

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0046235</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>DOCTORS NURSING & REHABILITATION CENTER, LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>1201 HAWTHORN RD</u> <u>SALEM</u> <u>62881</u> Number City Zip Code																																																			
County: <u>MARION</u>																																																			
Telephone Number: <u>(618) 548-4884</u> Fax # <u>(618) 548-5007</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>05/01/2003</u>		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>ROBERT HEDGES</u></td></tr><tr><td>(Title) <u>MEMBER</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td colspan="2"></td><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>ROBERT HEDGES</u>	(Title) <u>MEMBER</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____			(Telephone) <u>()</u> Fax # <u>()</u>																																				
Officer or Administrator of Provider	(Signed) _____																																																		
	(Type or Print Name) <u>ROBERT HEDGES</u>																																																		
	(Title) <u>MEMBER</u>																																																		
Paid Preparer	(Signed) _____																																																		
	(Date) _____																																																		
	(Print Name and Title) _____																																																		
	(Firm Name & Address) _____																																																		
		(Telephone) <u>()</u> Fax # <u>()</u>																																																	
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____			
☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL																																														
☐	Charitable Corp.	☐	Individual	☐	State																																														
☐	Trust	☐	Partnership	☐	County																																														
IRS Exemption Code _____		☐	Corporation	☐	Other _____																																														
		☐	"Sub-S" Corp.	_____																																															
		☒	Limited Liability Co.	_____																																															
		☐	Trust	_____																																															
		☐	Other _____	_____																																															
In the event there are further questions about this report, please contact:																																																			
Name: <u>BILL WEEAKS</u>		Telephone Number: <u>(217) 528-2244</u>																																																	
Email Address: _____																																																			
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																	

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER, LLC

0046235 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	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	<u>3,147</u>	<u>149</u>	<u>8,512</u>	<u>11,808</u>	8
9	SNF/PED					9
10	ICF	<u>16,919</u>	<u>4,657</u>	<u>1,089</u>	<u>22,665</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,066</u>	<u>4,806</u>	<u>9,601</u>	<u>34,473</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.71%

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 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 6,912

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

DOCTORS NURSING & REHABILITATION

#

0046235

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

Page 3

12/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	154,566	18,526	11,725	184,817		184,817		184,817			1
2	Food Purchase		201,030		201,030		201,030	(1,990)	199,040			2
3	Housekeeping	103,608	23,508		127,116		127,116		127,116			3
4	Laundry	55,374	26,066		81,440		81,440		81,440			4
5	Heat and Other Utilities			116,899	116,899		116,899	2,625	119,524			5
6	Maintenance	48,927	17,744	36,633	103,304		103,304	11,503	114,807			6
7	Other (specify):* SCAVENGER			12,013	12,013		12,013		12,013			7
8	TOTAL General Services	362,475	286,874	177,270	826,619		826,619	12,138	838,757			8
	B. Health Care and Programs											
9	Medical Director			23,400	23,400		23,400		23,400			9
10	Nursing and Medical Records	1,749,153	301,053	44,795	2,095,001		2,095,001	18,579	2,113,580			10
10a	Therapy	285,313			285,313		285,313		285,313			10a
11	Activities	41,705	5,951	1,253	48,909		48,909		48,909			11
12	Social Services	38,148		1,728	39,876		39,876		39,876			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,114,319	307,004	71,176	2,492,499		2,492,499	18,579	2,511,078			16
	C. General Administration											
17	Administrative	103,220		531,573	634,793		634,793	(420,288)	214,505			17
18	Directors Fees											18
19	Professional Services			165,187	165,187		165,187	(108,701)	56,486			19
20	Dues, Fees, Subscriptions & Promotions			39,911	39,911		39,911	(16,698)	23,213			20
21	Clerical & General Office Expenses	103,250	20,777	143,603	267,630		267,630	(72,672)	194,958			21
22	Employee Benefits & Payroll Taxes			373,974	373,974		373,974	58,962	432,936			22
23	Inservice Training & Education			1,153	1,153		1,153	60	1,213			23
24	Travel and Seminar			2,740	2,740		2,740	6,291	9,031			24
25	Other Admin. Staff Transportation			23,715	23,715		23,715	(12,916)	10,799			25
26	Insurance-Prop.Liab.Malpractice			56,384	56,384		56,384	2,640	59,024			26
27	Other (specify):*			55,079	55,079		55,079	(55,079)				27
28	TOTAL General Administration	206,470	20,777	1,393,319	1,620,566		1,620,566	(618,401)	1,002,165			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,683,264	614,655	1,641,765	4,939,684		4,939,684	(587,684)	4,352,000			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			29,233	29,233		29,233	(3,736)	25,497			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,476	51,476		51,476	(3,193)	48,283			32
33	Real Estate Taxes			200,025	200,025		200,025	1,781	201,806			33
34	Rent-Facility & Grounds			877,809	877,809		877,809		877,809			34
35	Rent-Equipment & Vehicles			199,511	199,511		199,511		199,511			35
36	Other (specify):*											36
37	TOTAL Ownership			1,358,054	1,358,054		1,358,054	(5,148)	1,352,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		357,695	499,124	856,819		856,819		856,819			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		357,695	564,824	922,519		922,519		922,519			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,683,264	972,350	3,564,643	7,220,257		7,220,257	(592,832)	6,627,425			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,467)	30		9
10	Interest and Other Investment Income	(6,412)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,990)	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	(345)	27		18
19	Entertainment				19
20	Contributions	(1,250)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,484)	27		24
25	Fund Raising, Advertising and Promotional	(15,993)	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 SEE SCH 5A	(101,022)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (185,963)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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)	(406,869)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (406,869)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (592,832)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

DOCTORS NURSING & REHABILITATION CENTER, LLC

Report Period Beginning: ID# 0046235

Ending: 01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	HEALTH CARE HORIZONS	\$ (45,000)	19	1
2	MARKETING SALARY	(42,059)	21	2
3	MARKETING TRAVEL	(12,916)	25	3
4	CHAMBER OF COMMERCE	(1,047)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(101,022)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

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

[illegible]

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	EVERGREEN NURSING	EFFINGHAM	HI CARE MGMT	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	37.5	DOUGLAS NURSING	MATTOON	H&I PROPERTIES	SPRINGFIELD	REAL ESTATE
MORRIS ESFORMES	15	TRANSITIONS NURSING	ROCK FALLS	HEALTHCARE	SPRINGFIELD	NURSE CONSULT
SANDRA SEGAL	10	TAMMERLANE HEALTHCARE	STERLING	HORIZONS		
		WESTERN, NORTHWESTERN, NORTHEASTERN	MISSOURI			
		NURSING				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 531,573	HI CARE MANAGEMENT		\$	\$ (531,573)	1
2	V	21	HOME OFFICE EXPENSE	120,000	HI CARE MANAGEMENT			(120,000)	2
3	V	19	ADMINISTRATIVE CONSULT	85,284	HI CARE MANAGEMENT			(85,284)	3
4	V	6	MAINTENANCE		HI CARE MANAGEMENT		11,503	11,503	4
5	V	5	UTILITIES		HI CARE MANAGEMENT		2,625	2,625	5
6	V	10	NURSING		HI CARE MANAGEMENT		18,579	18,579	6
7	V	17	ADMINISTRATION		HI CARE MANAGEMENT		111,285	111,285	7
8	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		89,202	89,202	8
9	V	19	PROFESSIONAL SVCS		HI CARE MANAGEMENT		20,923	20,923	9
10	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		342	342	10
11	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		60	60	11
12	V	24	TRAVEL		HI CARE MANAGEMENT		6,291	6,291	12
13	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		2,640	2,640	13
14	Total			\$ 736,857			\$ 263,450	\$ * (473,407)	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	22	PAYROLL TAX AND BENEFITS	\$	HI CARE MANAGEMENT		\$ 58,962	\$ 58,962	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 58,962	\$ * 58,962	39

* 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)		\$ 1,731	\$ 1,731	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		3,219	3,219	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		1,781	1,781	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES (HOME OFFICE)		660	660	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		185	185	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			\$			\$ 7,576	\$ * 7,576	39

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

Facility Name & ID Number DOCTORS NURSING & REHABILITATION # 0046235 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT					SALARY	\$ 46,326	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT					SALARY	44,434	17-7	2
3	MARTHA IRVINE	BOOKKEEPING						SALARY	3,462	21-7	3
4	DEREK HEDGES	VP OPERATIONS			SEE ATTACHED SCHEDULE			SALARY	20,524	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 114,746		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 & REHABILITATION CENTER, I # 0046235 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PER RESIDENT DAY	143,838	8	\$ 47,997	\$ 38,912	34,473	\$ 11,503	1
2	5	UTILITIES	PER RESIDENT DAY	143,838	8	10,952		34,473	2,625	2
3	10	NURSING	PER RESIDENT DAY	143,838	8	77,520	77,520	34,473	18,579	3
4	17	ADMINISTRATION	PER RESIDENT DAY	143,838	8	464,334	464,334	34,473	111,285	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	143,838	8	372,195	290,523	34,473	89,202	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	143,838	8	87,301		34,473	20,923	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	143,838	8	1,428		34,473	342	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	143,838	8	250		34,473	60	8
9	24	TRAVEL	PER RESIDENT DAY	143,838	8	26,248		34,473	6,291	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	143,838	8	11,015		34,473	2,640	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	143,838	8	246,018		34,473	58,962	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,345,258	\$ 871,289		\$ 322,412	25

Facility Name & ID Number DOCTORS NURSING & REHABILITATION CENTER, I # 0046235 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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)528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	30	DEPRECIATION	PER LICENSE BED	564	8	\$ 8,134	\$ 120	\$ 1,731	1
	2	32	INTEREST	PER LICENSE BED	564	8	15,128	120	3,219	2
	3	33	REAL ESTATE TAXES	PER LICENSE BED	564	8	8,372	120	1,781	3
	4	19	PROFESSIONAL FEES	PER LICENSE BED	564	8	3,100	120	660	4
	5	21	OFFICE EXPENSE	PER LICENSE BED	564	8	869	120	185	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				\$ 35,603	\$		\$ 7,576	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		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 PROPERTIES		X	MORTGAGE OFFICE		6/29/2005	\$	48,872	06/29/2012	0.0635	\$	3,219	1
2													2
3													3
4													4
5													5
	Working Capital												
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		600,000	REVOLV	PRIME +		8,070	6
7	MEMBER LOAN	X		WORKING CAPITAL	INTEREST		100,000	100,000				7,000	7
8	AVIV		X	WORKING CAPITAL	INTEREST							36,406	8
9	TOTAL Facility Related						\$ 100,000	\$ 748,872			\$ 54,695		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$ 100,000	\$ 748,872			\$ 54,695		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 2010 report.		\$	69,648	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.)		\$	134,625	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	64,977	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	136,829	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.		\$	201,806	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	42,007	8	
		2007	68,461	9	
		2008	71,978	10	
		2009	69,648	11	
		2010	134,625	12	
CURRENT YEAR ACCRUAL BASED ON 2011 PLUS 1.6%					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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	\$ 15,080	1
2					2
3	TOTALS			\$ 15,080	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6	H&I									6
7	PROP									7
8	OFC BLD		2005		55,935	1,731	39	1,731		8
	Improvement Type**									
9	WATER HEATER		2003		6,135	223	27.5	223		1,849
10	WATER HEATER		2004		8,145	296	27.5	296		2,310
11	TILING		2005		4,980	181	27.5	181		1,184
12	SIDEWALK		2005		6,300	420	15	420		2,100
13	WALL HEAT & A/C UNIT		2006		1,075	39	27.5	39		206
14	DOORS		2007		2,828	103	27.5	103		468
15	CARPETING		2007		23,768	2,738	5	4,752	2,014	23,768
16	ROOF (1 OF 2)		2008		2,475	90	27.5	90		319
17	FENCE		2008		3,964	264	15	264		858
18	THERAPY ROOM		2009		157,255	5,718	27.5	5,718		14,376
19	WATER HEATER		2010		14,133	514	27.5	514		647
20	AC UNIT		2011		2,690	2,690	27.5	69	(2,621)	69
21										21
22										22
23										23
24										24
25										25
26										26
27	ROOF (2 OF2) THIS PORTION PAID BY LANDLORD		2008		122,006					
28	WINDOWS (PAID BY LANDLORD)		2008		86,718					
29	A/C CORRIDORS EXISTING BUILDING(PAID BY LANDLORD)		2008		44,160					
30	SPRINKLER SYSTEM (PAID BY LANDLORD)		2009		93,600					
31	THERAPY ROOM ADDITION (PAID BY LANDLORD)		2009		553,516					
32										32
33										33
34										34
35										35
36										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)		\$ 1,189,683	\$ 15,007		\$ 14,400	\$ (607)	\$ 48,154	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	\$ 103,448	\$ 7,775	\$ 10,345	\$ 2,570	10 YRS	\$ 38,942	71
72	Current Year Purchases	8,182	8,182	752	(7,430)	10 YRS	752	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 111,630	\$ 15,957	\$ 11,097	\$ (4,860)		\$ 39,694	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	FACILITY	2001 CHEVY EXPRESS BUS	2004	\$ 23,000	\$	\$	\$		\$ 23,000	76
77										77
78										78
79										79
80	TOTALS			\$ 23,000	\$	\$	\$		\$ 23,000	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)	\$ 1,339,393	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,964	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,497	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,467)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 110,848	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		\$ 877,809			3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 877,809			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 190,917
- Description:
- SEE ATTACHED SCHEDULE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	PATIENT TRANSPORT	2011 FORD BRAUN	\$ 656.00	\$ 8,594	17
18					18
19					19
20					20
21	TOTAL		\$ 656.00	\$ 8,594	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		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)	\$			

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.)

	1	2	3	4	5	6	7	8		
	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	39-2	hrs	\$		\$ 198,080	\$		\$ 198,080	1
2	Licensed Speech and Language Development Therapist	39-2	hrs			93,268			93,268	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	hrs			207,776			207,776	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				357,695		357,695	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			\$		\$ 499,124	\$ 357,695		\$ 856,819	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 426,818	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100,000))	1,679,370		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,951		6
7	Other Prepaid Expenses	240		7
8	Accounts Receivable (owners or related parties)	858,708		8
9	Other(specify): REAL ESTATE ESCROW	45,754		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,012,841	\$	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	233,748		15
16	Equipment, at Historical Cost	134,630		16
17	Accumulated Depreciation (book methods)	(177,399)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 190,979	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,203,820	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 643,888	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	600,000		29
30	Accrued Salaries Payable	125,960		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,935		31
32	Accrued Real Estate Taxes(Sch.IX-B)	136,829		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,511,612	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	MEMBER LOANS	100,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,611,612	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,592,208	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,203,820	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,484,084	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,484,084	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	348,124	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	(240,000)	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)	\$ 108,124	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)	\$ 1,592,208	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	2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,658,865	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,658,865	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	919,931	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 919,931	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	975	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,950	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)	\$ 3,925	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,412	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,412	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)	\$ 7,589,133	30

	2		
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	826,619	31
32	Health Care	2,492,499	32
33	General Administration	1,620,566	33
	B. Capital Expense		
34	Ownership	1,358,054	34
	C. Ancillary Expense		
35	Special Cost Centers	856,819	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,220,257	40
41	Income before Income Taxes (line 30 minus line 40)**	368,876	41
42	Income Taxes	(20,752)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 348,124	43

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

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

TAX IS 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.

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	1,692	2,080	\$ 77,197	\$ 37.11	1
2	Assistant Director of Nursing	3,467	4,085	92,910	22.74	2
3	Registered Nurses	11,711	13,193	262,311	19.88	3
4	Licensed Practical Nurses	25,057	28,308	487,010	17.20	4
5	CNAs & Orderlies	60,202	65,442	685,297	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,059	16,591	285,313	17.20	8
9	Activity Director	1,698	1,949	20,555	10.55	9
10	Activity Assistants	2,301	2,534	21,150	8.35	10
11	Social Service Workers	3,019	3,438	38,148	11.10	11
12	Dietician					12
13	Food Service Supervisor	1,773	1,974	27,104	13.73	13
14	Head Cook	6,298	7,196	61,917	8.60	14
15	Cook Helpers/Assistants	7,396	8,044	65,545	8.15	15
16	Dishwashers					16
17	Maintenance Workers	3,333	3,669	48,927	13.34	17
18	Housekeepers	11,056	12,075	103,608	8.58	18
19	Laundry	6,011	6,658	55,374	8.32	19
20	Administrator	1,790	2,080	103,220	49.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,822	2,099	39,900	19.01	23
24	Clerical	3,897	4,252	63,350	14.90	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	993	1,081	10,282	9.51	31
32	Other Health C: <u>(CEN SUPP, MDS</u>	5,538	6,241	134,146	21.49	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	173,113	192,989	\$ 2,683,264 *	\$ 13.90	34

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	248	\$ 11,725	1-3	35
36	Medical Director	MONTHLY	23,400	9-3	36
37	Medical Records Consultant	32	2,072	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	2,511	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	21	1,253	11-3	44
45	Social Service Consultant	21	1,252	12-3	45
46	Other(specify) _____				46
47					47
48					48
49	TOTAL (lines 35 - 48)	322	\$ 42,213		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

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, \$7176
- (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.

\$

14,592

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.

\$

65,700

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.

\$

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?

5%

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

YES
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (C) PROFESSIONAL SERVICES

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
BRANSON JONES	LEGAL	\$ 90
COLE TAYLOR BANK	LEGAL	\$ 792
OGLETREE DEAKINS	AA PLAN	\$ 2,500
MDI ACHIEVE	IT	\$ 14,811
ILLINI TECH	IT	\$ 1,181
IIT SOURCETECH	IT	\$ 440
INNOVATIVE SOLUTIONS	PULSE OX	\$ 10,881
KBKB	ACCOUNTING	\$ 14,434
RICHARD PEELO	COST REPORTS	\$ 3,000
BPC	401K ADMIN	\$ 1,649
CT CORP	CORP AGENT	\$ 162
ILLINOIS DEP OF REGULATION		\$ 29
MARGEL PEDDICORD	CONSULTING	\$ 409
STRATTON	LEGAL	\$ 3,504
SANDBERG	LEGAL	\$ 241
IVANS	SOFTWARE SUPPORT	\$ 1,130
EMDEON	IT	\$ 238
PEHLMAN	ACCTG SVC	\$ 995
		\$ 56,486

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
IHCA	DUES	\$ 7,176
ALLSCRIPTS	SUBSCRIPTIONS	\$ 3,188
IDFPR	ADMIN LICENSE	\$ 100
INCEPTION TECHNOLOGIES	ANNUAL MAINT	\$ 716
GFS	TRAY CARD FEE	\$ 80
EHEALTH	ANNUAL SUBSCRIPTION	\$ 1,350
LTCNA	FEE	\$ 50
IHCA	NURISNG ACADEMY	\$ 1,250
MARION COUNTY	FOOD PERMIT	\$ 75
ILLINOIS SOS	VEHICLE LICENSE	\$ 277
DMA	SUBSCRIPTIONS	\$ 103
ILLINOIS SOS	VEHICLE LICENSE	\$ 99
ILLINOIS SOS	BUSINESS REGISTRATION	\$ 250
ALEXANDER HAMILTON	EMPLOYEE LAW	\$ 11
WOLTERS	OSHA GUIDE	\$ 34
MEDPASS	MANUALS	\$ 99
AICPA	ACCTG GUIDE	\$ 175
TAX	TAX	\$ 21
		\$ 15,054

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (G) TRAVEL AND SEMINAR

<u>OUT OF STATE TRAVEL</u>	<u>AMOUNT</u>
<u>IN STATE TRAVEL</u>	
CORP DON	\$ 5,839
<u>SEMINAR EXPENSE</u>	
IHCA	\$ 3,071
INHAA	\$ 23
IPC	\$ 38
LTCNA	\$ 60
TOTAL	\$ 9,031

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE OF RENTAL EQUIPMENT

<u>Item</u>	<u>Amount</u>
CONCENTRATORS	\$ 74,101
BEDS	\$ 97,023
IV PUMPS	\$ 929
DISHWASHER	\$ 963
SNAKE	\$ 116
ICE MACHINE	\$ 2,500
HAMMERS	\$ 225
WASHING MACHINE	\$ 3,273
COPIERS	\$ 9,702
POSTAGE EQUIPMENT	\$ 1,130
PORTABLE UNIT	\$ 955
 TOTAL RENTALS	 \$ 190,917

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SALES TAX EXCLUSION

TOTAL FOOD PURCHASES WITH TAX	\$ 201,030
TOTAL FOOD PURCHASES WITHOUT TAX	\$ 199,040
TOTAL SALES TAX	\$ 1,990

DOCTORS NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046235
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

OTHER ADMIN STAFF TRANSPORTATION

<u>EMPLOYEE</u>	<u>AMOUNT</u>
TRANSPORT VAN FUEL AND REPAIRS	\$ 7,070
KYLE MOOREW ADMINISTRATOR	\$ 2,386
NURSING	\$ 1,343
TOTALS	\$ 10,799