

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY

0010330 Report Period Beginning: 12/01/03 Ending: 11/30/04

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	202	Skilled (SNF)	202	73,932	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	202	TOTALS	202	73,932	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	5,478	3,249	7,524	16,251	8
9	SNF/PED					9
10	ICF	28,534	12,680	1	41,215	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,012	15,929	7,525	57,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.73%

D. How many bed-hold days during this year were paid by Public Aid? 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

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 05/01/1960

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 54 and days of care provided 7,387

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: 11/30/04

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

STATE OF ILLINOIS

Facility Name & ID Number REHAB & CARE CENTER - JACKSON CO # 0010330 Report Period Beginning: 12/01/03 Ending: 11/30/04

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	414,567	19,896	7,200	441,663		441,663		441,663		1
2	Food Purchase		224,177		224,177		224,177	(1,299)	222,878		2
3	Housekeeping	208,441	30,006	36,406	274,853		274,853		274,853		3
4	Laundry	184,952	15,271		200,223		200,223		200,223		4
5	Heat and Other Utilities			223,075	223,075		223,075		223,075		5
6	Maintenance	78,242	20,478	63,758	162,478		162,478		162,478		6
7	Other (specify):* Waste Removal			9,178	9,178		9,178		9,178		7
8	TOTAL General Services	886,202	309,828	339,617	1,535,647		1,535,647	(1,299)	1,534,348		8
	B. Health Care and Programs										
9	Medical Director			38,280	38,280		38,280		38,280		9
10	Nursing and Medical Records	3,237,556	87,465	28,714	3,353,735		3,353,735		3,353,735		10
10a	Therapy	191,610	2,261	46,947	240,818		240,818		240,818		10a
11	Activities	138,072			138,072		138,072		138,072		11
12	Social Services	110,404	2,369		112,773		112,773		112,773		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,677,642	92,095	113,941	3,883,678		3,883,678		3,883,678		16
	C. General Administration										
17	Administrative	61,547			61,547		61,547		61,547		17
18	Directors Fees										18
19	Professional Services			131,374	131,374		131,374		131,374		19
20	Dues, Fees, Subscriptions & Promotions			143,277	143,277		143,277	(18,524)	124,753		20
21	Clerical & General Office Expenses	182,603	26,228	33,820	242,651		242,651	(2,132)	240,519		21
22	Employee Benefits & Payroll Taxes			1,224,873	1,224,873		1,224,873	(4,645)	1,220,228		22
23	Inservice Training & Education			11,423	11,423		11,423		11,423		23
24	Travel and Seminar			13,050	13,050		13,050		13,050		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			45,457	45,457		45,457		45,457		26
27	Other (specify):* Bad Debt			8,283	8,283		8,283	(8,283)			27
28	TOTAL General Administration	244,150	26,228	1,611,557	1,881,935		1,881,935	(33,584)	1,848,351		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,807,994	428,151	2,065,115	7,301,260		7,301,260	(34,883)	7,266,377		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.

STATE OF ILLINOIS

Facility Name & ID Number **REHAB & CARE CENTER - JACKSON COUNTY** #0010330 Report Period Beginning: 12/01/03 Ending: 11/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			341,572	341,572	341,572	(12,234)	329,338				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						(2,464)	(2,464)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			341,572	341,572	341,572	(14,698)	326,874				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		414,269		414,269	414,269		414,269				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		414,269		414,269	414,269		414,269				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,807,994	842,420	2,406,687	8,057,101	8,057,101	(49,581)	8,007,520				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 REHAB & CARE CENTER - JACKSON COUNTY

0010330

Report Period Beginning: 12/01/03

Ending: 11/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,299)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,464)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,234)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,283)	27		24
25	Fund Raising, Advertising and Promotional	(18,524)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,777)	21,22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,581)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (49,581)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

REHAB & CARE CENTER - JACKSON COUNTY

ID# 0010330

Report Period Beginning: 12/01/03

Ending: 11/30/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	VENDING INCOME	\$ (4,645)	22	1
2	COPIES	(747)	21	2
3	POSTAGE	(130)	21	3
4	MISCELLANEOUS	(1,255)	21	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	(6,777)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY

0010330 Report Period Beginning:

12/01/03

Ending:

11/30/04

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,299)	0	0	0	0	0	0	0	0	0	0	(1,299)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,299)	0	0	0	0	0	0	0	0	0	0	(1,299)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(18,524)	0	0	0	0	0	0	0	0	0	0	(18,524)	20
21	Clerical & General Office Expenses	(2,132)	0	0	0	0	0	0	0	0	0	0	(2,132)	21
22	Employee Benefits & Payroll Taxes	(4,645)	0	0	0	0	0	0	0	0	0	0	(4,645)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(8,283)	0	0	0	0	0	0	0	0	0	0	(8,283)	27
28	TOTAL General Administration	(33,584)	0	0	0	0	0	0	0	0	0	0	(33,584)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,883)	0	0	0	0	0	0	0	0	0	0	(34,883)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY# 0010330

Report Period Beginning:

12/01/03

Ending:

11/30/04

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(12,234)	0	0	0	0	0	0	0	0	0	0	(12,234) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	(2,464)	0	0	0	0	0	0	0	0	0	0	(2,464) 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	(14,698)	0	0	0	0	0	0	0	0	0	0	(14,698) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(49,581)	0	0	0	0	0	0	0	0	0	0	(49,581) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
1	V		\$				\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$				\$	\$ *	14

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON Ct # 0010330 Report Period Beginning: 12/01/03 Ending: 11/30/04

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/01/03 Ending: 11/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number REHAB & CARE CENTER - JACKSON CO # 0010330 Report Period Beginning: 12/01/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1								\$	\$			\$	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related						\$	\$			\$	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$	\$			\$	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 2003 report.	\$			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.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$			3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			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.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	_____	8	
		2000	_____	9	
		2001	_____	10	
		2002	_____	11	
		2003	_____	12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2003	\$			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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REHAB & CARE CENTER - JACKSON COUNTY COUNTY JACKSON

FACILITY IDPH LICENSE NUMBER 0010330

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY

0010330 Report Period Beginning:

12/01/03 Ending:

11/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 150,000 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 1C. 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, nurse aide 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	FACILITY	871,200	1960	\$ 10,000	1
2					2
3	TOTALS	871,200		\$ 10,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100	1960	1960	\$ 1,069,483	\$	34.5	\$	\$	\$ 1,069,483	4
5		1966	1966	289,003		30			288,995	5
6	102	1972	1972	1,404,551		27			1,404,534	6
7										7
8										8
Improvement Type**										
9	PARKING LOTS		1972	63,650		22.5			63,650	9
10	BUILDING IMPROVEMENTS		1977	122,761		20			122,761	10
11	NEW ELECTRIC CABLE		1979	7,903		15			7,903	11
12										12
13	SPRINKLER SYSTEM		1978	1,005		24.51			983	13
14	BUILDING IMPROVEMENTS		1978	31,978		21.01			31,978	14
15	AIR CONDITIONING		1979	8,150		19.98			8,150	15
16	LANDSCAPING		1981	315		10			315	16
17	FIRE DOORS		1981	352		20			352	17
18	ELECTRICAL WORK		1981	9,584		20			9,584	18
19	ELECTRICAL WIRING		1981	12,896		20			12,896	19
20										20
21	AIR COMPRESSOR		1981	1,242		10			1,242	21
22										22
23	HOT WATER HEATING SYSTEM		1982	15,222		15			15,222	23
24	DOOR CLOSER		1982	650		15			650	24
25	FIRE DOORS		1982	5,288		15			5,288	25
26	ROOF REPAIRS		1982	322,299		15			322,299	26
27	ELECTRICAL WORK		1983	100,430		15			100,430	27
28	ELECTRIC PANEL MODIFICATION		1983	1,002		15			1,002	28
29	ROOF REPAIRS		1983	38,573		15			38,573	29
30	FIRE DOORS		1983	1,158		20			1,158	30
31	AIR HANDLING UNITS		1984	1,166		10			1,166	31
32	BOOSTER PUMP		1984	1,085		10			1,085	32
33	KEY LOCKS AND BUILDING		1984	1,592		15			1,592	33
34	GROUND FAULT RECEPTICLES		1984	1,022		15			1,022	34
35	ROOF REPAIRS		1984	121,210		15			121,210	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 REHAB & CARE CENTER - JACKSON COUNTY

0010330

Report Period Beginning:

12/01/03

Ending:

11/30/04

XI. OWNERSHIP COSTS (continued)

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

	1	2	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	Fire Alarm System	1984	\$ 52,151	\$	15	\$	\$	\$ 52,151		37
38	Interior Aluminum Doors	1985	1,144	57	20	57		1,056		38
39	Storage Shed	1985	1,095	55	20	55		1,071		39
40	Exterior Doors	1985	1,635	82	20	82		1,516		40
41	Fire Doors	1985	3,822	191	20	191		3,725		41
42	Key Locks and Buildings	1985	359		15			359		42
43	Ceiling Tiles	1985	957		15			957		43
44	Building Repair	1985	1,999		15			1,999		44
45	Fire Alarm System	1985	1,086		15			1,086		45
46	Heating System	1985	137,183		15			137,183		46
47										47
48	Call Light System	1985	19,148		15			19,148		48
49	Heating System	1986	2,418	121	20	121		2,238		49
50	Generator	1986	28,546	1,427	20	1,427		26,401		50
51	Emergency Generator	1986	15,400	770	20	770		14,245		51
52	Roof Repairs	2002	279,610	27,961	10	27,961		63,590		52
53	Dietary Renovation-Conveyor	1987	5,083		15			5,083		53
54	Dietary Renovation-Refrig/Freezer	1987	25,083	1,254	20	1,254		21,945		54
55	A.B.& C Renovations	1987	337,164	16,858	20	16,858		295,016		55
56	Vinyl Flooring	1987	29,000	1,450	20	1,450		25,375		56
57	Dietary Renovations	1987	276,810	13,841	20	13,841		242,204		57
58	A.B.& C Renovations-Final	1988	1,521	76	20	76		1,254		58
59	Dietary Renovations	1988	815	41	20	41		675		59
60	Roof Repairs	1989	16,485	549	15	549		16,485		60
61	Transfer Switch	1989	6,425	321	20	321		4,977		61
62	Kickplates	1989	1,685	56	15	56		1,682		62
63	Laundry Renovations	1989	187,559	9,378	20	9,378		145,359		63
64	Sprinkler	1990	3,150	126	25	126		1,827		64
65	Lockers	1990	4,233	212	20	212		3,073		65
66	Earthquake Valves	1990	5,648	282	20	282		4,090		66
67	Security System	1990	1,798	120	15	120		1,740		67
68	Cubicle Track	1990	5,729	382	15	382		5,539		68
69	Screens	1991	1,804	120	15	120		1,621		69
70	TOTAL (lines 4 thru 69)		\$ 5,090,115	\$ 75,730		\$ 75,730	\$	\$ 4,738,193		70

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY

0010330

Report Period Beginning:

12/01/03

Ending:

11/30/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 5,090,115	\$ 75,730		\$ 75,730	\$	\$ 4,738,193		1
2	Kickplates	1991 1,531	102	15	102		1,377		2
3	Medical Ancillary Center	1991 1,448	72	20	72		973		3
4	Boilers & Cooling Tower	1991 18,057	903	20	903		12,190		4
5	Asbestos Removal	1991 26,516		10			26,516		5
6	Hazmat Storage Building	1992 1,485	74	20	74		928		6
7	Boilers & Cooling Tower	1992 289,332	14,467	20	14,467		181,084		7
8	Asbestos Removal	1992 17,956		10			17,956		8
9	Engineering Study-Electrical Work	1992 16,098	805	20	805		10,062		9
10	Paging System	1993 4,385	292	15	292		3,359		10
11	Case Work Replacement	1993 85,585	4,279	20	4,279		49,210		11
12	Floor Tile/Vinyl Flooring/Fire Door	1993 34,880	1,744	20	1,744		20,056		12
13	Sealant	1993 16,150	646	25	646		7,429		13
14	Shelter	1993 7,995	400	20	400		4,598		14
15	Chain Link Fence	1993 4,990	333	15	333		3,826		15
16	Parking Lot	1993 29,310	1,954	15	1,954		22,471		16
17	Outside Lights	1993 18,839	1,256	15	1,256		14,443		17
18	Curbing & Sidewalks	1993 6,820	341	20	341		3,922		18
19	Sidewalk Extension	1994 4,999	250	20	250		2,625		19
20	Resurface & Striping	1994 1,543	103	15	103		1,080		20
21	HVAC System	1994 4,570	229	20	229		2,403		21
22	Boiler Room	1994 34,821	1,741	20	1,741		18,281		22
23	Floor Tile/Vinyl Flooring/Fire Door	1994 4,999	250	20	250		2,625		23
24	Masonry Work	1994 4,840	194	25	194		2,036		24
25	Sealant	1994 850	34	25	34		357		25
26	Visual Observation System	1994 60,480	4,032	15	4,032		42,336		26
27	Telephone System	1995 16,928	846	20	846		8,038		27
28	Boiler Room	1995 5,379	269	20	269		2,555		28
29	Safety Wire Glass	1995 2,600	173	15	173		1,645		29
30	Tuckpointing & Waterproofing	1996 1,800	72	25	72		612		30
31	Metal Fire Door	1996 1,785	89	20	89		758		31
32	Repair to Electric Facilities	1996 5,176	259	20	259		2,201		32
33	Shelving	1996 3,680	184	20	184		1,564		33
34	TOTAL (lines 1 thru 33)	\$ 5,825,942	\$ 112,123		\$ 112,123	\$	\$ 5,207,709		34

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY

0010330

Report Period Beginning:

12/01/03

Ending:

11/30/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,825,942	\$ 112,123		\$ 112,123	\$	\$ 5,207,709	1
2	Fire Doors	1997	707	35	20	35		264	2
3	Counter Top-Gray Essences	1998	784	52	15	52		290	3
4	Carpet-Bus Off, NSG. Admin., Chapel	1998	4,047		5			4,047	4
5	Metal Fire Retardant Door-Dietary	1998	2,912	146	20	146		936	5
6	Fuel Tank Removal & Upgrade	1998	85,056	4,253	20	4,253		28,721	6
7	Side Rails	1998	2,697	180	15	180		1,220	7
8	Smokers' Shelter 10x21	1999	1,671	167	10	167		859	8
9	Patio	1999	1,000	100	10	100		539	9
10	Chain Link Fence Extension	1999	510	34	15	34		184	10
11	Ceiling Tiles	1999	557	70	8	70		371	11
12	Mini-Kitchen	2000	3,342	167	20	167		826	12
13	HVAC	2000	2,039,632	134,417	15	134,417		438,980	13
14	Patio	2000	2,612	261	10	261		1,109	14
15	Rollup Curtains-Cabana	2001	2,820	282	10	282		987	15
16	Landscaping	2001	3,283	328	10	328		1,039	16
17	Handrails(220LF)	2001	2,114	140	15	140		515	17
18	Ceiling Tiles	2001	1,689	113	15	113		395	18
19	Roof Repairs	2001	700	47	15	47		168	19
20	Window Pictorials for Cafeteria	2001	3,554	355	10	355		1,095	20
21	Floor Tile-E&F Solarium	2001	2,175	109	20	109		381	21
22	Floor Tile-D Unit	2001	7,265	363	20	363		1,271	22
23	Ceiling Tiles	2001	325	22	15	22		73	23
24	Floor Tile-E Unit	2001	7,510	376	20	376		1,256	24
25	Handrails(360 LF)	2001	3,515	234	15	234		761	25
26	Knoblocks (2-Corbin Grade 1)	2001	564	38	15	38		123	26
27	Floor Tile-G Unit	2001	17,110	856	20	856		2,568	27
28	Steamer	2001	24,080	2,408	10	2,408		9,431	28
29	Marquee Sign	1995	4,491	449	10	449		4,265	29
30	Dining Room Curtains & Tension Rods	2002	563	113	5	113		320	30
31	Interior Fuse Panel with Breakers	2002	1,850	94	20	94		254	31
32	Supply Line for Steam Table	2002	377	19	20	19		52	32
33	Climate Control Basic Compressor 216QRBL	2002	1,029	69	15	69		138	33
34	TOTAL (lines 1 thru 33)		\$ 8,056,483	\$ 258,420		\$ 258,420	\$	\$ 5,711,147	34

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

STATE OF ILLINOIS

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY

0010330

Report Period Beginning:

12/01/03

Ending:

11/30/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 8,056,483	\$ 258,420		\$ 258,420		\$ 5,711,147		1
2	TV Wall Units	840	56	15	56		103		2
3	Window Treatments	703	141	5	141		270		3
4	EZ FLUSH RETRO KIT	2,405	60	20	60		60		4
5	UNIMAC 125LB WASHER	7,000	233	10	233		233		5
6	RE-WIRING-ADDITIONAL OUTLETS	1,524	70	20	70		70		6
7	PATCHWORK AND PAINT	5,860	293	5	293		293		7
8	UNDERGROUND CABLE	8,148	109	25	109		109		8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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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	TOTAL (lines 1 thru 33)	\$ 8,082,963	\$ 259,382		\$ 259,382		\$ 5,712,285		34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 763,734	\$ 65,512	\$ 65,512	\$	*5-20	\$ 505,253	71
72	Current Year Purchases	8,566	509	509		*3-20	509	72
73	Fully Depreciated Assets	900,445	3,935	3,935		*5-20	900,445	73
74								74
75	TOTALS	\$ 1,672,745	\$ 69,956	\$ 69,956	\$		\$ 1,406,207	75

D. Vehicle Depreciation (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)	\$ 9,765,708	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 329,338	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 329,338	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,118,492	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	Medical Ancillary Complex 1990	\$ 107,276	\$ 5,364	\$ 77,777	86
87	HVAC Project	103,052	6,870	27,499	87
88					88
89					89
90					90
91	TOTALS	\$ 210,328	\$ 12,234	\$ 105,276	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: _____

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2005 \$ _____
13. _____/2006 \$ _____
14. _____/2007 \$ _____

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: \$ _____ Description: _____
(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.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	350	\$ 10,493	\$ 787	350	\$ 11,280	1
2	Licensed Speech and Language Development Therapist		hrs		574	24,091	0	574	24,091	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A/8	2088 hrs	60,761	192	3,543	1,474	2,280	65,778	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/8	# of prescripts				254,750		254,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): VA LAB, MED SUPPLY						125,303		125,303	13
14	TOTAL			\$ 60,761	1,116	\$ 38,127	\$ 382,314	3,204	\$ 481,202	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number **REHAB & CARE CENTER - JACKSON COUNTY** # **0010330** Report Period Beginning: **12/01/03** Ending: **11/30/04**
XV. BALANCE SHEET - Unrestricted Operating Fund. As of **11/30/04** (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	\$ 965,780	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 96,653)	1,954,890		3
4	Supply Inventory (priced at)	6,411		4
5	Short-Term Investments	7,091		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,009		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from other funds	574,571		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,509,752	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	166,648		13
14	Buildings, at Historical Cost	8,136,640		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,672,745		16
17	Accumulated Depreciation (book methods)	(7,223,767)		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)	\$ 2,752,266	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,262,018	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 203,718	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,807		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	451,399		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	DEFERRED REVENUE	818,233		36
37	ACCRUED DPA ASSESSMENT	9,393		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,512,550	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,512,550	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,749,468	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,262,018	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,871,845	1
2	Restatements (describe):		2
3	PRIOR PERIOD AUDIT ADJUSTMENT	(73,052)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,798,793	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,049,325)	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)	\$ (1,049,325)	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)	\$ 4,749,468	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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,619,532	1
2	Discounts and Allowances for all Levels	(3,634,278)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,985,254	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,299	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,464	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)	\$ 3,763	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,522	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,522	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COPIES, POSTAGE, VENDING	5,522	28
28a	MISCELLANEOUS	7,715	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,237	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,007,776	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,535,647	31
32	Health Care	3,883,678	32
33	General Administration	1,771,037	33
B. Capital Expense			
34	Ownership	341,572	34
C. Ancillary Expense			
35	Special Cost Centers	414,269	35
36	Provider Participation Fee	110,898	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,057,101	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,049,325)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,049,325)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY

0010330

Report Period Beginning: 12/01/03

Ending:

11/30/04

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,073	2,088	\$ 64,998	\$ 31.13	1
2	Assistant Director of Nursing	2,061	2,088	52,625	25.20	2
3	Registered Nurses	37,565	38,035	810,584	21.31	3
4	Licensed Practical Nurses	22,232	22,482	552,817	24.59	4
5	Nurse Aides & Orderlies	134,522	135,848	1,660,431	12.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,075	2,088	60,761	29.10	7
8	Rehab/Therapy Aides	16,051	16,297	202,613	12.43	8
9	Activity Director	1,961	2,001	45,607	22.79	9
10	Activity Assistants	7,444	7,583	92,465	12.19	10
11	Social Service Workers	7,318	7,415	110,404	14.89	11
12	Dietician					12
13	Food Service Supervisor	4,144	4,176	49,355	11.82	13
14	Head Cook	1,999	2,033	38,134	18.76	14
15	Cook Helpers/Assistants	29,421	29,680	327,078	11.02	15
16	Dishwashers					16
17	Maintenance Workers	8,214	8,362	78,242	9.36	17
18	Housekeepers	16,898	17,113	208,441	12.18	18
19	Laundry	15,555	15,805	184,952	11.70	19
20	Administrator	2,054	2,088	61,547	29.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,050	2,088	45,607	21.84	23
24	Clerical	9,973	10,080	161,333	16.01	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	323,610	327,350	\$ 4,807,994 *	\$ 14.69	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 7,200	35
36	Medical Director	480	38,280	36
37	Medical Records Consultant		214	37
38	Nurse Consultant			38
39	Pharmacist Consultant		2,400	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Quality Assessment</u>		1,500	46
47	<u>Dental Consultant</u>	240	20,400	47
48	<u>Psych Consultant</u>		4,200	48
49	TOTAL (lines 35 - 48)	816	\$ 74,194	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	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. CNHA & IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (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 of Public Aid during this cost report period. \$ 110,898
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 of Public Aid, 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. \$ N/A Has any meal income been offset against related costs? _____ 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? 0%
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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? YES
Firm Name: KERBER, ECK & BRAECKEL, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.