



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

# 0010330 Report Period Beginning: 12/01/07 Ending: 11/30/08

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	178	Skilled (SNF)	178	65,148	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	178	TOTALS	178	65,148	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,657	2,521	8,139	14,317	8
9	SNF/PED					9
10	ICF	18,457	12,987	2,411	33,855	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,114	15,508	10,550	48,172	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.94%

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 6,124

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  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: 12/01/07 Ending: 11/30/08

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
	<b>A. General Services</b>										
1	Dietary	398,940	20,278		419,218		419,218		419,218		1
2	Food Purchase		247,047		247,047		247,047	(3,649)	243,398		2
3	Housekeeping	405,724	43,332	45,359	494,415		494,415		494,415		3
4	Laundry		12,237		12,237		12,237		12,237		4
5	Heat and Other Utilities			268,305	268,305		268,305		268,305		5
6	Maintenance	96,657	45,786	94,170	236,613		236,613		236,613		6
7	Other (specify):* WASTE REMOVAL			16,948	16,948		16,948		16,948		7
8	<b>TOTAL General Services</b>	<b>901,321</b>	<b>368,680</b>	<b>424,782</b>	<b>1,694,783</b>		<b>1,694,783</b>	<b>(3,649)</b>	<b>1,691,134</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	2,844,240	150,865	700,677	3,695,782		3,695,782		3,695,782		10
10a	Therapy	202,310	3,830	35,267	241,407		241,407		241,407		10a
11	Activities	124,382		184	124,566		124,566		124,566		11
12	Social Services	79,495	3,148	1,289	83,932		83,932		83,932		12
13	CNA Training										13
14	Program Transportation			54	54		54		54		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,250,427</b>	<b>157,843</b>	<b>775,751</b>	<b>4,184,021</b>		<b>4,184,021</b>		<b>4,184,021</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	66,155			66,155		66,155		66,155		17
18	Directors Fees										18
19	Professional Services			54,406	54,406		54,406		54,406		19
20	Dues, Fees, Subscriptions & Promotions			54,568	54,568		54,568	(29,606)	24,962		20
21	Clerical & General Office Expenses	216,336	28,843	54,720	299,899		299,899	(27,255)	272,644		21
22	Employee Benefits & Payroll Taxes			1,186,439	1,186,439	(9,119)	1,177,320		1,177,320		22
23	Inservice Training & Education										23
24	Travel and Seminar					9,119	9,119		9,119		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			300	300		300		300		26
27	Other (specify):* BAD DEBT			219,231	219,231		219,231	(219,231)			27
28	<b>TOTAL General Administration</b>	<b>282,491</b>	<b>28,843</b>	<b>1,569,664</b>	<b>1,880,998</b>		<b>1,880,998</b>	<b>(276,092)</b>	<b>1,604,906</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,434,239</b>	<b>555,366</b>	<b>2,770,197</b>	<b>7,759,802</b>		<b>7,759,802</b>	<b>(279,741)</b>	<b>7,480,061</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: 12/01/07 Ending: 11/30/08

## 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
	<b>D. Ownership</b>										
30	Depreciation			297,627	297,627	297,627	(12,234)	285,393			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	<b>TOTAL Ownership</b>			297,627	297,627	297,627	(12,234)	285,393			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		327,795		327,795	327,795		327,795			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			97,722	97,722	97,722		97,722			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		327,795	97,722	425,517	425,517		425,517			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,434,239	883,161	3,165,546	8,482,946	8,482,946	(291,975)	8,190,971			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		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	(3,649)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,744)	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	(10,394)	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	(219,231)	27		24
25	Fund Raising, Advertising and Promotional	(29,606)	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	(15,117)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (291,975)		\$	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>	\$ (291,975)		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.

		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						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  
 REHAB & CARE CENTER - JACKSON COUNTY

Report Period Beginning: 12/01/07  
 Ending: 11/30/08

ID# 0010330

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	VENDING INCOME	\$ (6,703)	21	1
2	COPIES	(427)	21	2
3	POSTAGE	(141)	21	3
4	MISCELLANEOUS	(7,846)	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>	(15,117)		49

STATE OF ILLINOIS

Summary A

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

# 0010330

Report Period Beginning:

12/01/07

Ending:

11/30/08

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	(3,649)	0	0	0	0	0	0	0	0	0	0	(3,649)	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>(3,649)</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>(3,649)</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	(29,606)	0	0	0	0	0	0	0	0	0	0	(29,606)	20
21	Clerical & General Office Expenses	(27,255)	0	0	0	0	0	0	0	0	0	0	(27,255)	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):*	(219,231)	0	0	0	0	0	0	0	0	0	0	(219,231)	27
28	<b>TOTAL General Administration</b>	<b>(276,092)</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>(276,092)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(279,741)</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>(279,741)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

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

# 0010330

Report Period Beginning:

12/01/07 Ending:

11/30/08

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	<b>TOTAL Ownership</b>	<b>(12,234)</b>	<b>0</b>	<b>(12,234)</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>(291,975)</b>	<b>0</b>	<b>(291,975)</b>	<b>45</b>									

**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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

\* 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: 12/01/07 Ending: 11/30/08

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: 12/01/07 Ending: 11/30/08

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: 12/01/07 Ending: 11/30/08

**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	N/A									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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 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 2008 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:	2003	N/A	8
	2004	N/A	9
	2005	N/A	10
	2006	N/A	11
	2007	N/A	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

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

**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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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 \_\_\_\_\_

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

# 0010330

Report Period Beginning:

12/01/07

Ending:

11/30/08

**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
	<b>Improvement Type**</b>										
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		VARIOUS			673,140	19
20	AGGREGATE		1988		2,336	56	VARIOUS	56		2,336	20
21	AGGREGATE		1989		212,154	9,699	VARIOUS	9,699		207,302	21
22	AGGREGATE		1990		20,558	620	VARIOUS	620		18,997	22
23	AGGREGATE		1991		49,356	975	VARIOUS	975		46,914	23
24	AGGREGATE		1992		324,871	15,346	VARIOUS	15,346		271,414	24
25	AGGREGATE		1993		208,954	9,327	VARIOUS	9,327		172,379	25
26	AGGREGATE		1994		117,102	6,833	VARIOUS	6,833		99,075	26
27	AGGREGATE		1995		29,398	1,288	VARIOUS	1,288		21,881	27
28	AGGREGATE		1996		12,441	604	VARIOUS	604		7,551	28
29	AGGREGATE		1997		707	35	VARIOUS	35		404	29
30	AGGREGATE		1998		95,496	4,631	VARIOUS	4,631		53,738	30
31	AGGREGATE		1999		3,738	347	VARIOUS	347		3,343	31
32	AGGREGATE		2000		2,045,586	134,845	VARIOUS	134,845		980,295	32
33	AGGREGATE		2001		76,704	5,671	VARIOUS	5,671		42,747	33
34	AGGREGATE		2002		283,429	28,160	VARIOUS	28,160		177,169	34
35	AGGREGATE		2003		1,543	66	VARIOUS	66		1,030	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:

12/01/07

Ending:

11/30/08

**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	\$	\$ 540	37
38	UNIMAC 125LB WASHER	2004	7,000	700	10	700		3,033	38
39	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	70	20	70		350	39
40	PATCHWORK AND PAINT	2004	5,860	293	5	293		1,465	40
41	UNDERGROUND CABLE	2004	8,148	109	25	109		545	41
42	PATCHWORK AND PAINT	2005	316	63	5	63		252	42
43	STEEL DOORS	2005	1,981	91	20	91		364	43
44	ROOF REPAIR	2005	422	14	30	14		56	44
45	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275	855	6	855		3,206	45
46	SEWER LINE	2006	3,935	53	25	53		159	46
47	ANNUNCIATOR RELOCATION	2006	1,750	97	15	97		291	47
48	REMOTE ANNUNCIATOR	2006	2,250	125	15	125		375	48
49	FIRE DOOR SLEEVES	2006	554	55	10	55		161	49
50	LIGHTED EXIT/ACCESS PATHWAYS	2007	180,187	12,012	15	12,012		12,012	50
51	KITCHEN DRAIN LINE	2007	5,852	293	20	293		439	51
52	GREASE TRAP/DRAIN/KITCHEN FLOOR	2007	10,608	530	20	530		707	52
53	ALZHEIMER'S UNIT	2007	89,334	4,467	20	4,467		4,467	53
54	HEAT PUMP	2008	3,829	351	10	351		351	54
55	RETAINING WALL	2008	975	33	5	33		33	55
56	CARPET	2008	1,693	56	5	56		56	56
57	FIRE PROOF DOORS - LAUNDRY	2008	2,215		20				57
58	MOTOR	2008	3,197		5				58
59	CAN LIGHTS	2008	2,000		20				59
60	ROOF EXHAUST MOTORS	2008	2,191		15				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)		\$ 8,400,527	\$ 238,890		\$ 238,890	\$	\$ 6,709,090	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: 12/01/07 Ending: 11/30/08

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	\$ 801,644	\$ 37,169	\$ 37,169	\$	*5-20	\$ 666,192	71
72	Current Year Purchases	48,130	2,535	2,535		*5-20	2,535	72
73	Fully Depreciated Assets	952,097				*5-20	952,097	73
74								74
75	TOTALS	\$ 1,801,871	\$ 39,704	\$ 39,704	\$		\$ 1,620,824	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)	\$ 10,212,398	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 278,594	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 278,594	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)	\$ 8,329,914	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	\$ 102,233	86
87	HVAC Project	103,052	6,870	54,979	87
88					88
89					89
90					90
91	TOTALS	\$ 210,328	\$ 12,234	\$ 157,212	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	<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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/01/07 Ending: 11/30/08

**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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	365	\$ 11,982	\$	365	\$ 11,982	1
2	Licensed Speech and Language Development Therapist		hrs		230	10,094		230	10,094	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A/8	1924 hrs	67,685	506	13,191		2,430	80,876	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	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 67,685	1,101	\$ 35,267	\$	3,025	\$ 102,952	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: 12/01/07 Ending: 11/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/08 (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	\$ 761,025	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>256,000</u> )	1,480,653		3
4	Supply Inventory (priced at )	7,782		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	880		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>	\$ 2,250,340	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	350,771		13
14	Buildings, at Historical Cost	8,013,843		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,058,113		16
17	Accumulated Depreciation (book methods)	(8,487,126)		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>	\$ 1,935,601	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,185,941	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 412,410	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,135		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	450,980		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>			36
37	<u>ACCRUED DPA ASSESSMENT</u>	8,277		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 890,802	\$	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>	\$ 890,802	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,295,139	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,185,941	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,330,599</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,330,599</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,200,224</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,200,224</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>COUNTY CONTRIBUTION TO MEDICAID REIMBURSE-</b>		<b>18</b>
<b>19</b>	<b>MENT TRANSFERRED TO STATE</b>	<b>(1,235,684)</b>	<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(1,235,684)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,295,139</b>	<b>24</b> *

\* 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	\$ 10,443,260	1
2	Discounts and Allowances for all Levels	(820,600)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,622,660	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	3,649	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,744	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>	\$ 5,393	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	10,394	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 10,394	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>COPIES, POSTAGE, VENDING</b>	7,271	28
28a	<b>MISCELLANEOUS</b>	37,452	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 44,723	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,683,170	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,694,783	31
32	Health Care	4,184,021	32
33	General Administration	1,880,998	33
<b>B. Capital Expense</b>			
34	Ownership	297,627	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	327,795	35
36	Provider Participation Fee	97,722	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,482,946	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,200,224	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,200,224	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:

12/01/07

Ending:

11/30/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,878	2,482	\$ 71,226	\$ 28.70	1
2	Assistant Director of Nursing	2,016	2,192	54,265	24.76	2
3	Registered Nurses	16,869	18,485	451,380	24.42	3
4	Licensed Practical Nurses	30,409	33,044	494,018	14.95	4
5	CNAs & Orderlies	110,428	118,619	1,493,818	12.59	5
6	CNA Trainees					6
7	Licensed Therapist	1,924	2,120	67,685	31.93	7
8	Rehab/Therapy Aides	15,443	17,341	255,495	14.73	8
9	Activity Director	1,860	2,120	48,263	22.77	9
10	Activity Assistants	5,392	6,138	76,672	12.49	10
11	Social Service Workers	7,948	8,428	81,328	9.65	11
12	Dietician					12
13	Food Service Supervisor	2,124	2,368	39,498	16.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,173	30,502	354,409	11.62	15
16	Dishwashers					16
17	Maintenance Workers	4,742	5,301	183,463	34.61	17
18	Housekeepers	15,576	17,751	216,926	12.22	18
19	Laundry	13,514	15,587	187,032	12.00	19
20	Administrator	1,960	2,120	66,155	31.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,868	2,120	48,662	22.95	23
24	Clerical	8,475	9,563	171,289	17.91	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	4,372	4,566	72,655	15.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	274,971	300,847	\$ 4,434,239 *	\$ 14.74	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	\$ 38,904	19,3	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	1,289	12,3	45
46	Other(specify) <u>Activity Consultant</u>	184	11,3	46
47	<u>Psych Consultant</u>	6,500	10,3	47
48	<u>Dental Consultant</u>	10,200	10,3	48
49	TOTAL (lines 35 - 48)	\$ 59,477		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	\$ 134,986	10,3	50
51	Licensed Practical Nurses	8,600	249,459	10,3	51
52	Certified Nurse Assistants/Aides	15,800	292,491	10,3	52
53	TOTAL (lines 50 - 52)	27,800	\$ 676,936		53

**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	ADMINISTRATOR		\$ 66,155	Workers' Compensation Insurance	\$ 167,177	IDPH License Fee	\$ 5,043			
				Unemployment Compensation Insurance	36,606	Advertising: Employee Recruitment				
				FICA Taxes	325,876	Health Care Worker Background Check				
				Employee Health Insurance	569,990	(Indicate # of checks performed )				
				Employee Meals		Patient Background Checks	160 2,560			
				Illinois Municipal Retirement Fund (IMRF)*	61,288	Marketing	24,562			
				Physical Examinations	1,086	IHCA and CNHA Dues	10,703			
				Employee Rel/Training	14,271	Other Dues and License	9,439			
				Employee Dental Insurance	1,026	Subscriptions	2,260			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 66,155	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,177,320	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,962
(List each licensed administrator separately.)								Less: Public Relations Expense		(24,562)
								Non-allowable advertising		(5,043)
								Yellow page advertising		( )
B. Administrative - Other										
Description			Amount							
			\$							
TOTAL (agree to Schedule V, line 17, col. 3)			\$							
(Attach a copy of any management service agreement)										
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount		
JANET PORTER	CONSULTANT	\$ 38,904					Out-of-State Travel	\$ 747		
DUANE MORRIS	ATTORNEY FEES	149								
VARIOUS	VARIOUS	1,162					In-State Travel	824		
KERBER, ECK & BRAECKEL	COST REPORT/AUDIT	4,700								
CMS	USER FEE	2,072								
MICHIGAN PEER REVIEW ORGANIZATION		1,910					Seminar Expense	5,260		
FR&R HEALTHCARE CONSULTING, INC.		5,509					Meals	837		
							Lodging	1,451		
							Entertainment Expense	( )		
							(agree to Sch. V,			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 54,406	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 9,119
(If total legal fees exceed \$5,000, attach copy of invoices.)										

\* Attach copy of IMRF notifications

\*\*See instructions.



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

# 0010330

Report Period Beginning: 12/01/07

Ending: 11/30/08

**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. \$ 97,722  
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? N/A  
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.