES & PERMITS XIX F	460
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,315
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,349
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,301
	PATIENT BACKGROUND CHECKS XIX F	766
		27,824
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	10,188
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,407
	MESSENGER SERVICE	0
		81,595

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	114,046
	UNEMPLOYMENT COMPENSATION XIX D	22,969
	WORKERS COMPENSATION INSURANC XIX D	51,421
	HOSPITALIZATION INSURANCE XIX D	8,631
	EMPLOYEE BENEFITS - OTHER XIX D	4,386
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	2,631
	CHICAGO HEAD TAX XIX D	0
		0
		204,084
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,449
		2,449
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	11,360
		11,360
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	45,761
		45,761
27	OTHER	
	BAD DEBTS VI 24	11,332
		11,332

GRAND TOTAL COLUMN 3 OTHER

766,094

**DOUGLAS REHABILITATION & CARE CENTER
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	85,490
LESS SALES TAX	<u>(39)</u>
NET FOOD	85,451
TOTAL PATIENT CENSUS	19,353
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	58,059
ADD # EMPLOYEE MEALS/DAY	23
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	8,395
PATIENT MEALS	58,059
ADD EMPLOYEE MEALS	<u>8,395</u>
TOTAL MEALS/YEAR	66,454
NET FOOD	85,451
DIVIDE TOTAL MEALS/YEAR	<u>66,454</u>
COST PER MEAL	1.29
TIME EMPLOYEE MEALS	<u>8,395</u>
EMPLOYEE MEAL RECLASSIFICATION	10,830
	=====

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			11,021	11,021		11,021	468	11,489			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,779	20,779		20,779	(6,819)	13,960			32
33	Real Estate Taxes			19,569	19,569		19,569	1,372	20,941			33
34	Rent-Facility & Grounds			388,882	388,882		388,882		388,882			34
35	Rent-Equipment & Vehicles			42,827	42,827		42,827		42,827			35
36	Other (specify):*											36
37	TOTAL Ownership			483,078	483,078		483,078	(4,979)	478,099			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,769	238,559	357,328		357,328		357,328			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		118,769	281,812	400,581		400,581		400,581			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,501,558	301,284	1,530,984	3,333,826		3,333,826	(98,466)	3,235,360			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	(687)	30		9
10	Interest and Other Investment Income	(9,611)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	2		13
14	Non-Care Related Interest		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		21		18
19	Entertainment		20		19
20	Contributions	(2,399)	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	(11,332)	27		24
25	Fund Raising, Advertising and Promotional	(12,858)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,315)	20		28
29	Other-Attach Schedule	(44,419)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,660)		\$	30

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)	(15,806)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,806)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (98,466)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

DOUGLAS REHABILITATION & CARE CENTER

ID# 0046250

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2	HEALTHCARE HORIZONS	(21,000)	19	2
3	MARKETING SALARY	(19,521)	21	3
4	MARKETING TRAVEL	(3,898)	25	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	(44,419)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(39)	0	0	0	0	0	0	0	0	0	0	(39)	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	1,034	0	0	0	0	0	0	0	0	0	1,034	5
6	Maintenance	0	6,136	0	0	0	0	0	0	0	0	0	6,136	6
7	Other (specify):*	0	161	0	0	0	0	0	0	0	0	0	161	7
8	TOTAL General Services	(39)	7,331	0	7,292	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	(39,852)	0	0	0	0	0	0	0	0	0	(39,852)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,000)	2,714	0	0	0	0	0	0	0	0	0	(18,286)	19
20	Fees, Subscriptions & Promotions	(16,572)	1,021	0	0	0	0	0	0	0	0	0	(15,551)	20
21	Clerical & General Office Expenses	(19,521)	(19,755)	0	0	0	0	0	0	0	0	0	(39,276)	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	748	0	0	0	0	0	0	0	0	0	748	24
25	Other Admin. Staff Transportation	(3,998)	1,916	0	0	0	0	0	0	0	0	0	(1,982)	25
26	Insurance-Prop.Liab.Malpractice	0	2,604	0	0	0	0	0	0	0	0	0	2,604	26
27	Other (specify):*	(11,332)	22,148	0	0	0	0	0	0	0	0	0	10,816	27
28	TOTAL General Administration	(72,323)	(28,456)	0	(100,779)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,362)	(21,125)	0	(93,487)	29								

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(687)	0	1,155	0	0	0	0	0	0	0	0	468	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,611)	0	2,792	0	0	0	0	0	0	0	0	(6,819)	32
33	Real Estate Taxes	0	0	1,372	0	0	0	0	0	0	0	0	1,372	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	(10,298)	0	5,319	0	(4,979)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(82,660)	(21,125)	5,319	0	0	0	0	0	0	0	0	(98,466)	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
ROBERT HEDGES	37.5			HI CARE	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	37.5	SEE ATTACHED SCHEDULE		MANAGEMENT		
MORRIS ESFORMES	15			HI CARE	SPRINGFIELD	REAL ESTATE
SANDRA SEGAL	10					
				HEALTHCARE	SPRINGFIELD	NURSE CONSULT
				HORIZONS		

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	\$ 119,004	HI CARE MANAGEMENT		\$	(119,004)	1
2	V	21	HOME OFFICE EXPENSE	60,000	" " "			(60,000)	2
3	V	5	UTILITIES		" " "			1,034	3
4	V	6	MAINTENANCE		" " "			6,136	4
5	V	7	SCAVENGER & EXTERM		" " "			161	5
6	V	17	ADMINISTRATIVE		" " "			79,152	6
7	V	19	PROFESSIONAL FEES		" " "			2,714	7
8	V	20	DUES & SUBSCRIPTION		" " "			1,021	8
9	V	21	OFFICE EXPENSE		" " "			40,245	9
10	V	24	TRAVEL & SEMINARS		" " "			748	10
11	V	25	TRANSPORTATION		" " "			1,916	11
12	V	26	INSURANCE		" " "			2,604	12
13	V	27	PAYROLL TAXES & GRP INS		" " "			22,148	13
14	Total		\$ 179,004				\$	157,879	\$ * (21,125) 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)		\$ 1,155	\$ 1,155	15
16	V	32 INTEREST		" " "		2,792	2,792	16
17	V	33 REAL ESTATE		" " "		1,372	1,372	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		\$			\$ 5,319	\$ * 5,319	39

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

Facility Name & ID Number **DOUGLAS REHABILITATION & CARE C** # **0046250** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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				SALARY	\$ 29,139	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	37.50			SEE	SALARY	29,139	17-7	4
5							ATTACHED				5
6							SCHEDULE				6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	2,148	21-7	7
8											8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	12,038	17-7	10
11											11
12											12
13								TOTAL	\$ 72,464		13

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

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER # 0046250 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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	130,175	7	\$ 6,954	19,353	\$ 1,034	1	
2	6	MAINTENANCE	PER RESIDENT DAY	130,175	7	41,271	39,501	19,353	6,136	2
3	7	SCAVENGER & EXTERMIN.	PER RESIDENT DAY	130,175	7	1,082	19,353		161	3
4	17	OFFICER SALARY- IRVINE	PER RESIDENT DAY	130,175	7	196,000	196,000	19,353	29,139	4
5	17	OFFICER SALARY- HEDGES	PER RESIDENT DAY	130,175	7	196,000	196,000	19,353	29,139	5
6	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	130,175	7	59,432	59,432	19,353	8,836	6
7	17	SPECIAL PROJ MNGR- HEDGE	PER RESIDENT DAY	130,175	7	80,970	80,970	19,353	12,038	7
8	19	PROFESSIONAL FEES	PER RESIDENT DAY	130,175	7	18,255		19,353	2,714	8
9	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	130,175	7	6,868		19,353	1,021	9
10	21	OFFICE EXPENSE	PER RESIDENT DAY	130,175	7	270,705	223,239	19,353	40,245	10
11	24	TRAVEL & SEMINARS	PER RESIDENT DAY	130,175	7	5,032		19,353	748	11
12	25	TRANSPORTATION	PER RESIDENT DAY	130,175	7	12,888		19,353	1,916	12
13	26	INSURANCE	PER RESIDENT DAY	130,175	7	17,518		19,353	2,604	13
14	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	130,175	7	148,977		19,353	22,148	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,061,952	\$ 795,142		\$ 157,879	25

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER # 0046250 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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	PER LICENSE BED	461	7	\$ 6,741	\$ 79	\$ 1,155	1
2	32	INTEREST	PER LICENSE BED	461	7	16,292	79	2,792	2
3	33	REAL ESTATE	PER LICENSE BED	461	7	8,006	79	1,372	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					\$ 31,039	\$	\$ 5,319	25

Facility Name & ID Number

DOUGLAS REHABILITATION & CARE CI

0046250

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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										
										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										1									
2	US BANK	X	MORTGAGE (OFFICE)		6/29/05					2,792									
3										3									
4										4									
5	MEMBERS LOANS			INTERERST		100,000	100,000			7,000									
Working Capital																			
6	COLE TALOR	X	WORKING CAPITAL	INTEREST	REVOLV		107,681			13,779									
7										7									
8										8									
9	TOTAL Facility Related					\$ 100,000	\$ 207,681			\$ 23,571									
B. Non-Facility Related*																			
10	IRS, IDR, ETC	X	LATE FEES							10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related					\$	\$			\$									
15	TOTALS (line 9+line14)					\$ 100,000	\$ 207,681			\$ 23,571									

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

1. Real Estate Tax accrual used on 2008 report.		\$	32,516	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.)		\$	26,042	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(6,474)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	26,043	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.		\$	19,569	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	32,669	8	
	2005	33,434	9	
	2006	32,544	10	
	2007	32,517	11	
	2008	26,042	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOUGLAS REHABILITATION & CARE CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0046250

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-1-00300-000</u>	<u>NURSING HOME</u>	\$ <u>23,631.00</u>	\$ <u>23,631.00</u>
2. <u>07-1-00300-001</u>	<u>NURSING HOME</u>	\$ <u>2,046.00</u>	\$ <u>2,046.00</u>
3. <u>07-1-00572-000</u>	<u>NURSING HOME</u>	\$ <u>365.00</u>	\$ <u>365.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>26,042.00</u>	\$ <u>26,042.00</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 27,000 B. General Construction Type: Exterior MASONRY FACE BR Frame STEEL & STEEL JOI Number of Stories 1

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: _____ 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>9,976</u>	2
3	TOTALS			\$ <u>9,976</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	H & I								
7	Properties								
8	Office	2005		45,218	1,155	39	1,155		4,300
Improvement Type**									
9	INSULATION		2004	10,441	380	27.5	380		2,043
10	REPLACE HEAT & CHILL LINES		2005	3,245	118	27.5	118		477
11	COMPRESSOR		2006	14,696	534	27.5	534		1,758
12	GENERATOR (1 OF 2)		2008	2,670	97	27.5	97		125
13	DRAPES		2008	3,962	634	5	792	158	1,188
14	PAINTING & WALL VINYL		2008	8,203	1,312	5	1,641	329	2,461
15	COMPRESSOR REPAIR		2009	19,021	259	27.5	259		259
16	INSTALL SPRINKLERS IN RESTROOMS AND CLOSETS		2009	6,877	94	27.5	94		94
17	ROOF TOP VENTILATING FANS		2009	4,251	58	27.5	58		58
18									
19									
20									
21									
22									
23	GENERATOR (2 OF 2) THIS PORTION PAID BY LANDLORD		2008	25,620					
24	HOT WATER HEATER (PAID BY LANDLORD)		2008	7,923					
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	\$ 26,284	\$ 3,370	\$ 2,628	\$ (742)	10 YRS	\$ 9,201	71
72	Current Year Purchases	2,666	1,600	133	(1,467)	10 YRS	133	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 28,950	\$ 4,970	\$ 2,761	\$ (2,209)		\$ 9,334	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			2007	\$ 18,000	\$ 2,565	\$ 3,600	\$ 1,035	5 YRS	\$ 10,800	76
77										77
78										78
79										79
80	TOTALS			\$ 18,000	\$ 2,565	\$ 3,600	\$ 1,035		\$ 10,800	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)	\$ 209,053	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,176	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,489	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (687)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 32,897	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 MATTON, 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:				\$ 388,882			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 388,882			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: \$ 42,827 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 _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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	\$		\$ 81,043	\$		\$ 81,043	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			20,411			20,411	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			137,105			137,105	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				90,349		90,349	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): OXYGEN ,LAB, XRAY	39-2					28,420		28,420	13
14	TOTAL			\$		\$ 238,559	\$ 118,769		\$ 357,328	14

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

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

0046250

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (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	\$ 151,425	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>35,000</u>)	183,660		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,642		6
7	Other Prepaid Expenses	357		7
8	Accounts Receivable (owners or related parties)	20,000		8
9	Other(specify): <u>R/E ESCROW</u>	63,557		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 463,641	\$	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	73,366		15
16	Equipment, at Historical Cost	28,950		16
17	Accumulated Depreciation (book methods)	(37,679)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			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)	\$ 64,637	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 528,278	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 723,743	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	107,681		29
30	Accrued Salaries Payable	46,284		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,264		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,043		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)	\$ 925,015	\$	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				43
44		100,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,025,015	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (496,737)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 528,278	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (352,469)	1
2	Restatements (describe):		2
3	ROUNDING	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (352,463)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(144,274)	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)	\$ (144,274)	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)	\$ (496,737)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTE # 0046250 Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 3,051,823	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,051,823	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,693	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 115,693	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***	9,611	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,611	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RENTAL APARTMENTS	9,620	28
28a	SALE OF VAN	2,805	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,425	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,189,552	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	545,797	31
32	Health Care	1,177,002	32
33	General Administration	727,368	33
B. Capital Expense			
34	Ownership	483,078	34
C. Ancillary Expense			
35	Special Cost Centers	357,328	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)*	\$ 3,333,826	40
41	Income before Income Taxes (line 30 minus line 40)**	(144,274)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (144,274)	43

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

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

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

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

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

0046250

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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	1,992	2,201	\$ 63,451	\$ 28.83	1
2	Assistant Director of Nursing	1,841	2,101	46,098	21.94	2
3	Registered Nurses	5,043	5,491	116,833	21.28	3
4	Licensed Practical Nurses	12,210	13,212	245,396	18.57	4
5	CNAs & Orderlies	42,206	44,980	471,933	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,114	1,186	13,666	11.52	8
9	Activity Director	1,876	2,062	26,063	12.64	9
10	Activity Assistants	2,757	3,157	25,558	8.10	10
11	Social Service Workers	1,579	1,748	27,273	15.60	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	32,091	15.43	13
14	Head Cook	5,458	6,056	49,633	8.20	14
15	Cook Helpers/Assistants	4,107	4,213	33,684	8.00	15
16	Dishwashers					16
17	Maintenance Workers	1,785	1,972	31,208	15.83	17
18	Housekeepers	7,986	8,584	72,064	8.40	18
19	Laundry	3,293	3,546	28,185	7.95	19
20	Administrator	1,807	2,080	65,624	31.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,837	2,080	38,843	18.67	23
24	Clerical	3,312	3,625	52,981	14.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	819	819	8,598	10.50	31
32	Other Health Care(specify)	2,595	2,878	52,376	18.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,473	114,071	\$ 1,501,558 *	\$ 13.16	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	114	\$ 4,955	1-3	35
36	Medical Director	2	330	9-3	36
37	Medical Records Consultant	30	2,314	10-3	37
38	Nurse Consultant	12	4,680	10-3	38
39	Pharmacist Consultant	MONTHLY	1,930	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	MONTHLY	4,338	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	48	3,534	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	206	\$ 22,081		49

C. CONTRACT NURSES

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 ASSOC. \$1648
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,908 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. \$ 10,830 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: _____
- (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.