

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

**I. IDPH Facility ID Number:** 0010330

**Facility Name:** REHAB & CARE CENTER - JACKSON COUNTY

**Address:** 1441 NORTH 14TH STREET MURPHYSBORO 62966  
 Number City Zip Code

**County:** JACKSON

**Telephone Number:** (618) 684-2136 **Fax #** (618) 684-5710

**HFS ID Number:** 37-6001092-004

**Date of Initial License for Current Owners:** \_\_\_\_\_

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** MARK DALLAS **Telephone Number:** (618) 529-1040

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/05 to 11/30/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>MARK DALLAS</u> <u>CPA, PARTNER</u>	
	(Firm Name & Address) <u>KERBER, ECK &amp; BRAECKEL, LLP</u> <u>1116 W. MAIN STREET, CARBONDALE, IL 62903</u>	
	(Telephone) <u>(618) 529-1040</u> Fax # <u>(618) 549-2311</u>	

**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 REHAB & CARE CENTER - JACKSON COUNTY

# 10330 Report Period Beginning: 12/01/05 Ending: 11/30/06

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	73,730	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	73,730	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	23,847	12,812	71	36,730	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,854	3,536	7,001	16,391	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,701	16,348	7,072	53,121	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.05%

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

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 6,435

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: 11/30/06

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON CO # 0010330 Report Period Beginning: 12/01/05 Ending: 11/30/06

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	
	<b>A. General Services</b>											
1	Dietary	377,368	20,802		398,170		398,170		398,170			1
2	Food Purchase		202,202		202,202		202,202	(5,071)	197,131			2
3	Housekeeping	233,447	40,492	41,155	315,094		315,094		315,094			3
4	Laundry	165,913	17,075		182,988		182,988		182,988			4
5	Heat and Other Utilities			244,382	244,382		244,382		244,382			5
6	Maintenance	65,985	30,227	66,275	162,487		162,487		162,487			6
7	Other (specify):* <b>Waste Removal</b>			14,419	14,419		14,419		14,419			7
8	<b>TOTAL General Services</b>	<b>842,713</b>	<b>310,798</b>	<b>366,231</b>	<b>1,519,742</b>		<b>1,519,742</b>	<b>(5,071)</b>	<b>1,514,671</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			38,280	38,280		38,280		38,280			9
10	Nursing and Medical Records	2,570,351	92,622	626,769	3,289,742		3,289,742		3,289,742			10
10a	Therapy	162,807	626	31,522	194,955		194,955		194,955			10a
11	Activities	113,728			113,728		113,728		113,728			11
12	Social Services	93,354	2,812		96,166		96,166		96,166			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>2,940,240</b>	<b>96,060</b>	<b>696,571</b>	<b>3,732,871</b>		<b>3,732,871</b>		<b>3,732,871</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	60,222			60,222		60,222		60,222			17
18	Directors Fees											18
19	Professional Services			10,962	10,962		10,962		10,962			19
20	Dues, Fees, Subscriptions & Promotions			28,863	28,863		28,863	(10,892)	17,971			20
21	Clerical & General Office Expenses	174,890	23,490	79,923	278,303		278,303	(24,848)	253,455			21
22	Employee Benefits & Payroll Taxes			1,239,567	1,239,567		1,239,567		1,239,567			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,342	6,342		6,342		6,342			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			34,426	34,426		34,426		34,426			26
27	Other (specify):* <b>Bad Debt</b>			302,129	302,129		302,129	(302,129)				27
28	<b>TOTAL General Administration</b>	<b>235,112</b>	<b>23,490</b>	<b>1,702,212</b>	<b>1,960,814</b>		<b>1,960,814</b>	<b>(337,869)</b>	<b>1,622,945</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,018,065</b>	<b>430,348</b>	<b>2,765,014</b>	<b>7,213,427</b>		<b>7,213,427</b>	<b>(342,940)</b>	<b>6,870,487</b>			<b>29</b>

\*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 REHAB & CARE CENTER - JACKSON COUNTY #0010330 Report Period Beginning: 12/01/05 Ending: 11/30/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation			323,435	323,435	323,435	(12,234)	311,201				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						(1,836)	(1,836)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			323,435	323,435	323,435	(14,070)	309,365				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		317,470		317,470	317,470		317,470				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,595	110,595	110,595		110,595				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		317,470	110,595	428,065	428,065		428,065				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,018,065	747,818	3,199,044	7,964,927	7,964,927	(357,010)	7,607,917				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: 12/01/05

Ending: 11/30/06

**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	(5,071)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,836)	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	(302,129)	27		24
25	Fund Raising, Advertising and Promotional	(10,892)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,848)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (357,010)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (357,010)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS

Summary A

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

# 0010330

Report Period Beginning:

12/01/05

Ending:

11/30/06

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,071)	0	0	0	0	0	0	0	0	0	0	(5,071)	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	<b>TOTAL General Services</b>	<b>(5,071)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,071)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(10,892)	0	0	0	0	0	0	0	0	0	0	(10,892)	20
21	Clerical & General Office Expenses	(24,848)	0	0	0	0	0	0	0	0	0	0	(24,848)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(302,129)	0	0	0	0	0	0	0	0	0	0	(302,129)	27
28	<b>TOTAL General Administration</b>	<b>(337,869)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(337,869)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(342,940)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(342,940)</b>	<b>29</b>

STATE OF ILLINOIS  
 REHAB & CARE CENTER - JACKSON COUNTY

Report Period Beginning:           0010330            
  12/01/05            
 Ending:   11/30/06          

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING INCOME	\$ (3,923)	21	1
2	COPIES	(240)	21	2
3	POSTAGE	(153)	21	3
4	MISCELLANEOUS	(20,532)	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	<b>Total</b>	(24,848)		49

STATE OF ILLINOIS

Summary B

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

# 0010330

Report Period Beginning:

12/01/05 Ending:

11/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(1,836)	0	0	0	0	0	0	0	0	0	0	(1,836)	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	<b>TOTAL Ownership</b>	<b>(14,070)</b>	<b>0</b>	<b>(14,070)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(357,010)</b>	<b>0</b>	<b>(357,010)</b>	<b>45</b>									

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

# 0010330

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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 C # 0010330 Report Period Beginning: 12/01/05 Ending: 11/30/06

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: 12/01/05 Ending: 11/30/06

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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: **12/01/05** Ending: **11/30/06**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	14										
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$	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**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 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 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	2001	N/A	8
	2002	N/A	9
	2003	N/A	10
	2004	N/A	11
	2005	N/A	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 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 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? \_\_\_\_\_ YES \_\_\_\_\_ 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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 REHAB & CARE CENTER - JACKSON COUNTY

# 0010330 Report Period Beginning:

12/01/05 Ending:

11/30/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 150,000 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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

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

# 0010330

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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 BHF 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
	<b>Improvement Type**</b>										
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		ADJUSTMENT		1981						14,702	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 &amp; ID Number REHAB &amp; CARE CENTER - JACKSON COUNTY

# 0010330

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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	31	20	31		1,144	38
39	Storage Shed	1985	1,095		20			1,095	39
40	Exterior Doors	1985	1,635	37	20	37		1,635	40
41	Fire Doors	1985	3,822		20			3,822	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	59	20	59		2,418	49
50	Generator	1986	28,546	718	20	718		28,546	50
51	Emergency Generator	1986	15,400	385	20	385		15,400	51
52	Roof Repairs	2002	279,610	27,961	10	27,961		119,512	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		24,453	54
55	A,B,& C Renovations	1987	337,164	16,858	20	16,858		328,732	55
56	Vinyl Flooring	1987	29,000	1,450	20	1,450		28,275	56
57	Dietary Renovations	1987	276,810	13,841	20	13,841		269,886	57
58	A,B,& C Renovations-Final	1988	1,521	76	20	76		1,406	58
59	Dietary Renovations	1988	815	41	20	41		757	59
60	Roof Repairs	1989	16,485		15			16,485	60
61	Transfer Switch	1989	6,425	321	20	321		5,619	61
62	Kickplates	1989	1,685		15			1,685	62
63	Laundry Renovations	1989	187,559	12,000	20	12,000		164,115	63
64	Sprinkler	1990	3,150	126	25	126		2,079	64
65	Lockers	1990	4,233	212	20	212		3,497	65
66	Earthquake Valves	1990	5,648	282	20	282		4,654	66
67	Security System	1990	1,798		15			1,798	67
68	Cubicle Track	1990	5,729		15			5,729	68
69	Screens	1991	1,804	63	15	63		1,804	69
70	TOTAL (lines 4 thru 69)		\$ 5,090,115	\$ 75,715		\$ 75,715	\$	\$ 4,900,737	70

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

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

# 0010330

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,090,115	\$ 75,715		\$ 75,715	\$	\$ 4,900,737	1
2	Kickplates	1991	1,531	52	15	52		1,531	2
3	Medical Ancillary Center	1991	1,448	72	20	72		1,117	3
4	Boilers & Cooling Tower	1991	18,057	903	20	903		13,996	4
5	Asbestos Removal	1991	26,516		10			26,516	5
6	Hazmat Storage Building	1992	1,485	74	20	74		1,076	6
7	Boilers & Cooling Tower	1992	289,332	14,467	20	14,467		210,018	7
8	Asbestos Removal	1992	17,956		10			17,956	8
9	Engineering Study-Electrical Work	1992	16,098	805	20	805		11,672	9
10	Paging System	1993	4,385	292	15	292		3,943	10
11	Case Work Replacement	1993	85,585	4,279	20	4,279		57,768	11
12	Floor Tile/Vinyl Flooring/Fire Door	1993	34,880	1,744	20	1,744		23,544	12
13	Sealant	1993	16,150	646	25	646		8,721	13
14	Shelter	1993	7,995	400	20	400		5,398	14
15	Chain Link Fence	1993	4,990	333	15	333		4,492	15
16	Parking Lot	1993	29,310	1,954	15	1,954		26,379	16
17	Outside Lights	1993	18,839	1,256	15	1,256		16,955	17
18	Curbing & Sidewalks	1993	6,820	341	20	341		4,604	18
19	Sidewalk Extension	1994	4,999	250	20	250		3,125	19
20	Resurface & Striping	1994	1,543	103	15	103		1,286	20
21	HVAC System	1994	4,570	229	20	229		2,861	21
22	Boiler Room	1994	34,821	1,741	20	1,741		21,763	22
23	Floor Tile/Vinyl Flooring/Fire Door	1994	4,999	250	20	250		3,125	23
24	Masonry Work	1994	4,840	194	25	194		2,424	24
25	Sealant	1994	850	34	25	34		425	25
26	Visual Observation System	1994	60,480	4,032	15	4,032		50,400	26
27	Telephone System	1995	16,928	846	20	846		9,730	27
28	Boiler Room	1995	5,379	269	20	269		3,093	28
29	Safety Wire Glass	1995	2,600	173	15	173		1,991	29
30	Tuckpointing & Waterproofing	1996	1,800	72	25	72		756	30
31	Metal Fire Door	1996	1,785	89	20	89		936	31
32	Repair to Electric Facilities	1996	5,176	259	20	259		2,719	32
33	Shelving	1996	3,680	184	20	184		1,932	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,825,942	\$ 112,058		\$ 112,058	\$	\$ 5,442,989	34

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

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

# 0010330

Report Period Beginning:

12/01/05

Ending:

11/30/06

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,825,942	\$ 112,058		\$ 112,058	\$	\$ 5,442,989	1
2	Fire Doors	1997	707	35	20	35		334	2
3	Counter Top-Gray Essences	1998	784	52	15	52		394	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		1,228	5
6	Fuel Tank Removal & Upgrade	1998	85,056	4,253	20	4,253		37,227	6
7	Side Rails	1998	2,697	180	15	180		1,580	7
8	Smokers' Shelter 10x21	1999	1,671	167	10	167		1,193	8
9	Patio	1999	1,000	100	10	100		739	9
10	Chain Link Fence Extension	1999	510	34	15	34		252	10
11	Ceiling Tiles	1999	557	70	8	70		511	11
12	Mini-Kitchen	2000	3,342	167	20	167		1,160	12
13	HVAC	2000	2,039,632	134,417	15	134,417		707,814	13
14	Patio	2000	2,612	261	10	261		1,631	14
15	Rollup Curtains-Cabana	2001	2,820	282	10	282		1,551	15
16	Landscaping	2001	3,283	328	10	328		1,695	16
17	Handrails(220LF)	2001	2,114	140	15	140		795	17
18	Ceiling Tiles	2001	1,689	113	15	113		621	18
19	Roof Repairs	2001	700	47	15	47		262	19
20	Window Pictorials for Cafeteria	2001	3,554	355	10	355		1,805	20
21	Floor Tile-E&F Solarium	2001	2,175	109	20	109		599	21
22	Floor Tile-D Unit	2001	7,265	363	20	363		1,997	22
23	Ceiling Tiles	2001	325	22	15	22		117	23
24	Floor Tile-E Unit	2001	7,510	376	20	376		2,008	24
25	Handrails(360 LF)	2001	3,515	234	15	234		1,229	25
26	Knoblocks (2-Corbin Grade 1 )	2001	564	38	15	38		199	26
27	Floor Tile-G Unit	2001	17,110	856	20	856		4,280	27
28	Steamer	2001	24,080	2,408	10	2,408		14,247	28
29	Marquee Sign	1995	4,491		10			4,491	29
30	Dining Room Curtains & Tension Rods	2002	563	113	5	113		546	30
31	Interior Fuse Panel with Breakers	2002	1,850	94	20	94		442	31
32	Supply Line for Steam Table	2002	377	19	20	19		90	32
33	Climate Control Basic Compressor 216QRBL	2002	1,029	69	15	69		276	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,056,483	\$ 257,906		\$ 257,906	\$	\$ 6,238,349	34

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

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	\$ 257,906		\$ 257,906	\$	\$ 6,238,349	1
2	TV Wall Units	2003	840	56	15	56		215	2
3	Window Treatments	2003	703	141	5	141		552	3
4	EZ FLUSH RETRO KIT	2004	2,405	120	20	120		300	4
5	UNIMAC 125LB WASHER	2004	7,000	700	10	700		1,633	5
6	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	70	20	70		210	6
7	PATCHWORK AND PAINT	2004	5,860	293	5	293		879	7
8	UNDERGROUND CABLE	2004	8,148	109	25	109		327	8
9	PATCHWORK AND PAINT	2005	316	63	5	63		126	9
10	STEEL DOORS	2005	1,981	91	20	91		182	10
11	ROOF REPAIR	2005	422	14	30	14		28	11
12	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275	855	6	855		1,496	12
13	SEWER LINE	2006	3,935	53	25	53		53	13
14	ANNUNCIATOR RELOCATION	2006	1,750	97	15	97		97	14
15	REMOTE ANNUNCIATOR	2006	2,250	125	15	125		125	15
16	FIRE DOOR SLEEVES	2006	554	51	10	51		51	16
17	CIP	2006	278,090						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	TOTAL (lines 1 thru 33)		\$ 8,376,536	\$ 260,744		\$ 260,744	\$	\$ 6,244,623	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: 12/01/05 Ending: 11/30/06

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	\$ 769,092	\$ 49,703	\$ 49,703	\$	*5-20	\$ 594,141	71
72	Current Year Purchases	19,281	754	754		*3-20	754	72
73	Fully Depreciated Assets	921,126				*5-20	921,126	73
74								74
75	TOTALS	\$ 1,709,499	\$ 50,457	\$ 50,457	\$		\$ 1,516,021	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)	\$ 10,096,035	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 311,201	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 311,201	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)	\$ 7,760,644	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	\$ 88,505	86
87	HVAC Project	103,052	6,870	41,239	87
88					88
89					89
90					90
91	TOTALS	\$ 210,328	\$ 12,234	\$ 129,744	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	<b>TOTAL</b>				\$ _____			7

\*\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ 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	<b>TOTAL</b>		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	280	\$ 8,286	\$	280	\$ 8,286	1
2	Licensed Speech and Language Development Therapist		hrs		352	14,644		352	14,644	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A/8	2112 hrs	59,795	85	1,695		2,197	61,490	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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>VA LAB, MED SUPPLY</b>									13
14	<b>TOTAL</b>			\$ 59,795	717	\$ 24,625	\$	2,829	\$ 84,420	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 REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/01/05 Ending: 11/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 563,471	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>800,000</u> )	2,144,320		3
4	Supply Inventory (priced at )	5,793		4
5	Short-Term Investments	278		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,006		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,714,868	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,583		13
14	Buildings, at Historical Cost	7,899,337		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,236,443		16
17	Accumulated Depreciation (book methods)	(7,890,388)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,415,975	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,130,843	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 171,194	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,571		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	415,290		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>DEFERRED REVENUE</u>	776,897		36
37	<u>ACCRUED DPA ASSESSMENT</u>	9,393		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,398,345	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,398,345	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,732,498	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,130,843	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,887,050	1
2	Restatements (describe):		2
3	<b>ADJUSTMENT TO BAD DEBT</b>	(430,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,457,050	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	275,448	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 275,448	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 3,732,498	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,585,231	1
2	Discounts and Allowances for all Levels	(2,399,696)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,185,535	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	5,071	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,836	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,907	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,571	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,571	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>COPIES, POSTAGE, VENDING</b>	4,316	28
28a	<b>MISCELLANEOUS</b>	29,046	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 33,362	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,240,375	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,519,742	31
32	Health Care	3,732,871	32
33	General Administration	1,960,814	33
<b>B. Capital Expense</b>			
34	Ownership	323,435	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	317,470	35
36	Provider Participation Fee	110,595	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,964,927	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	275,448	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 275,448	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:

12/01/05

Ending:

11/30/06

**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	2,093	2,240	\$ 64,507	\$ 28.80	1
2	Assistant Director of Nursing	2,097	2,112	49,053	23.23	2
3	Registered Nurses	20,046	20,270	419,549	20.70	3
4	Licensed Practical Nurses	30,079	30,391	383,760	12.63	4
5	CNAs & Orderlies	163,490	165,129	1,510,040	9.14	5
6	CNA Trainees					6
7	Licensed Therapist	2,077	2,112	59,069	27.97	7
8	Rehab/Therapy Aides	21,698	22,043	240,481	10.91	8
9	Activity Director	2,062	2,148	44,955	20.93	9
10	Activity Assistants	5,694	5,812	69,696	11.99	10
11	Social Service Workers	6,557	6,648	93,511	14.07	11
12	Dietician					12
13	Food Service Supervisor	2,364	2,581	47,438	18.38	13
14	Head Cook	2,088	2,112	31,061	14.71	14
15	Cook Helpers/Assistants	29,984	30,393	307,008	10.10	15
16	Dishwashers					16
17	Maintenance Workers	5,945	6,191	101,067	16.32	17
18	Housekeepers	13,719	14,042	199,051	14.18	18
19	Laundry	14,845	15,128	163,898	10.83	19
20	Administrator	2,068	2,168	59,575	27.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,065	2,096	44,359	21.16	23
24	Clerical	8,798	8,981	127,678	14.22	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	87	87	2,311	26.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>337,856</b>	<b>342,684</b>	<b>\$ 4,018,065 *</b>	<b>\$ 11.73</b>	<b>34</b>

\* 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			35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,400	10,3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	782	12,2	45
46	Other(specify)			46
47	Psych Consultant	4,400	10,3	47
48	Dental Consultant	10,200	10,3	48
49	<b>TOTAL (lines 35 - 48)</b>	<b>\$ 17,782</b>		<b>49</b>

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,500	\$ 74,699	10,3	50
51	Licensed Practical Nurses	12,000	420,207	10,3	51
52	Certified Nurse Assistants/Aides	6,000	113,390	10,3	52
53	<b>TOTAL (lines 50 - 52)</b>	<b>19,500</b>	<b>\$ 608,296</b>		<b>53</b>

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

# **0010330**

Report Period Beginning: **12/01/05**

Ending: **11/30/06**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MERLE K. TAYLOR			\$ 60,222	Workers' Compensation Insurance	\$ 178,776	IDPH License Fee	\$	
				Unemployment Compensation Insurance	28,849	Advertising: Employee Recruitment	2,707	
				FICA Taxes	298,087	Health Care Worker Background Check		
				Employee Health Insurance	410,403	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	182 2,912	
				Illinois Municipal Retirement Fund (IMRF)*	307,221	Marketing	8,185	
				Physical Examinations	2,062	IHCA and CNHA Dues	12,073	
				Employee Rel/Training	14,169	Other Dues and License	2,046	
						Subscriptions	940	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 60,222			Less: Public Relations Expense	(8,185)	
(List each licensed administrator separately.)						Non-allowable advertising	(2,707)	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>				TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,239,567	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$			\$ 17,971		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)								
<b>C. Professional Services</b>				Description			Amount	
Vendor/Payee	Type	Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**		
IL. DEPT. OF PUBLIC HEALTH	FEES	\$ 2,400			\$	Description		
DUANE MORRIS	ATTORNEY FEES	1,607				Amount		
VARIOUS	VARIOUS	2,355				Out-of-State Travel		
KERBER, ECK & BRAECKEL	COST REPORT/AUDIT	4,600				\$ 292		
						In-State Travel		
						821		
						Seminar Expense		
						3,655		
						Meals		
						772		
						Lodging		
						802		
						Entertainment Expense		
						( )		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 10,962	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)						TOTAL (agree to Sch. V, line 24, col. 8)		
						\$ 6,342		

\* Attach copy of IMRF notifications

\*\*See instructions.



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

# 0010330

Report Period Beginning: 12/01/05

Ending: 11/30/06

**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? 15 yrs.
- (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 during this cost report period. \$ 110,595  
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. \$ 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?  
**g. Does the facility transport residents to and from day training? \_\_\_\_\_**  
**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.