

Facility Name & ID Number DOUGLAS NURSING & REHABILITATION CENTER

0046250 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	28,914	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	28,914	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	443	226	2,302	2,971	8
9	SNF/PED					9
10	ICF	9,174	2,127		11,301	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,617	2,353	2,302	14,272	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.36%

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)

Day Care

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 03/01/2003

J. Was the facility purchased or leased after January 1, 1978?

YES Date 02/28/2003 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 2,257

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number

DOUGLAS NURSING & REHABILITATIO

0046250

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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	111,148	8,363	4,469	123,980		123,980		123,980		1
2	Food Purchase		92,027		92,027	(12,150)	79,877	(911)	78,966		2
3	Housekeeping	49,354	10,644		59,998		59,998		59,998		3
4	Laundry	28,163	4,921		33,084		33,084		33,084		4
5	Heat and Other Utilities			118,937	118,937		118,937	(828)	118,109		5
6	Maintenance	35,429	(4,034)	15,146	46,541		46,541	5,901	52,442		6
7	Other (specify):* SCAVENGER			13,305	13,305		13,305		13,305		7
8	TOTAL General Services	224,094	111,921	151,857	487,872	(12,150)	475,722	4,162	479,884		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	816,962	83,721	17,903	918,586		918,586	10,006	928,592		10
10a	Therapy	25,660			25,660		25,660		25,660		10a
11	Activities	40,061	2,377	1,611	44,049		44,049		44,049		11
12	Social Services	26,060		1,636	27,696		27,696		27,696		12
13	CNA Training										13
14	Program Transportation			5,314	5,314		5,314		5,314		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	908,743	86,098	32,464	1,027,305		1,027,305	10,006	1,037,311		16
	C. General Administration										
17	Administrative	65,600		56,760	122,360		122,360	4,058	126,418		17
18	Directors Fees										18
19	Professional Services			(45,914)	(45,914)		(45,914)	67,316	21,402		19
20	Dues, Fees, Subscriptions & Promotions			44,653	44,653		44,653	(21,299)	23,354		20
21	Clerical & General Office Expenses	53,951	4,830	23,595	82,376		82,376	12,952	95,328		21
22	Employee Benefits & Payroll Taxes			281,640	281,640	12,150	293,790	26,041	319,831		22
23	Inservice Training & Education			961	961		961	378	1,339		23
24	Travel and Seminar							2,043	2,043		24
25	Other Admin. Staff Transportation			16,117	16,117		16,117	(6,897)	9,220		25
26	Insurance-Prop.Liab.Malpractice			37,547	37,547		37,547	1,793	39,340		26
27	Other (specify):*			33,627	33,627		33,627	(33,627)			27
28	TOTAL General Administration	119,551	4,830	448,986	573,367	12,150	585,517	52,758	638,275		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,252,388	202,849	633,307	2,088,544		2,088,544	66,926	2,155,470		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 (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			10,490	10,490		10,490	3,612	14,102			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,989	27,989		27,989	829	28,818			32
33	Real Estate Taxes			26,767	26,767		26,767	(505)	26,262			33
34	Rent-Facility & Grounds			498,875	498,875		498,875		498,875			34
35	Rent-Equipment & Vehicles			15,918	15,918		15,918		15,918			35
36	Other (specify):*											36
37	TOTAL Ownership			580,039	580,039		580,039	3,936	583,975			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			478,678	478,678		478,678		478,678			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			167,413	167,413		167,413		167,413			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			646,091	646,091		646,091		646,091			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,252,388	202,849	1,859,437	3,314,674		3,314,674	70,862	3,385,536			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	2,329	30		9
10	Interest and Other Investment Income	(1,193)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(911)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(200)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,275)	27		24
25	Fund Raising, Advertising and Promotional	(14,208)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,449)	27		28
29	Other-Attach Schedule	8,375			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,532)		\$	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)	112,394		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 112,394		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 70,862		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
DOUGLAS NURSING & REHABILITATION CENTER

Report Period Beginning: 1/1/2012
Ending: 12/31/2012

ID# 0046250

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	EMPLOYEE MEAL INCOME	\$ 2,297	27	1
2	HEALTH CARE HORZ (EXPENSE REVERSAL)	27,630	19	2
3	HOME OFFICE (EXPENSE REVERSAL)	30,000	19	3
4	PRIOR YEAR ACCOUNTING CHARGES	(1,304)	19	4
5	NON INCLUDABLE MARKETING	(442)	19	5
6	NON INCLUDABLE LEGAL	(1,346)	19	6
7	MARKETING SALARIES	(28,687)	21	7
8	MARKETING TRAVEL	(6,897)	25	8
9	CHAMBER OF COMMERCE	(790)	20	9
10	NON INCLUDABLE MARKETING	(1,975)	20	10
11	NON INCLUDABLE BACKGROUND CHARGES	(6,187)	20	11
12	NON INCLUDABLE REAL ESTATE TAX	(2,033)	33	12
13	NON INCLUDABLE UTILITIES	(1,891)	5	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		8,375	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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	(911)	0	0	0	0	0	0	0	0	0	0	(911)	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	(1,891)	1,063	0	0	0	0	0	0	0	0	0	(828)	5
6	Maintenance	0	5,901	0	0	0	0	0	0	0	0	0	5,901	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,802)	6,964	0	0	0	0	0	0	0	0	0	4,162	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	10,006	0	0	0	0	0	0	0	0	0	10,006	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	10,006	0	0	0	0	0	0	0	0	0	10,006	16
	C. General Administration													
17	Administrative	0	4,058	0	0	0	0	0	0	0	0	0	4,058	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	54,538	12,245	533	0	0	0	0	0	0	0	0	67,316	19
20	Fees, Subscriptions & Promotions	(23,160)	1,861	0	0	0	0	0	0	0	0	0	(21,299)	20
21	Clerical & General Office Expenses	(28,687)	41,423	216	0	0	0	0	0	0	0	0	12,952	21
22	Employee Benefits & Payroll Taxes	0	26,041	0	0	0	0	0	0	0	0	0	26,041	22
23	Inservice Training & Education	0	378	0	0	0	0	0	0	0	0	0	378	23
24	Travel and Seminar	0	2,043	0	0	0	0	0	0	0	0	0	2,043	24
25	Other Admin. Staff Transportation	(6,897)	0	0	0	0	0	0	0	0	0	0	(6,897)	25
26	Insurance-Prop.Liab.Malpractice	0	1,793	0	0	0	0	0	0	0	0	0	1,793	26
27	Other (specify):*	(33,627)	0	0	0	0	0	0	0	0	0	0	(33,627)	27
28	TOTAL General Administration	(37,833)	89,842	749	0	52,758	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(40,635)	106,812	749	0	66,926	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/2012 Ending:

12/31/2012

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	2,329	0	1,283	0	0	0	0	0	0	0	0	3,612	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,193)	0	2,022	0	0	0	0	0	0	0	0	829	32
33	Real Estate Taxes	(2,033)	0	1,528	0	0	0	0	0	0	0	0	(505)	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	(897)	0	4,833	0	3,936	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)	(41,532)	106,812	5,582	0	0	0	0	0	0	0	0	70,862	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>ROBERT HEDGES</u>	<u>37.5</u>	<u>DOCTORS NURSING</u>	<u>SALEM</u>	<u>HI CARE</u>	<u>SPRINGFIELD</u>	<u>MANAGEMENT</u>
<u>WILLIAM IRVINE</u>	<u>37.5</u>	<u>EVERGREEN NURSING</u>	<u>EFFINGHAM</u>	<u>MANAGEMENT</u>		
<u>MORRIS ESFORMES</u>	<u>15</u>	<u>TRANSITIONS NURSING</u>	<u>ROCK FALLS</u>			
<u>SANDRA SEGAL</u>	<u>10</u>	<u>TAMMERLANE HEALTHCARE</u>	<u>STERLING</u>	<u>H&I PROPERTIES</u>	<u>SPRINGFIELD</u>	<u>REAL ESTATE</u>
				<u>HEALTHCARE</u>	<u>SPRINGFIELD</u>	<u>NURSE CONSULT</u>
				<u>HORIZONS</u>		

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	<u>17</u>	<u>MANAGEMENT FEES</u>	\$ <u>56,760</u>	<u>HI CARE MANAGEMENT</u>		\$ <u>(56,760)</u>	1
2	V	<u>6</u>	<u>MAINTENANCE</u>		<u>HI CARE MANAGEMENT</u>	<u>5,901</u>	<u>5,901</u>	2
3	V	<u>5</u>	<u>UTILITIES</u>		<u>HI CARE MANAGEMENT</u>	<u>1,063</u>	<u>1,063</u>	3
4	V	<u>10</u>	<u>NURSING</u>		<u>HI CARE MANAGEMENT</u>	<u>10,006</u>	<u>10,006</u>	4
5	V	<u>17</u>	<u>ADMINISTRATION</u>		<u>HI CARE MANAGEMENT</u>	<u>60,818</u>	<u>60,818</u>	5
6	V	<u>21</u>	<u>OFFICE EXPENSE</u>		<u>HI CARE MANAGEMENT</u>	<u>41,423</u>	<u>41,423</u>	6
7	V	<u>19</u>	<u>PROFESSIONAL SVCS</u>		<u>HI CARE MANAGEMENT</u>	<u>12,245</u>	<u>12,245</u>	7
8	V	<u>20</u>	<u>DUES AND SUBSCRIPTIONS</u>		<u>HI CARE MANAGEMENT</u>	<u>1,861</u>	<u>1,861</u>	8
9	V	<u>23</u>	<u>TRAINING AND EDUCATION</u>		<u>HI CARE MANAGEMENT</u>	<u>378</u>	<u>378</u>	9
10	V	<u>24</u>	<u>TRAVEL</u>		<u>HI CARE MANAGEMENT</u>	<u>2,043</u>	<u>2,043</u>	10
11	V	<u>26</u>	<u>LIABILITY INSURANCE</u>		<u>HI CARE MANAGEMENT</u>	<u>1,793</u>	<u>1,793</u>	11
12	V	<u>22</u>	<u>PAYROLL TAX AND BENEFITS</u>		<u>HI CARE MANAGEMENT</u>	<u>26,041</u>	<u>26,041</u>	12
13	V							13
14	Total		\$ <u>56,760</u>			\$ <u>163,572</u>	\$ * <u>106,812</u>	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)		\$ 1,283	\$	1,283	15
16	V	32 INTEREST		H&I PROPERTIES (HOME OFFICE)		2,022		2,022	16
17	V	33 REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		1,528		1,528	17
18	V	19 PROFESSIONAL FEES		H&I PROPERTIES (HOME OFFICE)		533		533	18
19	V	21 OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		216		216	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		\$			\$ 5,582	\$ *	5,582	39

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

Facility Name & ID Number DOUGLAS NURSING & REHABILITATION # 0046250 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT					SALARY	\$ 24,462	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT					SALARY	23,462	17-7	2
3	MARTHA IRVINE	BOOKKEEPING			SEE			SALARY	1,828	21-7	3
4	DEREK HEDGES	VP OPERATIONS			ATTACHED			SALARY	11,066	17-7	4
5					SCHEDULE						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,818		13

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

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

Facility Name & ID Number DOUGLAS NURSING & REHABILITATION CENTER # 0046250 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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 S 6TH ST
 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	6	MAINTENANCE	PER RESIDENT DAY	112,777	5	\$ 46,629	\$ 39,723	14,272	\$ 5,901	1
2	5	UTILITIES	PER RESIDENT DAY	112,777	5	8,403	14,272	14,272	1,063	2
3	10	NURSING	PER RESIDENT DAY	112,777	5	79,070	79,070	14,272	10,006	3
4	17	ADMINISTRATION	PER RESIDENT DAY	112,777	5	480,583	480,583	14,272	60,818	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	112,777	5	327,320	265,760	14,272	41,423	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	112,777	5	96,762	14,272	14,272	12,245	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	112,777	5	14,702	14,272	14,272	1,861	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	112,777	5	2,984	14,272	14,272	378	8
9	24	TRAVEL	PER RESIDENT DAY	112,777	5	16,146	14,272	14,272	2,043	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	112,777	5	14,166	14,272	14,272	1,793	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	112,777	5	205,777	14,272	14,272	26,041	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					\$ 1,292,542	\$ 865,136		\$ 163,572	25

Facility Name & ID Number DOUGLAS NURSING & REHABILITATION CENTER # 0046250 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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 6TH ST
 City / State / Zip Code SPRINGFIELD, IL 62703
 Phone Number (217) 528-0044
 Fax Number (217) 528-3412

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	444	5	\$ 7,213	\$ 79	\$ 1,283	1
2	32	INTEREST	PER LICENSE BED	444	5	11,364	79	2,022	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	444	5	8,587	79	1,528	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	444	5	2,993	79	533	4
5	21	OFFICE EXPENSE	PER LICENSE BED	444	5	1,214	79	216	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					\$ 31,371	\$	\$ 5,582	25

Facility Name & ID Number

DOUGLAS NURSING & REHABILITATIO

0046250

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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	Name of Lender	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	US BANK (H&I PROP)		X	MORTGAGE HOME OFFICE		06/29/2005	\$	\$ 39,063		06/29/2017	0.0425	\$ 2,022	1					
2													2					
3	MEMBER LOAN	X		INTEREST			100,000	100,000			0.0700	7,000	3					
4	ALLIANCE LAUNDRY		X	LAUNDRY EQUIPMENT		3/20/2012	32,618	32,112		03/20/2018	0.0862	1,861	4					
5													5					
	Working Capital																	
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		390,000			PRIME +	19,128	6					
7													7					
8													8					
9	TOTAL Facility Related						\$ 132,618	\$ 561,175				\$ 30,011	9					
	B. Non-Facility Related*																	
10	AVIV		X	WORKING CAPITAL	INTEREST	04/19/2011	305,613	305,613		04/30/2013	0.1000		10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$ 305,613	\$ 305,613				\$	14					
15	TOTALS (line 9+line14)						\$ 438,231	\$ 866,788				\$ 30,011	15					

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

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

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

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 2011 report.		\$	26,282		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.)		\$	25,342		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(940)		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	27,202		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.		\$	26,262		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	32,517	8	FOR BHF USE ONLY	
	2008	26,042	9	13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
	2009	25,886	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2010	26,875	11	15	LESS REFUND FROM LINE 6 \$ 15
	2011	25,342	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2012 TAX IS PRIOR YR PLUS 7%					

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOUGLAS NURSING & REHABILITATION CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0046250

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

TELEPHONE (217) 528-2244 FAX #: (217) 528-4115

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(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>23,451.04</u>	\$ <u>23,451.04</u>
2. <u>07-1-00572-000</u>	<u>NURSING HOME</u>	\$ <u>362.76</u>	\$ <u>362.76</u>
3. <u>22-03.0-107-017</u>	<u>HOME OFFICE</u>	\$ <u>3,428.58</u>	\$ <u>610.09</u>
4. <u>22-03.0-107-018</u>	<u>HOME OFFICE</u>	\$ <u>5,158.22</u>	\$ <u>917.87</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>32,400.60</u></u>	\$ <u><u>25,341.76</u></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 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 MASONARY Frame STEEL 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).

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	<u>HOME OFFICE</u>		<u>2005</u>	\$ <u>10,320</u>	1
2					2
3	TOTALS			\$ 10,320	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	PROP								
8	OFFC BLD	2005		46,777	1,283	39	1,283		
	Improvement Type**								
9	INSULATION		2004	10,441	380	27.5	380		3,182
10	REPLACE HEAT & CHILL LINES		2005	3,245	118	27.5	118		831
11	COMPRESSOR REPAIR		2006	14,696	534	27.5	534		3,361
12	GENERATOR (1 OF 2)		2008	2,670	97	27.5	97		416
13	DRAPES		2008	3,962	228	5	792	564	3,564
14	PAINTING & WALL VINYL		2008	8,203	473	5	1,641	1,168	7,384
15	COMPRESSOR REPAIR		2009	19,021	691	27.5	691		2,332
16	INSTALL SPRINKLERS IN REST ROOM AND CLOSET		2009	6,877	250	27.5	250		844
17	ROOF TOP VENTILATING FANS		2009	4,251	155	27.5	155		523
18	PUMPS		2010	3,461	103	27.5	103		266
19	NEW BEARING AND SEALS ON FAN		2010	3,132	126	27.5	126		289
20	HOT WATER BOOSTER HEATER		2010	2,853	114	27.5	114		261
21	AC CIRCULATION PUMP		2011	3,415	124	27.5	124		202
22	WATER HEATER		2011	5,564	202	27.5	202		227
23									
24	SEWER LINE REPAIRS		2012	8,350	13	27.5	13		13
25									
26									
27									
28									
29									
30	GENERATOR (2 OF 2) THIS PORTION PAID BY LANDLORD		2008	25,620					
31	HOT WATER HEATER (PAID BY LANDLORD)		2008	7,923					
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

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

0046250

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)		\$ 180,461	\$ 4,891		\$ 6,623	\$ 1,732	\$ 23,695	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 42,166	\$ 2,221	\$ 4,217	\$ 1,996	10 YRS	\$ 21,324	71
72	Current Year Purchases	32,618	4,661	3,262	(1,399)	10 YRS	3,262	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 74,784	\$ 6,882	\$ 7,479	\$ 597		\$ 24,586	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 265,565	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,773	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,102	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,329	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 48,281	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ELITE MATTOON LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		79		\$ 498,875			3
4	Additions							4
5								5
6								6
7	TOTAL		79		\$ 498,875			7

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 14,606 Description: SEE ATTACHED SCHEDULE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	PATIENT TRANSPORT	2011 FORD BRAUN	\$ 656.00	\$ 1,312	17
18					18
19					19
20					20
21	TOTAL		\$ 656.00	\$ 1,312	21

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

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

Facility Name & ID Number DOUGLAS NURSING & REHABILITATION CENTER # 0046250 Report Period Beginning: 1/1/2012 Ending: 12/31/2012
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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-2	hrs	\$		\$ 147,323	\$		\$ 147,323	1
2	Licensed Speech and Language Development Therapist	39-2	hrs			74,996			74,996	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	hrs			174,661			174,661	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				81,698		81,698	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 396,980	\$ 81,698		\$ 478,678	14

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

Facility Name & ID Number DOUGLAS NURSING & REHABILITATION CENTER # 0046250 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 33,501	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>35,000</u>)	850,231		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,984		6
7	Other Prepaid Expenses	26,619		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 913,335	\$	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	100,141		15
16	Equipment, at Historical Cost	74,784		16
17	Accumulated Depreciation (book methods)	(68,994)		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)	\$ 105,931	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,019,266	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,653,810	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	727,724		29
30	Accrued Salaries Payable	56,385		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,619		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)	\$ 2,464,538	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	100,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,564,538	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,545,272)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,019,266	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (969,062)	1
2	Restatements (describe):		2
3	PRIOR YR ADJUST TO RE TAX DEPOSIT	(36,937)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,005,999)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(233,660)	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) ASSUMPTION OF DEBT	(305,613)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (539,273)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,545,272)	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,048,181	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,048,181	3
B. Ancillary Revenue			
4	Day Care	7,454	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,454	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***	1,193	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,193	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	FINGER PRINT INCOME	14,317	28
28a	APARTMENT INCOME	9,869	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,186	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,081,014	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	487,872	31
32	Health Care	1,027,305	32
33	General Administration	573,367	33
B. Capital Expense			
34	Ownership	580,039	34
C. Ancillary Expense			
35	Special Cost Centers	478,678	35
36	Provider Participation Fee	167,413	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,314,674	40
41	Income before Income Taxes (line 30 minus line 40)**	(233,660)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (233,660)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,296,591	44
45	Private Pay - Net Inpatient Revenue	362,731	45
46	Medicare - Net Inpatient Revenue	1,371,809	46
47	Other-(specify) <u>INSURANCE</u>	17,050	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,048,181	49

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

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

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

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

Facility Name & ID Number DOUGLAS NURSING & REHABILITATION CENTER

0046250

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

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	2,072	\$ 57,712	\$ 27.85	1
2	Assistant Director of Nursing	2,039	2,121	41,235	19.44	2
3	Registered Nurses	4,303	4,440	95,772	21.57	3
4	Licensed Practical Nurses	10,343	11,079	207,507	18.73	4
5	CNAs & Orderlies	29,770	32,671	342,447	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,266	2,453	25,660	10.46	8
9	Activity Director	1,790	1,915	19,496	10.18	9
10	Activity Assistants	2,359	2,416	20,565	8.51	10
11	Social Service Workers	1,395	1,622	26,060	16.07	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,072	34,033	16.43	13
14	Head Cook	3,154	3,673	32,259	8.78	14
15	Cook Helpers/Assistants	4,946	5,247	44,856	8.55	15
16	Dishwashers					16
17	Maintenance Workers	1,833	2,126	35,429	16.66	17
18	Housekeepers	5,567	5,762	49,354	8.57	18
19	Laundry	3,263	3,342	28,163	8.43	19
20	Administrator	1,968	2,072	65,600	31.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,952	2,072	25,264	12.19	23
24	Clerical	1,854	1,977	28,687	14.51	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	951	951	9,633	10.13	31
32	Other Health C: <u>MDS Trans</u>	3,392	3,472	62,656	18.05	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,025	93,555	\$ 1,252,388 *	\$ 13.39	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	108	\$ 4,469	1-3	35
36	Medical Director	MONTHLY	6,000	9-3	36
37	Medical Records Consultant	14	1,705	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	1,413	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	MONTHLY	3,000	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,611	11-3	44
45	Social Service Consultant	22	1,610	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	166	\$ 19,808		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
LESTER ROBERTSON	ADMINISTRATOR	0	\$ 65,600	Workers' Compensation Insurance	\$ 36,759	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	75,784	Advertising: Employee Recruitment	7,808		
				FICA Taxes	102,007	Health Care Worker Background Check	655		
				Employee Health Insurance	26,961	(Indicate # of checks performed <u>28</u>)	830		
				Employee Meals	12,150	Patient Background Checks	52		
				Illinois Municipal Retirement Fund (IMRF)*					
				RETIREMENT PLAN	2,514				
				EARNED TIME OFF	63,656	SEE ATTACHED	12,071		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,600	TOTAL (agree to Schedule V, line 22, col.8)		\$ 23,354			
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
MANAGEMENT FEES			\$ 56,760				Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 56,760	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 23,354		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
SEE ATTACHED SCHEDULE			\$ 21,402				Out-of-State Travel	\$	
							In-State Travel		
							CORP DON	2,043	
							Seminar Expense		
							Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 21,402	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,043

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number DOUGLAS NURSING & REHABILITATION CENTER

0046250

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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. IHCA \$5611
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,268 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 167,413
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. \$ 12,150 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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? YES
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. \$ _____
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/12

SCHEDULE XIX (C) PROFESSIONAL SERVICES

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
LTC SOLUTIONS	PULSE OX AUDIT	\$ 1,818
KBKB	ACCOUNTING/TAX	\$ 8,901
CTB	LEGAL	\$ 533
CCH	TAX	\$ 33
ITT SOURCE TECH	IT	\$ 1,598
MDI	IT	\$ 4,564
BPC	401K ADMIN	\$ 267
HORWOOD MARCUS	LEGAL	\$ 655
MARGEL PEDDICORD	CONSULTING	\$ 47
STRATTON	LEGAL	\$ 1,491
IVANS	SOFTWARE SUPPORT	\$ 484
EMDEON	IT	\$ 105
TALX	TAX	\$ 380
PEHLMAN	ACCTG SVC	\$ 526
TOTALS		\$ 21,402

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/12

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
IHCA	DUES	\$ 5,611
MES	SUBSCRIP FEE	\$ 127
EHEALTH	CAREWATCH	\$ 2,700
ALLSCRIPTS	SUBSCRIP FEE	\$ 3,187
AMEX	FEES	\$ 6
TROXELL	FEES	\$ 6
ILLINOIS SECRETARY OF STA	ANNUAL RPT	\$ 50
COLES COUNTY HEALTH DEP	FOOD PERMIT	\$ 250
IDPR	LICENSE	\$ 32
ALEXANDER HAMILTON	EMPLOYEE LAW	\$ -
WOLTERS	OSHA GUIDE	\$ -
MEDPASS	MANUALS	\$ 52
AICPA	ACCTG GUIDE	\$ 50
TAX	TAX	\$ -
TOTALS		\$ 12,071

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/12

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

TOTAL FOOD PURCHASE	\$ 92,027
LESS SALES TAX	\$ <u>(911)</u>
NET FOOD	\$ 91,116
TOTAL PATIENT CENSUS	14,272
MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	42,816
EMPLOYEES MEALS PER DAY	18
DAYS PER YEAR	<u>366</u>
TOTAL EMPLOYEE MEALS	6,588
TOTAL MEALS PER YEAR	49,404
COST PER MEAL	\$ 1.84
TOTAL EMPLOYEE MEAL COST	\$ 12,150

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/12

SCHEDULE OF RENTAL EQUIPMENT

<u>Item</u>	<u>Amount</u>
CONCENTRATORS	\$ 1,371
BEDS	\$ 5,006
STORAGE UNIT	\$ 709
DISHWASHER	\$ 822
POSTAGE MACHINE	\$ 870
COPIER	\$ 5,828
TOTAL	\$ 14,606

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/12

OTHER ADMIN STAFF TRANSPORTATION

<u>EMPLOYEE</u>	<u>AMOUNT</u>
TRANSPORT VAN FUEL AND REPAIRS	\$ 3,081
LESTER ROBERTSON - ADMINISTRATOR	\$ 1,201
BOM, NURSING, MAINT	\$ 4,938

TOTAL \$ 9,220