

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 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
IRS Exemption Code _____	<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 12/01/06 to 11/30/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) MARK DALLAS
CPA, PARTNER

(Firm Name & Address) KERBER, ECK & BRAECKEL, LLP
1116 W. MAIN STREET, CARBONDALE, IL 62903

(Telephone) (618) 529-1040 Fax # (618) 549-2311

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

0010330 Report Period Beginning: 12/01/06 Ending: 11/30/07

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)	178	71,296	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	178	71,296	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	5,900	2,456	6,798	15,154	8
9	SNF/PED					9
10	ICF	18,086	12,643	1,785	32,514	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,986	15,099	8,583	47,668	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.86%

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 6,063

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: 11/30/07

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON CO # 0010330 Report Period Beginning: 12/01/06 Ending: 11/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	415,911	25,319		441,230		441,230		441,230		1
2	Food Purchase		217,349		217,349		217,349	(4,762)	212,587		2
3	Housekeeping	236,320	38,815	40,788	315,923		315,923		315,923		3
4	Laundry	177,258	13,970		191,228		191,228		191,228		4
5	Heat and Other Utilities			278,395	278,395		278,395		278,395		5
6	Maintenance	69,005	23,815	90,942	183,762		183,762		183,762		6
7	Other (specify):* WASTE REMOVAL			15,137	15,137		15,137		15,137		7
8	TOTAL General Services	898,494	319,268	425,262	1,643,024		1,643,024	(4,762)	1,638,262		8
	B. Health Care and Programs										
9	Medical Director			38,280	38,280		38,280		38,280		9
10	Nursing and Medical Records	2,685,418	119,313	475,571	3,280,302		3,280,302		3,280,302		10
10a	Therapy	175,111	856	27,728	203,695		203,695		203,695		10a
11	Activities	120,110			120,110		120,110		120,110		11
12	Social Services	80,084	3,954	1,507	85,545		85,545		85,545		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,060,723	124,123	543,086	3,727,932		3,727,932		3,727,932		16
	C. General Administration										
17	Administrative	61,533			61,533		61,533		61,533		17
18	Directors Fees										18
19	Professional Services			25,209	25,209		25,209		25,209		19
20	Dues, Fees, Subscriptions & Promotions			34,797	34,797		34,797	(18,009)	16,788		20
21	Clerical & General Office Expenses	213,906	26,594	62,225	302,725		302,725	(30,247)	272,478		21
22	Employee Benefits & Payroll Taxes			1,224,239	1,224,239		1,224,239		1,224,239		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,651	16,651		16,651		16,651		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			46,547	46,547		46,547		46,547		26
27	Other (specify):* BAD DEBT			275,574	275,574		275,574	(275,574)			27
28	TOTAL General Administration	275,439	26,594	1,685,242	1,987,275		1,987,275	(323,830)	1,663,445		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,234,656	469,985	2,653,590	7,358,231		7,358,231	(328,592)	7,029,639		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY #0010330 Report Period Beginning: 12/01/06 Ending: 11/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			299,109	299,109	299,109	(12,234)	286,875				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			299,109	299,109	299,109	(12,234)	286,875				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		290,563		290,563	290,563		290,563				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,247	107,247	107,247		107,247				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		290,563	107,247	397,810	397,810		397,810				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,234,656	760,548	3,059,946	8,055,150	8,055,150	(340,826)	7,714,324				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: 12/01/06

Ending: 11/30/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,762)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,750)	21		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	(16,238)	21		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	(275,574)	27		24
25	Fund Raising, Advertising and Promotional	(18,009)	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	(12,259)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (340,826)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (340,826)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 REHAB & CARE CENTER - JACKSON COUNTY

ID# 0010330

Report Period Beginning: 12/01/06

Ending: 11/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING INCOME	\$ (4,055)	21	1
2	COPIES	(22)	21	2
3	POSTAGE	(168)	21	3
4	MISCELLANEOUS	(8,014)	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	(12,259)		49

STATE OF ILLINOIS

Summary A

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

0010330

Report Period Beginning:

12/01/06

Ending:

11/30/07

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	(4,762)	0	0	0	0	0	0	0	0	0	0	(4,762)	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	(4,762)	0	0	0	0	0	0	0	0	0	0	(4,762)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	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	(18,009)	0	0	0	0	0	0	0	0	0	0	(18,009)	20
21	Clerical & General Office Expenses	(30,247)	0	0	0	0	0	0	0	0	0	0	(30,247)	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):*	(275,574)	0	0	0	0	0	0	0	0	0	0	(275,574)	27
28	TOTAL General Administration	(323,830)	0	0	0	0	0	0	0	0	0	0	(323,830)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(328,592)	0	0	0	0	0	0	0	0	0	0	(328,592)	29

STATE OF ILLINOIS

Summary B

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

0010330

Report Period Beginning:

12/01/06 Ending:

11/30/07

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	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,234)	0	(12,234)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(340,826)	0	(340,826)	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
N/A						

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.

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	N/A								\$	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: 12/01/06 Ending: 11/30/07

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: **12/01/06** Ending: **11/30/07**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2	N/A									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

<p>Important, 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 2006 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 2007 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:	2002	N/A	8
	2003	N/A	9
	2004	N/A	10
	2005	N/A	11
	2006	N/A	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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. <u>NA</u>	_____	\$ _____	\$ _____
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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

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).

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		871,200	1960	\$ 10,000	1
2					2
3	TOTALS	871,200		\$ 10,000	3

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

0010330

Report Period Beginning:

12/01/06

Ending:

11/30/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1960	1960	\$ 1,069,483	\$	34.5	\$	\$	\$ 1,069,483	4
5			1966	1966	289,003		30			289,003	5
6	102		1972	1972	1,404,551		27			1,404,551	6
7											7
8											8
Improvement Type**											
9	AGGREGATE		1972		63,650		VARIOUS			63,650	9
10	AGGREGATE		1977		122,761		VARIOUS			122,761	10
11	AGGREGATE		1978		32,983		VARIOUS			32,983	11
12	AGGREGATE		1979		16,053		VARIOUS			16,053	12
13	AGGREGATE		1981		24,389		VARIOUS			24,389	13
14	AGGREGATE		1982		343,459		VARIOUS			343,459	14
15	AGGREGATE		1983		141,163		VARIOUS			141,163	15
16	AGGREGATE		1984		178,226		VARIOUS			178,226	16
17	AGGREGATE		1985		168,428		VARIOUS			168,428	17
18	AGGREGATE		1986		46,364		VARIOUS			46,364	18
19	AGGREGATE		1987		673,140	16,711	VARIOUS	16,711		673,140	19
20	AGGREGATE		1988		2,336	117	VARIOUS	117		2,280	20
21	AGGREGATE		1989		212,154	9,699	VARIOUS	9,699		197,603	21
22	AGGREGATE		1990		20,558	620	VARIOUS	620		18,377	22
23	AGGREGATE		1991		49,356	975	VARIOUS	975		45,939	23
24	AGGREGATE		1992		324,871	15,346	VARIOUS	15,346		256,068	24
25	AGGREGATE		1993		208,954	11,245	VARIOUS	11,245		163,052	25
26	AGGREGATE		1994		117,102	6,833	VARIOUS	6,833		92,242	26
27	AGGREGATE		1995		29,398	1,288	VARIOUS	1,288		20,593	27
28	AGGREGATE		1996		12,441	604	VARIOUS	604		6,947	28
29	AGGREGATE		1997		707	35	VARIOUS	35		369	29
30	AGGREGATE		1998		95,496	4,631	VARIOUS	4,631		49,107	30
31	AGGREGATE		1999		3,738	347	VARIOUS	347		2,996	31
32	AGGREGATE		2000		2,045,586	134,845	VARIOUS	134,845		845,450	32
33	AGGREGATE		2001		76,704	5,671	VARIOUS	5,671		37,076	33
34	AGGREGATE		2002		283,429	28,160	VARIOUS	28,160		149,009	34
35	AGGREGATE		2003		1,543	197	VARIOUS	197		964	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:

12/01/06

Ending:

11/30/07

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	EZ FLUSH RETRO KIT	2004	\$ 2,405	\$ 120	20	\$ 120	\$	\$ 420	37
38	UNIMAC 125LB WASHER	2004	7,000	700	10	700		2,333	38
39	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	70	20	70		280	39
40	PATCHWORK AND PAINT	2004	5,860	293	5	293		1,172	40
41	UNDERGROUND CABLE	2004	8,148	109	25	109		436	41
42	PATCHWORK AND PAINT	2005	316	63	5	63		189	42
43	STEEL DOORS	2005	1,981	91	20	91		273	43
44	ROOF REPAIR	2005	422	14	30	14		42	44
45	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275	855	6	855		2,351	45
46	SEWER LINE	2006	3,935	53	25	53		106	46
47	ANNUNCIATOR RELOCATION	2006	1,750	97	15	97		194	47
48	REMOTE ANNUNCIATOR	2006	2,250	125	15	125		250	48
49	FIRE DOOR SLEEVES	2006	554	55	10	55		106	49
50	LIGHTED EXIT/ACCESS PATHWAYS	2007	180,187		15				50
51	KITCHEN DRAIN LINE	2007	5,852	146	20	146		146	51
52	GREASE TRAP/DRAIN/KITCHEN FLOOR	2007	10,608	177	20	177		177	52
53	ALZHEIMER'S UNIT	2007	89,334		20				53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,384,427	\$ 240,292		\$ 240,292	\$	\$ 6,470,200	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: 12/01/06 Ending: 11/30/07

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	\$ 751,344	\$ 44,488	\$ 44,488	\$	*5-20	\$ 620,125	71
72	Current Year Purchases	50,300	2,095	2,095		*3-20	2,095	72
73	Fully Depreciated Assets	952,097				*5-20	952,097	73
74								74
75	TOTALS	\$ 1,753,741	\$ 46,583	\$ 46,583	\$		\$ 1,574,317	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)	\$ 10,148,168	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 286,875	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,875	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)	\$ 8,044,517	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	\$ 96,869	86
87	HVAC Project	103,052	6,870	48,109	87
88					88
89					89
90					90
91	TOTALS	\$ 210,328	\$ 12,234	\$ 144,978	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: N/A

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

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

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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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)	
TOTAL TRAINED	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	340	\$ 10,445	\$	340	\$ 10,445	1
2	Licensed Speech and Language Development Therapist		hrs		377	15,813		377	15,813	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A/8	2057 hrs	65,419				2,057	65,419	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# 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):									13
14	TOTAL			\$ 65,419	717	\$ 26,258	\$	2,774	\$ 91,677	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: 12/01/06 Ending: 11/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/07 (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	\$ 735,281	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>345,000</u>)	1,861,828		3
4	Supply Inventory (priced at)	7,210		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,003		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,605,322	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	350,771		13
14	Buildings, at Historical Cost	8,005,131		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,002,595		16
17	Accumulated Depreciation (book methods)	(8,189,498)		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)	\$ 2,168,999	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,774,321	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 290,778	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,531		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	436,932		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	<u>DEFERRED REVENUE</u>	689,204		36
37	<u>ACCRUED DPA ASSESSMENT</u>	8,277		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,443,722	\$	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)	\$ 1,443,722	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,330,599	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,774,321	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,732,498	1
2	Restatements (describe):		2
3	ADJUSTMENT FOR UNRECORDED EXPENSES	(313,563)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,418,935	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,688,385	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)	\$ 1,688,385	17
	B. Transfers (Itemize):		
18	COUNTY CONTRIBUTION TO MEDICAID REIMBURSE-		18
19	MENT TRANSFERRED TO STATE	(1,776,721)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,776,721)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,330,599	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	\$ 10,479,036	1
2	Discounts and Allowances for all Levels	(793,487)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,685,549	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	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,762	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,750	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)	\$ 6,512	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,238	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,238	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COPIES, POSTAGE, VENDING	4,245	28
28a	MISCELLANEOUS	26,023	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,268	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,738,567	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,643,024	31
32	Health Care	3,727,932	32
33	General Administration	1,982,307	33
B. Capital Expense			
34	Ownership	299,109	34
C. Ancillary Expense			
35	Special Cost Centers	290,563	35
36	Provider Participation Fee	107,247	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,050,182	40
41	Income before Income Taxes (line 30 minus line 40)**	1,688,385	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,688,385	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: **12/01/06**

Ending:

11/30/07

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	2,000	2,400	\$ 66,046	\$ 27.52	1
2	Assistant Director of Nursing	2,164	2,304	53,013	23.01	2
3	Registered Nurses	17,001	17,243	400,002	23.20	3
4	Licensed Practical Nurses	32,947	33,166	526,287	15.87	4
5	CNAs & Orderlies	113,992	115,399	1,430,566	12.40	5
6	CNA Trainees					6
7	Licensed Therapist	2,057	2,088	65,419	31.33	7
8	Rehab/Therapy Aides	16,616	16,852	251,196	14.91	8
9	Activity Director	2,058	2,088	46,248	22.15	9
10	Activity Assistants	5,831	5,976	76,954	12.88	10
11	Social Service Workers	7,201	7,257	82,344	11.35	11
12	Dietician					12
13	Food Service Supervisor	2,065	2,223	38,165	17.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,957	31,438	375,248	11.94	15
16	Dishwashers					16
17	Maintenance Workers	5,900	6,019	98,363	16.34	17
18	Housekeepers	17,029	17,424	207,600	11.91	18
19	Laundry	14,077	14,338	177,776	12.40	19
20	Administrator	2,061	2,112	61,683	29.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,052	2,088	46,142	22.10	23
24	Clerical	9,104	9,353	166,723	17.83	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	4,388	4,407	64,881	14.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	289,500	294,175	\$ 4,234,656 *	\$ 14.40	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		\$ 12,353	19,3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,952	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		1,507	12,3	45
46	Other(specify)				46
47	Psych Consultant		4,400	10,3	47
48	Dental Consultant		9,350	10,3	48
49	TOTAL (lines 35 - 48)		\$ 33,562		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,400	\$ 128,592	10,3	50
51	Licensed Practical Nurses	6,700	194,857	10,3	51
52	Certified Nurse Assistants/Aides	7,400	133,313	10,3	52
53	TOTAL (lines 50 - 52)	17,500	\$ 456,762		53

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

0010330

Report Period Beginning: **12/01/06**

Ending: **11/30/07**

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			\$ 61,533	Workers' Compensation Insurance	\$ 76,759	IDPH License Fee	\$	
				Unemployment Compensation Insurance	40,225	Advertising: Employee Recruitment	818	
				FICA Taxes	311,688	Health Care Worker Background Check		
				Employee Health Insurance	480,800	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	2,547	
				Illinois Municipal Retirement Fund (IMRF)*	291,685	Marketing	17,191	
				Physical Examinations	474	IHCA and CNHA Dues	12,100	
				Employee Rel/Training	22,608	Other Dues and License	1,610	
						Subscriptions	531	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 61,533			Less: Public Relations Expense	(17,191)	
(List each licensed administrator separately.)						Non-allowable advertising	(818)	
						Yellow page advertising	()	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount					
			\$	\$ 1,224,239		\$ 16,788		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description		Description		
				Line #	Amount	Amount		
C. Professional Services						Out-of-State Travel		
Vendor/Payee	Type	Amount				\$ 328		
JANET PORTER	CONSULTANT	\$ 12,353						
DUANE MORRIS	ATTORNEY FEES	1,821						
VARIOUS	VARIOUS	2,388				In-State Travel		
KERBER, ECK & BRAECKEL	COST REPORT/AUDIT	8,647				1,823		
						Seminar Expense		
						12,156		
						Meals		
						836		
						Lodging		
						1,508		
						Entertainment Expense		
						()		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 25,209	TOTAL		TOTAL (agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$		\$ 16,651		

* Attach copy of IMRF notifications

**See instructions.

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

0010330

Report Period Beginning: 12/01/06

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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. \$ 107,247
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? _____
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 \$5,000, 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.