FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0046250

Facility Name: DOUGLAS REHABILITATION & CARE CENTER LLC

Address: 3516 POWELL LANE (Number) MATTOON (City) 61938 (Zip Code)

County: COLES

Telephone Number: (217) 234-6401 **Fax #** (217) 258-3300

HFS ID Number:

Date of Initial License for Current Owners: 05/01/2003

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 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.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) ROBERT HEDGES

(Title) MEMBER

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: BILL WEEAKS Telephone Number: (217) 528-2244
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 DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	79	Skilled (SNF)	79	28,835	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,835	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	125	85	3,079	3,289	8
9	SNF/PED					9
10	ICF	9,646	1,426		11,072	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,771	1,511	3,079	14,361	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.80%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 02/28/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 79 and days of care provided 3,079

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE C] # 0046250 Report Period Beginning: 01/01/2011 Ending: 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	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	109,895	7,234	4,833	121,962		121,962		121,962			1
2	Food Purchase		84,209		84,209	(11,032)	73,177	(834)	72,343			2
3	Housekeeping	46,730	6,906		53,636		53,636		53,636			3
4	Laundry	25,409	4,380		29,789		29,789		29,789			4
5	Heat and Other Utilities			156,397	156,397		156,397	1,093	157,490			5
6	Maintenance	32,378	2,747	48,897	84,022		84,022	4,792	88,814			6
7	Other (specify):* SCAVANGER			11,726	11,726		11,726		11,726			7
8	TOTAL General Services	214,412	105,476	221,853	541,741	(11,032)	530,709	5,051	535,760			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	805,295	76,109	15,743	897,147		897,147	7,740	904,887			10
10a	Therapy	16,607			16,607		16,607		16,607			10a
11	Activities	41,884	3,458	1,636	46,978		46,978		46,978			11
12	Social Services	25,994		1,673	27,667		27,667		27,667			12
13	CNA Training											13
14	Program Transportation			441	441		441		441			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	889,780	79,567	24,993	994,340		994,340	7,740	1,002,080			16
	C. General Administration											
17	Administrative	64,000		125,743	189,743		189,743	(79,383)	110,360			17
18	Directors Fees											18
19	Professional Services			27,137	27,137		27,137	2,150	29,287			19
20	Dues, Fees, Subscriptions & Promotions			43,488	43,488		43,488	(18,406)	25,082			20
21	Clerical & General Office Expenses	72,001	5,639	23,122	100,762		100,762	5,875	106,637			21
22	Employee Benefits & Payroll Taxes			192,772	192,772	11,032	203,804	24,563	228,367			22
23	Inservice Training & Education			2,280	2,280		2,280	(275)	2,005			23
24	Travel and Seminar							2,621	2,621			24
25	Other Admin. Staff Transportation			11,498	11,498		11,498	(5,343)	6,155			25
26	Insurance-Prop.Liab.Malpractice			41,657	41,657		41,657	1,100	42,757			26
27	Other (specify):* BAD DEBT, PENALTY			54,074	54,074		54,074	(54,074)				27
28	TOTAL General Administration	136,001	5,639	521,771	663,411	11,032	674,443	(121,172)	553,271			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,240,193	190,682	768,617	2,199,492		2,199,492	(108,381)	2,091,111			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 REHABILITATION & CARE CENTER LLC #0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			7,043	7,043		7,043	3,405	10,448			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,824	27,824		27,824	978	28,802			32
33	Real Estate Taxes			26,098	26,098		26,098	1,173	27,271			33
34	Rent-Facility & Grounds			405,239	405,239		405,239		405,239			34
35	Rent-Equipment & Vehicles			72,387	72,387		72,387		72,387			35
36	Other (specify):*											36
37	**TOTAL Ownership**			538,591	538,591		538,591	5,556	544,147			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,130	449,001	538,131		538,131		538,131			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,252	43,252		43,252		43,252			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		89,130	492,253	581,383		581,383		581,383			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,240,193	279,812	1,799,461	3,319,466		3,319,466	(102,825)	3,216,641			45

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LL(# 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2,266	30		9
10	Interest and Other Investment Income	(1,141)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(834)	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	(17,290)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,164)	27		24
25	Fund Raising, Advertising and Promotional	(17,611)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,620)	27		28
29	Other-Attach Schedule SEE 5A	(44,989)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,383)		$	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)	13,558		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 13,558		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (102,825)		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

DOUGLAS REHABILITATION & CARE CENTER LLC

ID# 0046250

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	HEALTH CARE HORIZONS	$ (7,000)	19	1
2	CHAMBER OF COMMERCE	(938)	20	2
3	MARKETING SALARIES	(31,408)	21	3
4	MARKETING TRAVEL	(5,343)	25	4
5	CHAMBER EXPO	(300)	23	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(44,989)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(834)	0	0	0	0	0	0	0	0	0	0	(834)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,093	0	0	0	0	0	0	0	0	0	1,093	5
6	Maintenance	0	4,792	0	0	0	0	0	0	0	0	0	4,792	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(834)	5,885	0	0	0	0	0	0	0	0	0	5,051	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	7,740	0	0	0	0	0	0	0	0	0	7,740	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	7,740	0	0	0	0	0	0	0	0	0	7,740	16
	C. General Administration													
17	Administrative	0	(79,383)	0	0	0	0	0	0	0	0	0	(79,383)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,000)	8,716	434	0	0	0	0	0	0	0	0	2,150	19
20	Fees, Subscriptions & Promotions	(18,549)	143	0	0	0	0	0	0	0	0	0	(18,406)	20
21	Clerical & General Office Expenses	(31,408)	37,161	122	0	0	0	0	0	0	0	0	5,875	21
22	Employee Benefits & Payroll Taxes	0	24,563	0	0	0	0	0	0	0	0	0	24,563	22
23	Inservice Training & Education	(300)	25	0	0	0	0	0	0	0	0	0	(275)	23
24	Travel and Seminar	0	2,621	0	0	0	0	0	0	0	0	0	2,621	24
25	Other Admin. Staff Transportation	(5,343)	0	0	0	0	0	0	0	0	0	0	(5,343)	25
26	Insurance-Prop.Liab.Malpractice	0	1,100	0	0	0	0	0	0	0	0	0	1,100	26
27	Other (specify):*	(54,074)	0	0	0	0	0	0	0	0	0	0	(54,074)	27
28	**TOTAL General Administration**	(116,674)	(5,054)	556	0	0	0	0	0	0	0	0	(121,172)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(117,508)	8,571	556	0	0	0	0	0	0	0	0	(108,381)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,266	0	1,139	0	0	0	0	0	0	0	0	3,405	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,141)	0	2,119	0	0	0	0	0	0	0	0	978	32
33	Real Estate Taxes	0	0	1,173	0	0	0	0	0	0	0	0	1,173	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**	1,125	0	4,431	0	0	0	0	0	0	0	0	5,556	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)**	(116,383)	8,571	4,987	0	0	0	0	0	0	0	0	(102,825)	45

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	TRANSITIONS NURSING	ROCK FALLS			
SANDRA SEGAL	10	TAMMERLANE HEALTHCARE	STERLING	H&I PROPERTIES	SPRINGFIELD	REAL ESTATE
		WESTERN, NORTHWESTERN, NORTHEASTERN	MISSOURI			
		NURSING		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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 125,743	HI CARE MANAGEMENT		$	$ (125,743)	1
2	V	6	MAINTENANCE		HI CARE MANAGEMENT		4,792	4,792	2
3	V	5	UTILITIES		HI CARE MANAGEMENT		1,093	1,093	3
4	V	10	NURSING		HI CARE MANAGEMENT		7,740	7,740	4
5	V	17	ADMINISRATION		HI CARE MANAGEMENT		46,360	46,360	5
6	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		37,161	37,161	6
7	V	19	PROFESSIONAL SVCS		HI CARE MANAGEMENT		8,716	8,716	7
8	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		143	143	8
9	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		25	25	9
10	V	24	TRAVEL		HI CARE MANAGEMENT		2,621	2,621	10
11	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		1,100	1,100	11
12	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT		24,563	24,563	12
13	V								13
14	Total			$ 125,743			$ 134,314	$ * 8,571	14

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES (HOME OFFICE)		$ 1,139	$ 1,139	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		2,119	2,119	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		1,173	1,173	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES (HOME OFFICE)		434	434	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		122	122	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			$			$ 4,987	$ * 4,987	39

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number DOUGLAS REHABILITATION & CARE C # 0046250 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT					SALARY	$ 19,299	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT					SALARY	18,511	17-7	2
3	MARTHA IRVINE	BOOKKEEPING			SEE			SALARY	1,442	21-7	3
4	DEREK HEDGES	VP OPERATIONS			ATTACHED			SALARY	8,550	17-7	4
5					SCHEDULE						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 47,802		13

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

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 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 [X] 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	14,361	$ 4,792	1
2	5	UTILITIES	PER RESIDENT DAY	143,838	8	10,952		14,361	1,093	2
3	10	NURSING	PER RESIDENT DAY	143,838	8	77,520	77,520	14,361	7,740	3
4	17	ADMINISTRATION	PER RESIDENT DAY	143,838	8	464,334	464,334	14,361	46,360	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	143,838	8	372,195	290,523	14,361	37,161	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	143,838	8	87,301		14,361	8,716	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	143,838	8	1,428		14,361	143	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	143,838	8	250		14,361	25	8
9	24	TRAVEL	PER RESIDENT DAY	143,838	8	26,248		14,361	2,621	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	143,838	8	11,015		14,361	1,100	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	143,838	8	246,018		14,361	24,563	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		$ 134,314	25

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 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 [X] 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 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	$	79	$ 1,139	1
2	32	INTEREST	PER LICENSE BED	564	8	15,128		79	2,119	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	564	8	8,372		79	1,173	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	564	8	3,100		79	434	4
5	21	OFFICE EXPENSE	PER LICENSE BED	564	8	869		79	122	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	$		$ 4,987	25

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CI # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$	$ 32,174	06/29/2012	0.0635	$ 2,119	1
2												2
3	MEMBER LOAN	X			INTEREST		100,000	100,000		0.0700	7,000	3
4												4
5												5
	Working Capital											
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		391,000		PRIME +	20,824	6
7												7
8												8
9	TOTAL Facility Related						$ 100,000	$ 523,174			$ 29,943	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	$ 523,174			$ 29,943	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.)**

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 25,886	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 26,875	2
3. Under or (over) accrual (line 2 minus line 1).		$ 989	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 26,282	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.		$ 27,271	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	32,544	8
	2007	32,517	9
	2008	26,042	10
	2009	25,886	11
	2010	26,875	12

2011 TAX ESTIMATE IS 2010 PLUS 1.4%

	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DOUGLAS REHABILITATION & CARE CENTER LLC COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0046250

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-1-00300-000	NURSING HOME	$ 23,321.80	$ 23,321.80
2.	07-1-00300-001	NURSING HOME	$ 2,019.18	$ 2,019.18
3.	07-1-00572-000	NURSING HOME	$ 360.82	$ 360.82
4.	22-03.0-107-017	HOME OFFICE	$ 3,342.98	$ 468.00
5.	22-03.0-107-018	HOME OFFICE	$ 5,029.40	$ 705.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,074.18	$ 26,874.80

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,000 B. General Construction Type: Exterior MASONARY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HOME OFFICE		2005	$ 8,124	1
2					2
3	TOTALS			$ 8,124	3

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6	H&I										6
7	PROP										7
8	OFFC BLD			2005	36,824	1,139	39	1,139			8
	Improvement Type**										
9	INSULATION			2004	10,441	380	27.5	380		2,803	9
10	REPLACE HEAT & CHILL LINES			2005	3,245	118	27.5	118		713	10
11	COMPRESSOR REPAIR			2006	14,696	534	27.5	534		2,826	11
12	GENERATOR (1 OF 2)			2008	2,670	97	27.5	97		319	12
13	DRAPES			2008	3,962	228	5	792	564	2,772	13
14	PAINTING & WALL VINYL			2008	8,203	473	5	1,641	1,168	5,743	14
15	COMPRESSOR REPAIR			2009	19,021	691	27.5	691		1,641	15
16	INSTALL SPRINKLERS IN REST ROOM AND CLOSET			2009	6,877	250	27.5	250		594	16
17	ROOF TOP VENTILATING FANS			2009	4,251	155	27.5	155		368	17
18	PUMPS			2010	3,461	126	27.5	126		163	18
19	NEW BEARING AND SEALS ON FAN			2010	3,132	114	27.5	114		147	19
20	HOT WATER BOOSTER HEATER			2010	2,853	103	27.5	103		133	20
21	AC CIRCULATION PUMP			2011	3,415	83	27.5	83		83	21
22	WATER HEATER			2011	5,564	8	27.5	8		8	22
23											23
24											24
25											25
26	GENERATOR (2 OF 2) THIS PORTION PAID BY LANDLORD			2008	25,620						26
27	HOT WATER HEATER (PAID BY LANDLORD)			2008	7,923						27
28											28
29											29
30											30
31											31
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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 162,158	$ 4,499		$ 6,231	$ 1,732	$ 18,313	70

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER# 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 42,166	$ 3,683	$ 4,217	$ 534	10 YRS	$ 17,107	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 42,166	$ 3,683	$ 4,217	$ 534		$ 17,107	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)	$ 212,448	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,182	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 10,448	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,266	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 35,420	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.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ELITE MATTOON LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] 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		$ 405,239			3
4	Additions							4
5								5
6								6
7	TOTAL		79		$ 405,239 **			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 [X] NO Terms: *

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	$

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

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

16. Rental Amount for movable equipment: $ 72,387 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

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)	$			

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.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$		$ 170,525	$		$ 170,525	1
2	Licensed Speech and Language Development Therapist	39-2	hrs			57,806			57,806	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	hrs			220,670			220,670	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				89,130		89,130	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			$		$ 449,001	$ 89,130		$ 538,131	14

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 104,132	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	645,974		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,920		6
7	Other Prepaid Expenses	114,412		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 867,438	$	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	91,791		15
16	Equipment, at Historical Cost	42,166		16
17	Accumulated Depreciation (book methods)	(58,504)		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)**	$ 75,453	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 942,891	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,114,145	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	391,000		29
30	Accrued Salaries Payable	59,274		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,178		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,283		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	INTERCOMPANY	212,073		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,811,953	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	100,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 100,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,911,953	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (969,062)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 942,891	$	48

***(See instructions.)**

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (815,274)	1
2	Restatements (describe):		2
3	POST CLOSING	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (815,270)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(153,792)	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)**	$ (153,792)	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)**	$ (969,062)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTE # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,375,688	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,375,688	3
	B. Ancillary Revenue		
4	Day Care	3,163	4
5	Other Care for Outpatients		5
6	Therapy	772,765	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 775,928	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,141	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,141	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	FINGERPRINT INCOME	3,762	28
28a	RENT OF APARTMENTS	9,918	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,680	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,166,437	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	541,741	31
32	Health Care	994,340	32
33	General Administration	663,411	33
	B. Capital Expense		
34	Ownership	538,591	34
	C. Ancillary Expense		
35	Special Cost Centers	538,131	35
36	Provider Participation Fee	43,252	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,319,466	40
41	**Income before Income Taxes (line 30 minus line 40)****	(153,029)	41
42	**Income Taxes**	(763)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (153,792)	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 CASH BASIS

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

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,063	2,221	$ 61,990	$ 27.91	1
2	Assistant Director of Nursing	1,006	1,094	30,283	27.68	2
3	Registered Nurses	2,972	3,133	66,753	21.31	3
4	Licensed Practical Nurses	12,593	13,235	245,641	18.56	4
5	CNAs & Orderlies	30,040	32,713	342,880	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,431	1,632	16,607	10.18	8
9	Activity Director	1,616	1,812	18,764	10.36	9
10	Activity Assistants	2,223	2,773	23,120	8.34	10
11	Social Service Workers	1,446	1,632	25,994	15.93	11
12	Dietician					12
13	Food Service Supervisor	1,788	2,080	34,767	16.71	13
14	Head Cook	3,896	4,406	37,935	8.61	14
15	Cook Helpers/Assistants	4,235	4,438	37,193	8.38	15
16	Dishwashers					16
17	Maintenance Workers	1,760	1,965	32,378	16.48	17
18	Housekeepers	4,934	5,387	46,730	8.67	18
19	Laundry	2,766	3,044	25,409	8.35	19
20	Administrator	1,984	2,080	64,000	30.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,118	2,480	40,548	16.35	23
24	Clerical	1,918	2,086	31,453	15.08	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	307	307	6,325	20.60	31
32	Other Health C: MDS,CENT SUPP	2,873	2,873	51,423	17.90	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,969	91,391	$ 1,240,193 *	$ 13.57	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	110	$ 4,833	1-3	35
36	Medical Director	MONTHLY	5,500	9-3	36
37	Medical Records Consultant	22	1,730	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	1,419	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	MONTHLY	3,000	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,636	11-3	44
45	Social Service Consultant	24	1,637	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	180	$ 19,755		49

C. CONTRACT NURSES

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTEI # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LESTER ROBERTSON	ADMINISTRATOR	0	$ 64,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 64,000

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 125,743
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 125,743

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 29,287
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 29,287

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,306
Unemployment Compensation Insurance	53,619
FICA Taxes	95,809
Employee Health Insurance	27,897
Employee Meals	11,032
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS	3,672
PENSION PLANS	2,032
TOTAL (agree to Schedule V, line 22, col.8)	$ 228,367

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,801
Health Care Worker Background Check	2,167
(Indicate # of checks performed 72)	
Patient Background Checks 2	1,349
SEE ATTACHED	13,775
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,082

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
CORP DON	2,621
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,621

**See instructions.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LL(# 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER LLC # 0046250 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 $4724**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,016** 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. $ **43,252**
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. $ **11,032** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	AMOUNT
LTC SOLUTIONS	PULSE OX AUDIT	$ 4,043
KBKB	ACCOUNTING/TAX	$ 12,553
RICHARD PEELO	COST REPORTS	$ 3,000
CTB	LEGAL	$ 792
BRANKLEY SMITH	PROFESSIONAL	$ 103
RELIABLE ENVRIOMENTAL	ASBESTOS SAMPLING	$ 600
IDPH	EXPANSION REVIEW	$ 2,748
ITT SOURCE TECH	IT	$ 545
MDI	IT	$ 1,342
BPC	401K ADMIN	$ 687
CT CORP	CORP AGENT	$ 67
ILLINOIS DEP OF REGULATION		$ 12
MARGEL PEDDICORD	CONSULTING	$ 170
STRATTON	LEGAL	$ 1,460
SANDBERG	LEGAL	$ 100
IVANS	SOFTWARE SUPPORT	$ 471
EMDEON	IT	$ 99
ILLINI TECH	IT	$ 81
PEHLMAN	ACCTG SVC	$ 414
TOTALS		$ 29,287

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	AMOUNT
IHCA	DUES	$ 4,724
IHCA	NURSE WEBINAR	$ 1,250
EHEALTH	CAREWATCH	$ 2,700
ALLSCRIPTS	SUBSCRIP FEE	$ 3,984
CARDMEMEBER SVCS	FEES	$ 95
CLIA LABS	CERTIFICATE FEE	$ 150
ILLINOIS SECRETARY OF STATE	ANNUAL RPT	$ 408
COLES COUNTY HEALTH DEPT	FOOD PERMIT	$ 250
ILLINOIS STATE FIRE MARSHALL	PERMIT	$ 70
ALEXANDER HAMILTON	EMPLOYEE LAW	$ 5
WOLTERS	OSHA GUIDE	$ 15
MEDPASS	MANUALS	$ 41
AICPA	ACCTG GUIDE	$ 73
TAX	TAX	$ 10
TOTALS		$ 13,775

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

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

TOTAL FOOD PURCHASE	$	84,209
LESS SALES TAX	$	(834)
NET FOOD	$	83,375
TOTAL PATIENT CENSUS		14,361
MEALS PER DAY		3
TOTAL PATIENT MEALS		43,083
EMPLOYEES MEALS PER DAY		18
DAYS PER YEAR		365
TOTAL EMPLOYEE MEALS		6,570
TOTAL MEALS PER YEAR		49,653
COST PER MEAL	$	1.68
TOTAL EMPLOYEE MEAL COST	$	11,032

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
CONCENTRATORS	$ 1,417
BEDS	$ 18,900
CHILLER	$ 42,861
DISHWASHER	$ 1,200
HEATERS	$ 502
POSTAGE MACHINE	$ 1,386
COPIER	$ 6,121
TOTAL	$ 72,387

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE V, LINE 23 INSERVICE TRAINING AND EDUCATION

HS CLASS	$	77
INHA	$	250
ERNST LAYTON FIRE TRAINING	$	98
IHCA NURSING ACADEMY	$	950
MEDICARE UPDATE	$	250
HSC ATVITIES TRAINING	$	355
LTCNA	$	25
TOTALS	$	2,005

DOUGLAS REHABILITATION AND CARE CENTER
FACILITY ID 0046250
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	AMOUNT
TRANSPORT VAN FUEL AND REPAIRS	$ 1,571
LESTER ROBERTSON - ADMINISTRATOR	$ 1,943
BOM	$ 856
MAINTENANCE DEPT	$ 492
NURSING DEPT	$ 1,293
TOTAL	$ 6,155