

Facility Name & ID Number DOUGLAS NURSING & REHAB CTR

0046250 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3	242	2,769	3,014	8
9	SNF/PED					9
10	ICF	8,190	2,331		10,521	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,193	2,573	2,769	13,535	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.81%

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)

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 2,507

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number **DOUGLAS NURSING & REHAB CTR** # **0046250** Report Period Beginning: **1/1/2016** Ending: **12/31/2016**

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	130,760	7,020	5,476	143,256		143,256		143,256		1
2	Food Purchase		93,600		93,600	(2,544)	91,056	830	91,886		2
3	Housekeeping	89,501	11,449		100,950		100,950		100,950		3
4	Laundry	23,610	4,621		28,231		28,231		28,231		4
5	Heat and Other Utilities			105,388	105,388		105,388	(10,645)	94,743		5
6	Maintenance	46,703	4,738	21,313	72,754		72,754	1,156	73,910		6
7	Other (specify):* SCAVENGER			11,223	11,223		11,223		11,223		7
8	TOTAL General Services	290,574	121,428	143,400	555,402	(2,544)	552,858	(8,659)	544,199		8
	B. Health Care and Programs										
9	Medical Director			8,000	8,000		8,000		8,000		9
10	Nursing and Medical Records	887,188	95,359	150,457	1,133,004		1,133,004		1,133,004		10
10a	Therapy	14,212			14,212		14,212		14,212		10a
11	Activities	39,765	1,420	1,879	43,064		43,064		43,064		11
12	Social Services	33,600		1,790	35,390		35,390		35,390		12
13	CNA Training										13
14	Program Transportation			3,271	3,271		3,271		3,271		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	974,765	96,779	165,397	1,236,941		1,236,941		1,236,941		16
	C. General Administration										
17	Administrative	71,919			71,919		71,919	103,809	175,728		17
18	Directors Fees										18
19	Professional Services			121,263	121,263		121,263	3,355	124,618		19
20	Dues, Fees, Subscriptions & Promotions			41,218	41,218		41,218	(25,196)	16,022		20
21	Clerical & General Office Expenses	59,146	12,124	28,528	99,798		99,798	(10,114)	89,684		21
22	Employee Benefits & Payroll Taxes			188,361	188,361	2,544	190,905	23,526	214,431		22
23	Inservice Training & Education										23
24	Travel and Seminar			806	806		806	265	1,071		24
25	Other Admin. Staff Transportation			6,867	6,867		6,867	969	7,836		25
26	Insurance-Prop.Liab.Malpractice			33,375	33,375		33,375	507	33,882		26
27	Other (specify):*			263,895	263,895		263,895	(263,895)			27
28	TOTAL General Administration	131,065	12,124	684,313	827,502	2,544	830,046	(166,774)	663,272		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,396,404	230,331	993,110	2,619,845		2,619,845	(175,433)	2,444,412		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.

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

#0046250

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			13,160	13,160		13,160	1,786	14,946			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,227	21,227		21,227	1,840	23,067			32
33	Real Estate Taxes			28,413	28,413		28,413	138	28,551			33
34	Rent-Facility & Grounds			601,039	601,039		601,039		601,039			34
35	Rent-Equipment & Vehicles			47,839	47,839		47,839		47,839			35
36	Other (specify):*											36
37	TOTAL Ownership			711,678	711,678		711,678	3,764	715,442			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,831	274,773	368,604		368,604		368,604			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,112	110,112		110,112		110,112			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		93,831	384,885	478,716		478,716		478,716			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,396,404	324,162	2,089,673	3,810,239		3,810,239	(171,669)	3,638,570			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	(10,737)	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				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	(920)	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	(545)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,905)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(263,300)	27		24
25	Fund Raising, Advertising and Promotional	(17,513)	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	(24,645)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (319,565)		\$	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)	147,896		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 147,896		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (171,669)		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	

ID# 0046250

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	MARKETING COORDINATOR	\$ (16,251)	21	1
2	NON RELATED REAL ESTATE TAX	(2,232)	33	2
3	FINGERPRINT INCOME	(50)	27	3
4	EMPLOYEE MEAL INCOME	1,750	2	4
5	CHAMBER OF COMMERCE	(536)	20	5
6	ADVERTISING	(7,200)	20	6
7	MARKETING TRAVEL	(411)	25	7
8	NON INCLUDABLE UTILITIES	(965)	5	8
9	DUNN & BRADSTREET NON INCLUDABLE	2,398	19	9
10	RELATED EXPENSE	(1,128)	19	10
11	ADVERTISING	(20)	20	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	(24,645)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOUGLAS NURSING & REHAB CTR# 0046250

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	830	0	0	0	0	0	0	0	0	0	0	830	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	(11,702)	1,057	0	0	0	0	0	0	0	0	0	(10,645)	5
6	Maintenance	0	1,156	0	0	0	0	0	0	0	0	0	1,156	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,872)	2,213	0	0	0	0	0	0	0	0	0	(8,659)	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	103,809	0	0	0	0	0	0	0	0	0	103,809	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(635)	2,616	1,374	0	0	0	0	0	0	0	0	3,355	19
20	Fees, Subscriptions & Promotions	(25,269)	73	0	0	0	0	0	0	0	0	0	(25,196)	20
21	Clerical & General Office Expenses	(16,251)	5,745	392	0	0	0	0	0	0	0	0	(10,114)	21
22	Employee Benefits & Payroll Taxes	0	23,526	0	0	0	0	0	0	0	0	0	23,526	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	265	0	0	0	0	0	0	0	0	0	265	24
25	Other Admin. Staff Transportation	(411)	1,380	0	0	0	0	0	0	0	0	0	969	25
26	Insurance-Prop.Liab.Malpractice	0	507	0	0	0	0	0	0	0	0	0	507	26
27	Other (specify):*	(263,895)	0	0	0	0	0	0	0	0	0	0	(263,895)	27
28	TOTAL General Administration	(306,461)	137,921	1,766	0	(166,774)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(317,333)	140,134	1,766	0	(175,433)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOUGLAS NURSING & REHAB CTR

0046250

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	0	0	1,786	0	0	0	0	0	0	0	0	1,786	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,840	0	0	0	0	0	0	0	0	1,840	32
33	Real Estate Taxes	(2,232)	0	2,370	0	0	0	0	0	0	0	0	138	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,232)	0	5,996	0	3,764	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(319,565)	140,134	7,762	0	(171,669)	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
ROBERT HEDGES	37.5	DOCTORS NURSING	SALEM	HI CARE	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	37.5	EVERGREEN NURSING	EFFINGHAM	MANAGEMENT		
MORRIS ESFORMES	15					
SANDRA SEGAL	10			H&I PROPERTIES	SPRINGFIELD	REAL ESTATE
				HEALTHCARE	SPRINGFIELD	NURSE CONSULT
				HORIZONS		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	17	MANAGEMENT FEES	\$				1	
2	V	6	MAINTENANCE				1,156	2	
3	V	5	UTILITIES				1,057	3	
4	V	10	NURSING					4	
5	V	17	ADMINISTRATION				103,809	5	
6	V	21	OFFICE EXPENSE				5,745	6	
7	V	19	PROFESSIONAL SVCS				2,616	7	
8	V	20	DUES AND SUBSCRIPTIONS				73	8	
9	V	24	TRAINING AND EDUCATION				265	9	
10	V	25	TRAVEL				1,380	10	
11	V	26	LIABILITY INSURANCE				507	11	
12	V	22	PAYROLL TAX AND BENEFITS				23,526	12	
13	V							13	
14	Total		\$			\$	\$ *	140,134	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)		\$ 1,786	\$	1,786	15
16	V	32 INTEREST		H&I PROPERTIES (HOME OFFICE)		1,840		1,840	16
17	V	33 REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		2,370		2,370	17
18	V	21 OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		392		392	18
19	V	19 PROFESSIONAL SVCS		H&I PROPERTIES (HOME OFFICE)		1,374		1,374	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		\$			\$ 7,762	\$ *	7,762	39

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

Facility Name & ID Number DOUGLAS NURSING & REHAB CTR # 0046250 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	139,401	7.085	0.18	SALARY	\$ 30,008	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	37.50	139,401	7.085	0.18	SALARY	30,008	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	7,237	7.085	0.18	SALARY	1,237	17-7	3
4	DEREK HEDGES	VP OPERATIONS	VP OPERATIONS	0.00	89,925	7.085	0.18	SALARY	19,358	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	\$ 80,611		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 & REHAB CTR

0046250

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

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	76,412	3	\$ 6,524	\$ 2,197	13,535	\$ 1,156	1
2	5	UTILITIES	PER RESIDENT DAY	76,412	3	5,970		13,535	1,057	2
3	10	NURSING	PER RESIDENT DAY	76,412	3			13,535	0	3
4	17	ADMINISTRATION	PER RESIDENT DAY	76,412	3	586,056	586,056	13,535	103,809	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	76,412	3	32,431		13,535	5,745	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	76,412	3	14,768		13,535	2,616	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	76,412	3	414		13,535	73	7
8	24	TRAINING AND EDUCATION	PER RESIDENT DAY	76,412	3	1,495		13,535	265	8
9	25	TRAVEL	PER RESIDENT DAY	76,412	3	7,788		13,535	1,380	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	76,412	3	2,860		13,535	507	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	76,412	3	132,818		13,535	23,526	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					\$ 791,124	\$ 588,253		\$ 140,134	25

Facility Name & ID Number DOUGLAS NURSING & REHAB CTR

0046250

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

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	319	3	\$ 7,213	\$ 79	\$ 1,786	1
2	32	INTEREST	PER LICENSE BED	319	3	7,430	79	1,840	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	319	3	9,569	79	2,370	3
4	21	OFFICE EXPENSE	PER LICENSE BED	319	3	1,581	79	392	4
5	19	PROFESSIONAL SVCS	PER LICENSE BED	319	3	5,550	79	1,374	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					\$ 31,343	\$ 79	\$ 7,762	25

Facility Name & ID Number

DOUGLAS NURSING & REHAB CTR

0046250

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	US BANK (H&I PROP)		X	MORTGAGE HOME OFFICE		06/29/2005	\$	\$	06/29/2017	0.0425	\$ 1,840	1								
2												2								
3	MEMBER LOAN	X		WORKING CAPITAL	INTEREST	07/18/2003	99,667	299,667	10/01/2023	0.0700	6,395	3								
4	ALLIANCE LAUNDRY		X	LAUNDRY EQUIPMENT		03/20/2012	32,618	13,948	03/20/2018	0.0862	950	4								
5												5								
Working Capital																				
6	MB FINANCIAL BANK		X	WORKING CAPITAL	INTEREST	REVOLV		290,000	2/15/17	PRIME +	13,882	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 132,285	\$ 603,615			\$ 23,067	9								
B. Non-Facility Related*																				
10	AVIV		X	WORKING CAPITAL		05/01/2013	305,613	283,006	05/01/2020	0.0800		10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 305,613	\$ 283,006			\$	14								
15	TOTALS (line 9+line14)						\$ 437,898	\$ 886,621			\$ 23,067	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 2015 report.		\$	28,945	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.)		\$	27,432	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,513)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,064	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.		\$	28,551	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	25,342	8	
	2012	26,409	9	
	2013	25,737	10	
	2014	26,780	11	
	2015	27,432	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOUGLAS NURSING & REHAB CTR COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0046250

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

TELEPHONE (217) 528-2244 FAX #: (217) 528-3412

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-1-00300-000</u>	<u>NURSING HOME</u>	\$ <u>24,578.60</u>	\$ <u>24,578.60</u>
2. <u>07-1-00572-000</u>	<u>NURSING HOME</u>	\$ <u>545.40</u>	\$ <u>545.40</u>
3. <u>22-03.0-107-017</u>	<u>HOME OFFICE</u>	\$ <u>3,721.04</u>	\$ <u>921.61</u>
4. <u>22-03.0-107-018</u>	<u>HOME OFFICE</u>	\$ <u>5,598.32</u>	\$ <u>1,386.56</u>
5. <u>07-1-00300-001</u>	<u>DUPLEX</u>	\$ <u>2,231.78</u>	\$
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>36,675.14</u></u>	\$ <u><u>27,432.17</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number DOUGLAS NURSING & REHAB CTR

0046250

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,116 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).

Blank lines for listing other business entities.

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.

Table with 4 columns: Use, Square Feet, Year Acquired, Cost. Row 1: HOME OFFICE, 2005, \$14,364. Row 2: (blank). Row 3: TOTALS, \$14,364.

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	OFFC BLD	2005		65,106	1,786	39	1,786		8	
Improvement Type**										
9	INSULATION		2004	10,441	380	27.5	380		4,701	9
10	REPLACE HEAT & CHILL LINES		2005	3,245	118	27.5	118		1,303	10
11	COMPRESSOR REPAIR		2006	14,696	534	27.5	534		5,498	11
12	GENERATOR (1 OF 2)		2008	2,670	97	27.5	97		805	12
13	DRAPES		2008	3,962		5			3,962	13
14	PAINTING & WALL VINYL		2008	8,203		5			8,203	14
15	COMPRESSOR REPAIR		2009	19,021	691	27.5	691		5,096	15
16	INSTALL SPRINKLERS IN REST ROOM AND CLOSET		2009	6,877	250	27.5	250		1,845	16
17	ROOF TOP VENTILATING FANS		2009	4,251	155	27.5	155		1,144	17
18	PUMPS		2010	3,461	103	27.5	103		678	18
19	NEW BEARING AND SEALS ON FAN		2010	3,132	126	27.5	126		766	19
20	HOT WATER BOOSTER HEATER		2010	2,853	114	27.5	114		717	20
21	AC CIRCULATION PUMP		2011	3,415	124	27.5	124		699	21
22	WATER HEATER		2011	5,564	202	27.5	202		1,037	22
23										23
24	SEWER LINE REPAIRS		2012	8,350	304	27.5	304		1,227	24
25	THERAPY ROOM ADDITION AND UPGRAGE MECHANICALS		2013	1,237,453						25
26	(PAID BY LANDLORD)									26
27	ROOF REPLACEMENT PAID BY LANDLORD		2014	111,900						27
28	SEWER INSTALL FRONT OF BUILDING		2015	8,550	219	27.5	219		246	28
29	GENERATOR TIMER, CAT GENERATOR		2016	1,240	21	27.5	21		21	29
30										30
31										31
32										32
33										33
34										34
35			2008	25,620						35
36	HOT WATER HEATER (PAID BY LANDLORD)		2008	7,923						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)	\$ 1,557,933	\$ 5,224		\$ 5,224	\$	\$ 37,948	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	\$ 118,762	\$ 9,722	\$ 9,722	\$	5-10 YRS	\$ 69,742	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 118,762	\$ 9,722	\$ 9,722	\$		\$ 69,742	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)	\$ 1,691,059	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,946	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,946	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 107,690	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

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		\$ 601,039			3
4	Additions							4
5								5
6								6
7	TOTAL		79		\$ 601,039			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 38,659 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	\$ 9,180	17
18					18
19					19
20					20
21	TOTAL		\$ 816.00	\$ 9,180	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.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 104,840	\$		\$ 104,840	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			36,456			36,456	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			133,477			133,477	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				93,831		93,831	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			\$		\$ 274,773	\$ 93,831		\$ 368,604	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.

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (5,447)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>80,000</u>)	879,469		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,503		6
7	Other Prepaid Expenses	4,839		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>RE TAX ESCROW</u>	27,485		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 914,849	\$	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	97,766		15
16	Equipment, at Historical Cost	130,927		16
17	Accumulated Depreciation (book methods)	(128,194)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	34,544		21
22	Other Long-Term Assets (spe <u>INSURANCE</u>)	19,750		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 154,793	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,069,642	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 636,226	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	290,000		29
30	Accrued Salaries Payable	80,062		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,813		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,197		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>ADVANCE BILLING</u>	46,370		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,093,668	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	596,621		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>RELATED PARTY AP</u>	1,614,500		43
44	<u>RESTRICTED RTF</u>	9,554		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,220,675	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,314,343	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,244,701)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,069,642	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,343,451)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,343,451)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(901,250)	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)	\$ (901,250)	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)	\$ (2,244,701)	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	\$ 2,818,764	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,818,764	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	78,196	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 78,196	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***	29	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RENTAL	12,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,908,989	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	555,402	31
32	Health Care	1,236,941	32
33	General Administration	827,502	33
B. Capital Expense			
34	Ownership	711,678	34
C. Ancillary Expense			
35	Special Cost Centers	368,604	35
36	Provider Participation Fee	110,112	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,810,239	40
41	Income before Income Taxes (line 30 minus line 40)**	(901,250)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (901,250)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,214,129	44
45	Private Pay - Net Inpatient Revenue	377,666	45
46	Medicare - Net Inpatient Revenue	1,121,830	46
47	Other-(specify) INSURANCE	105,049	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,818,674	49

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

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

*** 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 & REHAB CTR

0046250

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	1,308	1,386	\$ 42,389	\$ 30.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,818	1,858	46,008	24.76	3
4	Licensed Practical Nurses	13,685	14,515	296,421	20.42	4
5	CNAs & Orderlies	33,409	35,254	415,599	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	977	1,282	14,212	11.09	8
9	Activity Director	1,659	1,944	22,856	11.76	9
10	Activity Assistants	1,788	1,823	16,909	9.28	10
11	Social Service Workers	1,930	2,159	33,600	15.56	11
12	Dietician					12
13	Food Service Supervisor	2,060	2,213	31,212	14.10	13
14	Head Cook	5,302	5,542	48,795	8.80	14
15	Cook Helpers/Assistants	5,793	5,981	50,753	8.49	15
16	Dishwashers					16
17	Maintenance Workers	2,727	3,015	46,703	15.49	17
18	Housekeepers	9,142	9,616	89,501	9.31	18
19	Laundry	2,584	2,744	23,610	8.60	19
20	Administrator	1,880	2,115	71,919	34.00	20
21	Assistant Administrator					21
22	Other Administrative	1,041	1,161	12,672	10.91	22
23	Office Manager	1,495	1,747	30,223	17.30	23
24	Clerical					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	903	1,051	11,699	11.13	31
32	Other Health C: <u>MDS, Transport</u>	3,595	3,898	75,072	19.26	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	93,096	99,304	\$ 1,380,153 *	\$ 13.90	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	120	\$ 5,476	1-3	35
36	Medical Director	MONTHLY	8,000	9-3	36
37	Medical Records Consultant	40	3,028	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	MONTHLY	1,353	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	MONTHLY		10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,879	11-3	44
45	Social Service Consultant	29	1,790	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	219	\$ 21,526		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,561	\$ 80,124	10-3	50
51	Licensed Practical Nurses	106	2,440	10-3	51
52	Certified Nurse Assistants/Aides	1,794	46,559	10-3	52
53	TOTAL (lines 50 - 52)	3,461	\$ 129,123		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			
JANET DOBBS	ADMINISTRATOR	0	\$ 71,919	Workers' Compensation Insurance	\$ 9,075	IDPH License Fee	\$ 1,990			
				Unemployment Compensation Insurance	47,079	Advertising: Employee Recruitment	2,686			
				FICA Taxes	110,714	Health Care Worker Background Check	1,402			
				Employee Health Insurance	43,122	(Indicate # of checks performed <u>127</u>)				
				Employee Meals	2,544	Patient Background Checks	57			
				Illinois Municipal Retirement Fund (IMRF)*			854			
				401K	2,703	SEE ATTACHED SCHEDULE	9,090			
				Earned Time Off	(806)					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,919	TOTAL (agree to Schedule V, line 22, col.8)			\$ 214,431	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,022
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
			\$			\$	Out-of-State Travel	\$		
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense			
C. Professional Services							IHCA		1,071	
Vendor/Payee	Type		Amount				Entertainment Expense		()	
			\$				(agree to Sch. V, line 24, col. 8)			
SEE ATTACHED SCHEDULE			124,618	TOTAL			\$	TOTAL	\$ 1,071	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 124,618							

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DOUGLAS NURSING & REHAB CTR

0046250

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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. \$4,345
- (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? 27.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,835 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. \$ 110,112
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. \$ 2,544 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? 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?
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. YES
Attach invoices and a summary of services for all architect and appraisal fees

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/16

SCHEDULE XIX (C) PROFESSIONAL SERVICES

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
Matrix Care	E-H-R	\$ 21,998
ESOLUTION	AR	\$ 1,960
INOVATICE LTC SOLUTIONS	BILLING	\$ 3,708
SMARTLINX	PAYROLL	\$ 6,560
TALX Corp	Tax Credit	\$ 275
Benefit Planning Consult	401K Third Party Admin	\$ 294
WAGE WORKS	SECTION 125 COMP	\$ 32
MNS	BILLING	\$ 750
GOVING & ASSOC	AGENCY FEE	\$ 15,300
COMPASS CFO	ACCOUNTING	\$ 25,468
RICHTER HEALTHCARE	BILLING	\$ 15,815
WILLIAM RADKEY	LEGAL	\$ 339
GROTEFELD HOFFMAN	LEGAL	\$ 10,000
Sikich	Accounting	\$ 22,119
TOTALS		\$ 124,618

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/16

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
IHCA	DUES	\$ 4,345
EHEALTH	CAREWATCH	\$ 3,529
MES HPSI	DUES	\$ 150
MEDPASS	SUBSCRIPTION	\$ 73
ILLINOIS SECRETARY OF STATE FEES		\$ 408
COLES COUNTY HEALTH DEPT	FOOD PERMIT	\$ 300
CLINTECH	DUES	\$ 285
		<hr/>
TOTALS		\$ 9,090

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/16

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

TOTAL FOOD PURCHASE	\$	92,000	
LESS SALES TAX	\$	<u>(920)</u>	
NET FOOD	\$	91,080	
TOTAL PATIENT CENSUS		13,535	
MEALS PER DAY		<u>3</u>	
TOTAL PATIENT MEALS		40,605	
TOTAL EMPLOYEE MEALS		1,167	
TOTAL MEALS PER YEAR		41,772	
COST PER MEAL	\$	2.18	
TOTAL EMPLOYEE MEAL COST	\$	2,544	Reclassified to Employee Benefits

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/16

SCHEDULE OF RENTAL EQUIPMENT

<u>Item</u>	<u>Amount</u>
CONCENTRATORS	\$ 556
POSTAGE MACHINE	\$ 155
COPIER	\$ 6,002
Desktop computers	\$ 10,814
IV PUMPS	\$ 5,421
KNEE BRACE	\$ 630
MOTION EQUIPMENT	\$ 4,931
BEDS/MATTRESS	<u>\$ 10,150</u>
 TOTAL	 \$ 38,659

DOUGLAS NURSING & REHABILITATION CENTER LLC
FACILITY ID 0046250
COST REPORT PERIOD ENDING 12/31/16

OTHER ADMIN STAFF TRANSPORTATION

<u>EMPLOYEE</u>	<u>AMOUNT</u>
TRANSPORT VAN FUEL AND REPAIRS	\$ 2,654
MISTY ENLOE STAFF	\$ 2,520
AMY STONEBURNEF SOCIAL SERVICE	\$ 351
OTHER FACILITY STAFF	\$ 570
BRENDA REED DON	\$ 361
CORPORATE TRAVEL	<u>\$ 1,380</u>
Total	\$ 7,836

DOUGLAS NURSING & REHABILITATION CENTER LLC
 FACILITY ID 0046250
 SCHEDULE VII
 C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
 REPORT PERIOD ENDING 12/31/2016

FACILITY ID	0046417	0046235	TOTAL
<u>NAME</u>	<u>EVERGREEN</u>	<u>DOCTORS</u>	<u>OTHER</u>
	<u>NURSING AND REHAB</u>	<u>NURSING AND REHAB</u>	
ROBERT HEDGES	\$ 68,536	\$ 70,865	\$ 139,401
WILLIAM IRVINE	\$ 68,536	\$ 70,865	\$ 139,401
MARTHA IRVINE	\$ 3,558	\$ 3,679	\$ 7,237
DEREK HEDGES	\$ 44,211	\$ 45,714	\$ 89,925
	\$ 184,841	\$ 191,123	\$ 375,964