

Facility Name & ID Number DOCTORS NURSING & REHAB CTR

0046235 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,509	2,100	6,009	16,618	8
9	SNF/PED					9
10	ICF	12,380	4,156		16,536	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,889	6,256	6,009	33,154	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.69%

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)

Outpatient therapy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 05/01/2003

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

YES Date 03/01/2003 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 120 and days of care provided 6,009

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

DOCTORS NURSING & REHAB CTR

0046235

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	165,736	17,354	10,705	193,795		193,795	193,795		1	
2	Food Purchase		205,442		205,442		205,442	(1,881)	203,561	2	
3	Housekeeping	110,240	30,484		140,724		140,724		140,724	3	
4	Laundry	53,292	13,961		67,253		67,253		67,253	4	
5	Heat and Other Utilities			112,326	112,326		112,326	(1,290)	111,036	5	
6	Maintenance	35,762	6,233	33,115	75,110		75,110	4,381	79,491	6	
7	Other (specify):* SCAVENGER			23,410	23,410		23,410		23,410	7	
8	TOTAL General Services	365,030	273,474	179,556	818,060		818,060	1,210	819,270	8	
	B. Health Care and Programs										
9	Medical Director			33,000	33,000		33,000		33,000	9	
10	Nursing and Medical Records	1,840,720	283,579	41,957	2,166,256		2,166,256		2,166,256	10	
10a	Therapy	291,986			291,986		291,986		291,986	10a	
11	Activities	40,061	5,991	1,274	47,326		47,326		47,326	11	
12	Social Services	27,475		1,374	28,849		28,849		28,849	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	2,200,242	289,570	77,605	2,567,417		2,567,417		2,567,417	16	
	C. General Administration										
17	Administrative	110,982		340,054	451,036		451,036	(84,526)	366,510	17	
18	Directors Fees									18	
19	Professional Services			221,119	221,119		221,119	(94,505)	126,614	19	
20	Dues, Fees, Subscriptions & Promotions			29,921	29,921		29,921	(7,915)	22,006	20	
21	Clerical & General Office Expenses	86,742	16,899	144,524	248,165		248,165	(142,555)	105,610	21	
22	Employee Benefits & Payroll Taxes			407,709	407,709		407,709	52,590	460,299	22	
23	Inservice Training & Education							1,215	1,215	23	
24	Travel and Seminar			897	897		897		897	24	
25	Other Admin. Staff Transportation			18,600	18,600	(816)	17,784	(1,285)	16,499	25	
26	Insurance-Prop.Liab.Malpractice			61,767	61,767		61,767	9,212	70,979	26	
27	Other (specify):*			202,399	202,399		202,399	(202,399)		27	
28	TOTAL General Administration	197,724	16,899	1,426,990	1,641,613	(816)	1,640,797	(470,168)	1,170,629	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,762,996	579,943	1,684,151	5,027,090	(816)	5,026,274	(468,958)	4,557,316	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			24,401	24,401		24,401	5,460	29,861			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,803	51,803		51,803	(18,368)	33,435			32
33	Real Estate Taxes			64,366	64,366		64,366	3,453	67,819			33
34	Rent-Facility & Grounds			769,189	769,189		769,189		769,189			34
35	Rent-Equipment & Vehicles			196,646	196,646	816	197,462		197,462			35
36	Other (specify):*											36
37	TOTAL Ownership			1,106,405	1,106,405	816	1,107,221	(9,455)	1,097,766			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		324,587	783,596	1,108,183		1,108,183		1,108,183			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			230,263	230,263		230,263		230,263			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		324,587	1,013,859	1,338,446		1,338,446		1,338,446			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,762,996	904,530	3,804,415	7,471,941		7,471,941	(478,413)	6,993,528			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	(4,916)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,747	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	2		13
14	Non-Care Related Interest	(21,385)	32		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(202,399)	27		24
25	Fund Raising, Advertising and Promotional	(7,442)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(70,494)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (303,893)		\$	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)	(174,520)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (174,520)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (478,413)		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

BHF USE ONLY						
48		49		50		51
						52

DOCTORS NURSING & REHAB CTR

ID# 0046235

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARY	\$ (50,180)	21	1
2	HEALTH CARE HORIZONS	(9,000)	19	2
3	MARKETING TRAVEL	(5,628)	25	3
4	CHAMBER OF COMMERCE	(640)	20	4
5	COLLECTION LEGAL	(2,070)	19	5
6	D&B	(1,099)	19	6
7	SALES TAX FOOD	(1,877)	2	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		(70,494)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	(1,881)	0	0	0	0	0	0	0	0	0	0	(1,881)	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	(4,916)	3,626	0	0	0	0	0	0	0	0	0	(1,290)	5
6	Maintenance	0	4,381	0	0	0	0	0	0	0	0	0	4,381	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,797)	8,007	0	0	0	0	0	0	0	0	0	1,210	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	(84,526)	0	0	0	0	0	0	0	0	0	(84,526)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,169)	(82,336)	0	0	0	0	0	0	0	0	0	(94,505)	19
20	Fees, Subscriptions & Promotions	(8,082)	167	0	0	0	0	0	0	0	0	0	(7,915)	20
21	Clerical & General Office Expenses	(50,180)	(92,959)	584	0	0	0	0	0	0	0	0	(142,555)	21
22	Employee Benefits & Payroll Taxes	0	52,590	0	0	0	0	0	0	0	0	0	52,590	22
23	Inservice Training & Education	0	1,215	0	0	0	0	0	0	0	0	0	1,215	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(5,628)	4,343	0	0	0	0	0	0	0	0	0	(1,285)	25
26	Insurance-Prop.Liab.Malpractice	0	9,212	0	0	0	0	0	0	0	0	0	9,212	26
27	Other (specify):*	(202,399)	0	0	0	0	0	0	0	0	0	0	(202,399)	27
28	TOTAL General Administration	(278,458)	(192,294)	584	0	(470,168)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(285,255)	(184,287)	584	0	(468,958)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/2015 Ending:

12/31/2015

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	2,747	0	2,713	0	0	0	0	0	0	0	0	5,460	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,385)	0	3,017	0	0	0	0	0	0	0	0	(18,368)	32
33	Real Estate Taxes	0	0	3,453	0	0	0	0	0	0	0	0	3,453	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	(18,638)	0	9,183	0	(9,455)	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)	(303,893)	(184,287)	9,767	0	(478,413)	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>EVERGREEN NURSING</u>	<u>EFFINGHAM</u>	<u>HI CARE MGMT</u>	<u>SPRINGFIELD</u>	<u>MANAGEMENT</u>
<u>WILLIAM IRVINE</u>	<u>37.5</u>	<u>DOUGLAS NURSING</u>	<u>MATTOON</u>	<u>H&I PROPERTIES</u>	<u>SPRINGFIELD</u>	<u>REAL ESTATE</u>
<u>MORRIS ESFORMES</u>	<u>15</u>			<u>HEALTHCARE</u>	<u>SPRINGFIELD</u>	<u>NURSE CONSULT</u>
<u>SANDRA SEGAL</u>	<u>10</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	17	<u>MANAGEMENT FEES</u>	\$ <u>340,054</u>			\$	<u>(340,054)</u>	1	
2	V	21	<u>HOME OFFICE EXPENSE</u>	<u>110,000</u>				<u>(110,000)</u>	2	
3	V	19	<u>ADMINISTRATIVE CONSULT</u>	<u>85,284</u>				<u>(85,284)</u>	3	
4	V	6	<u>MAINTENANCE</u>					<u>4,381</u>	4	
5	V	5	<u>UTILITIES</u>					<u>3,626</u>	5	
6	V	17	<u>ADMINISTRATION</u>					<u>255,528</u>	6	
7	V	21	<u>OFFICE EXPENSE</u>					<u>17,041</u>	7	
8	V	19	<u>PROFESSIONAL SVCS</u>					<u>2,948</u>	8	
9	V	20	<u>DUES AND SUBSCRIPTIONS</u>					<u>167</u>	9	
10	V	23	<u>TRAINING AND EDUCATION</u>					<u>1,215</u>	10	
11	V	25	<u>TRAVEL</u>					<u>4,343</u>	11	
12	V	26	<u>LIABILITY INSURANCE</u>					<u>9,212</u>	12	
13	V	22	<u>PAYROLL TAX AND BENEFITS</u>					<u>52,590</u>	13	
14	Total		\$ <u>535,338</u>				\$	<u>351,051</u>	\$ * <u>(184,287)</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)		\$ 2,713	\$	2,713	15
16	V	32 INTEREST		H&I PROPERTIES (HOME OFFICE)		3,017		3,017	16
17	V	33 REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		3,453		3,453	17
18	V	21 OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		584		584	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		\$			\$ 9,767	\$ *	9,767	39

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	118,398	16.15	0.40	SALARY	\$ 80,128	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	37.50	112,825	16.15	0.40	SALARY	76,356	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	8,615	16.15	0.40	SALARY	5,831	17-7	3
4	DEREK HEDGES	COO	OFFICE MGMT	0.00	60,050	16.15	0.40	SALARY	40,639	17-7	4
5	MORRIS ESFORMES			15.00							5
6	SANDRA SEGAL			10.00							6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 202,954		13

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

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

Facility Name & ID Number DOCTORS NURSING & REHAB CTR

0046235

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	82,143	3	\$ 10,854	\$ 3,101	33,154	\$ 4,381	1
2	5	UTILITIES	PER RESIDENT DAY	82,143	3	8,983		33,154	3,626	2
3	10	NURSING	PER RESIDENT DAY	82,143	3			33,154	0	3
4	17	ADMINISTRATION	PER RESIDENT DAY	82,143	3	633,101	633,101	33,154	255,528	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	82,143	3	42,222		33,154	17,041	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	82,143	3	7,303		33,154	2,948	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	82,143	3	414		33,154	167	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	82,143	3	3,010		33,154	1,215	8
9	25	TRAVEL	PER RESIDENT DAY	82,143	3	10,760		33,154	4,343	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	82,143	3	22,824		33,154	9,212	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	82,143	3	130,298		33,154	52,590	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					\$ 869,769	\$ 636,202		\$ 351,051	25

Facility Name & ID Number DOCTORS NURSING & REHAB CTR

0046235

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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 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)528-0412

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	30	DEPRECIATION	PER LICENSE BED	319	3	\$ 7,213	\$ 120	\$ 2,713	1
2	32	INTEREST	PER LICENSE BED	319	3	8,019	120	3,017	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	319	3	9,180	120	3,453	3
4	21	OFFICE EXPENSE	PER LICENSE BED	319	3	1,552	120	584	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					\$ 25,964	\$	\$ 9,767	25

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	US BANK H&I PROPERTIES		X			06/29/2005	\$	\$ 67,202	06/29/2017	0.0425	\$ 3,017	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV		725,000	08/15/2016	PRIME +	30,418	6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$ 792,202			\$ 33,435	9						
B. Non-Facility Related*																		
10	AVIV		X	WORKING CAPITAL		05/01/2013		305,613	05/01/2020	0.0800	21,385	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$ 305,613			\$ 21,385	14						
15	TOTALS (line 9+line14)						\$	\$ 305,613			\$ 54,820	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 2014 report.		\$	148,041		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.)		\$	108,154		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(39,887)		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	107,706		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.		\$	67,819		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	134,625	8	FOR BHF USE ONLY	
	2011	142,309	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$
	2012	144,448	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2013	147,713	11	15	LESS REFUND FROM LINE 6 \$
	2014	108,154	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
Prior Yr					

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOCTORS NURSING & REHAB CTR COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0046235

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 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-03-400-012</u>	<u>NURSING HOME</u>	\$ <u>104,701.02</u>	\$ <u>104,701.02</u>
2. <u>22-03.0-107-018</u>	<u>HOME OFFICE</u>	\$ <u>5,514.42</u>	\$ <u>2,074.39</u>
3. <u>22-03.0-107-017</u>	<u>HOME OFFICE</u>	\$ <u>3,665.34</u>	\$ <u>1,378.81</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>113,880.78</u></u>	\$ <u><u>108,154.22</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 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame METAL 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			2005	\$ 21,818	1
2					2
3	TOTALS			\$ 21,818	3

Facility Name & ID Number **DOCTORS NURSING & REHAB CTR**# **0046235**

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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					\$	\$		\$	\$	\$	4
5											5
6	H&I										6
7	PROP										7
8	OFC BLD		2005		98,895	2,713	39	2,713			8
	Improvement Type**										
9	WATER HEATER		2003		6,135	223	27.5	223		2,741	9
10	WATER HEATER		2004		8,145	296	27.5	296		3,490	10
11	TILING		2005		4,980	181	27.5	181		1,908	11
12	SIDEWALK		2005		6,300	420	15	420		4,410	12
13	WALL HEAT & A/C UNIT		2006		1,075	39	27.5	39		363	13
14	DOORS		2007		2,828	103	27.5	103		880	14
15	CARPETING		2007		23,768		5			23,768	15
16	ROOF (1 OF 2)		2008		2,475	90	27.5	90		1,633	16
17	FENCE		2008		3,964	264	15	264		1,981	17
18	THERAPY ROOM		2009		157,255	5,718	27.5	5,718		37,405	18
19	WATER HEATER		2010		14,133	514	27.5	514		2,703	19
20	AC UNIT		2011		2,690		27.5	98	98	461	20
21	FREEZER		2012		4,291	235	7	613	378	2,375	21
22	AC UNIT		2012		2,950	107	27.5	107		334	22
23	ROOF FLASHING		2013		3,350	86	27.5	86		226	23
24	ELECTRICAL BREAKER		2013		2,109	54	27.5	54		137	24
25	FLOORING IN ALL HALLWAYS (NORTH, WEST, SW, PHOENIX)		2014		19,144	491	27.5	491		512	25
26	ISLANDAIRE HVAC ON PHOENIX WING ROOM 110		2015		6,299	61	27.5	61		61	26
27	5 TON AC UNIT KITCHEN		2015		2,989	17	27.5	17		17	27
28											28
29											29
30											30
31											31
32	ROOF (2 OF 2) THIS PORTION PAID BY LANDLORD		2008		122,006						32
33	WINDOWS (PAID BY LANDLORD)		2008		86,718						33
34	A/C CORRIDORS EXISTING BUILDING (PAID BY LANDLORD)		2008		44,160						34
35	SPRINKLER SYSTEM (PAID BY LANDLORD)		2009		93,600						35
36	THERAPY ROOM ADDITION (PAID BY LANDLORD)		2009		553,516						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 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)		\$ 1,273,775	\$ 11,612		\$ 12,088	\$ 476	\$ 85,405	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	\$ 196,318	\$ 14,964	\$ 17,235	\$ 2,271	5-10yrs	\$ 104,329	71
72	Current Year Purchases	2,691	538	538		5-10yrs	538	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 199,009	\$ 15,502	\$ 17,773	\$ 2,271		\$ 104,867	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)	\$ 1,494,602	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 27,114	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,861	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,747	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 190,272	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SALEM ASSOCIATES 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:		120		\$ 769,189			3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 769,189			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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 187,850 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	\$ 816.00	\$ 9,792	17
18					18
19					19
20					20
21	TOTAL		\$ 816.00	\$ 9,792	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 DOCTORS NURSING & REHAB CTR # 0046235 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
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>
--	---	--

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	288,193	\$		\$	288,193	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				136,053				136,053	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				359,350				359,350	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					324,587			324,587	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			\$		\$	783,596	\$	324,587	\$	1,108,183	14

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

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

0046235

Report Period Beginning: **1/1/2015**

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2015** (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	\$ (28,479)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100,000))	2,302,511		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,264		6
7	Other Prepaid Expenses	170,623		7
8	Accounts Receivable (owners or related parties)	504,500		8
9	Other(specify): Due from Medicare	34,719		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,000,138	\$	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	251,112		15
16	Equipment, at Historical Cost	222,777		16
17	Accumulated Depreciation (book methods)	(249,858)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	54,362		21
22	Other Long-Term Assets (spec Deposit)	30,000		22
23	Other(specify): RE tax escrow	107,842		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 416,235	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,416,373	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 983,594	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	725,000		29
30	Accrued Salaries Payable	94,483		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,700		31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,701		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Medicaid Advance	199,115		36
37	Advance Billing	98,206		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,216,799	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	157,278		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)	\$ 157,278	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,374,077	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,042,296	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,416,373	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 659,599	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 659,599	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	382,697	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)	\$ 382,697	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)	\$ 1,042,296	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	\$ 7,470,628	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,470,628	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	381,831	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 381,831	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***	2,179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,179	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,854,638	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	818,060	31
32	Health Care	2,567,417	32
33	General Administration	1,641,613	33
B. Capital Expense			
34	Ownership	1,106,405	34
C. Ancillary Expense			
35	Special Cost Centers	1,108,183	35
36	Provider Participation Fee	230,263	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,471,941	40
41	Income before Income Taxes (line 30 minus line 40)**	382,697	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 382,697	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,744,450	44
45	Private Pay - Net Inpatient Revenue	838,551	45
46	Medicare - Net Inpatient Revenue	2,667,920	46
47	Other-(specify) INSURANCE	219,707	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,470,628	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 DOCTORS NURSING & REHAB CTR

0046235

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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	1,984	2,080	\$ 69,096	\$ 33.22	1
2	Assistant Director of Nursing	1,921	2,000	53,725	26.86	2
3	Registered Nurses	15,082	16,526	367,348	22.23	3
4	Licensed Practical Nurses	23,798	26,179	499,655	19.09	4
5	CNAs & Orderlies	62,055	66,636	716,561	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,271	16,316	291,986	17.90	8
9	Activity Director	1,801	2,050	23,208	11.32	9
10	Activity Assistants	1,910	2,013	16,853	8.37	10
11	Social Service Workers	2,078	2,349	27,475	11.70	11
12	Dietician					12
13	Food Service Supervisor	1,858	2,103	31,127	14.80	13
14	Head Cook	7,244	7,898	69,323	8.78	14
15	Cook Helpers/Assistants	6,333	7,125	65,286	9.16	15
16	Dishwashers					16
17	Maintenance Workers	2,451	2,677	35,762	13.36	17
18	Housekeepers	11,434	12,502	110,240	8.82	18
19	Laundry	5,794	6,313	53,292	8.44	19
20	Administrator	1,776	2,080	110,982	53.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,964	2,141	31,999	14.95	23
24	Clerical	519	528	4,563	8.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	623	646	6,596	10.21	31
32	Other Health C: <u>Cent Supply, MDS</u>	5,382	6,000	127,739	21.29	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,278	186,162	\$ 2,712,816 *	\$ 14.57	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	216	\$ 10,705	1-3	35
36	Medical Director	MONTHLY	33,000	9-3	36
37	Medical Records Consultant	32	2,137	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	MONTHLY	3,291	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,274	11-3	44
45	Social Service Consultant	22	1,274	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	292	\$ 51,681		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-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 DOCTORS NURSING & REHAB CTR

0046235

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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, \$7200
- (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. \$ 22,498 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. \$ 230,263
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? YES For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 25%
- 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

DOCTORS NURSING AND REHABILITATION CARE CENTER
 FACILITY ID 0046235
 SCHEDULES
 COST REPORT PERIOD ENDING 12/31/15

SCHEDULE XIX (C) PROFESSIONAL SERVICES

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
IIT SOURCETECH	IT	
TALX	PAYROLL	\$ 2,701
COMPASS CFO SERVICES	ACCOUNTING	\$ 60,000
SIKICH	ACCOUNTING	\$ 15,319
HEALTHLINK	BILLING	\$ 3,419
SMARTLINX	PAYROLL	\$ 7,768
MDI	BILLING/MDS	\$ 32,525
BPC	401K Third Party Admin	\$ 370
ESOLUTONS	BILLING	\$ 1,879
INNOVATIVE LTC SOLUTIONS	BILLING	\$ 1,684
IIT/SOURCETECH	IT	\$ 755
WILLIAM RADKEY	LEGAL	\$ 115
WAGE WORKS	PAYROLL	\$ 79
TOTAL		\$ 126,614

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/15

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
ALLSCRIPTS	SUBSCRIPTIONS	\$ 3,224
MES	DUES	\$ 175
EHEALTH	ANNUAL SUBSCRIPTION	\$ 4,213
SMARTLINX	LICENSE	\$ 218
IHCA	DUES	\$ 7,200
CARDMEMBER SVCS	FEES	\$ 278
ILLINOIS SECRETARY OF STA	FEES	\$ 408
MEDPASS	SUBSCRIPTIONS	<u>\$ 166</u>

TOTALS \$ 15,882

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/15

SCHEDULE XIX (G) TRAVEL AND SEMINAR

<u>SEMINARS</u>	<u>AMOUNT</u>
IHCA	\$ 897
Total	<hr/> <u>\$ 897</u>

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/15

SCHEDULE OF RENTAL EQUIPMENT

<u>Item</u>	<u>Amount</u>
CONCENTRATORS	\$ 75,591
BEDS	\$ 72,389
IV PUMPS	\$ 4,735
ICE MACHINE	\$ 3,426
WASHING MACHINE	\$ 5,868
COPIERS	\$ 13,552
POSTAGE EQUIPMENT	\$ 964
COMPUTERS	\$ 9,825
STORAGE UNIT	\$ 1,500
TOTAL RENTALS	\$ 187,850

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/15

SALES TAX EXCLUSION

TOTAL FOOD PURCHASES WITH TAX \$ 189,627

TOTAL FOOD PURCHASES WITHOUT TAX \$ 187,750

TOTAL SALES TAX \$ 1,877

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/15

OTHER ADMIN STAFF TRANSPORTATION

<u>EMPLOYEE</u>	<u>AMOUNT</u>
TRANSPORT VAN FUEL AND REPAIRS	\$ 7,543
KYLE MOOREW ADMINISTRATOR	\$ 3,316
Other Employee Travel	\$ 1,297
Corporate Staff Travel	<u>\$ 4,343</u>
TOTALS	\$ 16,499

DOCTORS NURSING AND REHAB CENTER
 FACILITY ID 0046235
 SCHEDULE VII
 C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
 REPORT PERIOD ENDING 12/31/2015

FACILITY ID	0046417 EVERGREEN	0046250 DOUGLAS	TOTAL
<u>NAME</u>	<u>NURSING AND REHAB</u>	<u>NURSING AND REHAB</u>	<u>OTHER</u>
ROBERT HEDGES	\$ 77,677	\$ 40,721	\$ 118,398
WILLIAM IRVINE	\$ 74,021	\$ 38,804	\$ 112,825
MARTHA IRVINE	\$ 5,652	\$ 2,963	\$ 8,615
DEREK HEDGES	\$ 39,396	\$ 20,654	\$ 60,050
	\$ 196,746	\$ 103,142	\$ 299,888

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/15

RECLASSIFICATIONS

<u>FROM</u>	<u>Amount</u>
Line 25 Other Admin Staff Transportation	\$ (816)

<u>TO</u>	
Line 35 Rent Equipment & Vehicles	\$ 816

To correct accounting miscode discovered after close