



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

# 0010330 Report Period Beginning: 12/01/08 Ending: 11/30/09

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	64,970	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	64,970	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	3,750	2,968	7,504	14,222	8
9	SNF/PED					9
10	ICF	20,771	13,090	1,950	35,811	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,521	16,058	9,454	50,033	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.01%

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 6,256

Medicare Intermediary Wisconsin Phycician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: 11/30/09

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

**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	447,845	19,681	40,778	508,304		508,304	508,304			1
2	Food Purchase		267,390		267,390		267,390	(4,515)	262,875		2
3	Housekeeping	389,215	33,828	42,223	465,266	(187,257)	278,009	278,009			3
4	Laundry		13,718		13,718	187,257	200,975	200,975			4
5	Heat and Other Utilities			229,855	229,855		229,855	229,855			5
6	Maintenance	93,971	39,328	84,965	218,264		218,264	218,264			6
7	Other (specify):* <b>WASTE REMOVAL</b>			20,879	20,879		20,879	20,879			7
8	<b>TOTAL General Services</b>	931,031	373,945	418,700	1,723,676		1,723,676	(4,515)	1,719,161		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			38,280	38,280		38,280	38,280			9
10	Nursing and Medical Records	3,165,911	37,936	782,144	3,985,991		3,985,991	3,985,991			10
10a	Therapy	194,094	585	33,394	228,073		228,073	228,073			10a
11	Activities	129,781		509	130,290		130,290	130,290			11
12	Social Services	78,727	2,269	768	81,764		81,764	81,764			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,568,513	40,790	855,095	4,464,398		4,464,398	4,464,398			16
	<b>C. General Administration</b>										
17	Administrative	66,019			66,019		66,019	66,019			17
18	Directors Fees										18
19	Professional Services			28,626	28,626		28,626	28,626			19
20	Dues, Fees, Subscriptions & Promotions			40,231	40,231		40,231	(18,407)	21,824		20
21	Clerical & General Office Expenses	224,578	29,652	41,717	295,947		295,947	(14,538)	281,409		21
22	Employee Benefits & Payroll Taxes			1,155,089	1,155,089	(7,302)	1,147,787	1,147,787			22
23	Inservice Training & Education										23
24	Travel and Seminar					7,302	7,302	7,302			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			46,507	46,507		46,507	46,507			26
27	Other (specify):* <b>BAD DEBT</b>			260,126	260,126		260,126	(260,126)			27
28	<b>TOTAL General Administration</b>	290,597	29,652	1,572,296	1,892,545		1,892,545	(293,071)	1,599,474		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,790,141	444,387	2,846,091	8,080,619		8,080,619	(297,586)	7,783,033		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.

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			290,095	290,095	290,095	(12,234)	277,861				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>			290,095	290,095	290,095	(12,234)	277,861				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		458,399		458,399	458,399		458,399				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,455	97,455	97,455		97,455				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		458,399	97,455	555,854	555,854		555,854				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,790,141	902,786	3,233,641	8,926,568	8,926,568	(309,820)	8,616,748				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.)**

		<b>1</b>	<b>2</b>	<b>3</b>	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,515)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,248)	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	(1,925)	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	(260,126)	27		24
25	Fund Raising, Advertising and Promotional	(18,407)	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	(10,365)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (309,820)		\$	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.)**

		<b>1</b>	<b>2</b>	
		<b>Amount</b>	<b>Reference</b>	
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>	\$ (309,820)		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.)**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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
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REHAB & CARE CENTER - JACKSON COUNTY

ID# 0010330

Report Period Beginning: 12/01/08

Ending: 11/30/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	VENDING INCOME	\$ (6,039)	21	1
2	COPIES	(131)	21	2
3	POSTAGE	(112)	21	3
4	MISCELLANEOUS	(4,083)	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>	(10,365)		49

## STATE OF ILLINOIS

Summary A

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

# 0010330

Report Period Beginning:

12/01/08

Ending:

11/30/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,515)	0	0	0	0	0	0	0	0	0	0	(4,515)	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>(4,515)</b>	<b>0</b>	<b>(4,515)</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	(18,407)	0	0	0	0	0	0	0	0	0	0	(18,407)	20
21	Clerical & General Office Expenses	(14,538)	0	0	0	0	0	0	0	0	0	0	(14,538)	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):*	(260,126)	0	0	0	0	0	0	0	0	0	0	(260,126)	27
28	<b>TOTAL General Administration</b>	<b>(293,071)</b>	<b>0</b>	<b>(293,071)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(297,586)</b>	<b>0</b>	<b>(297,586)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

12/01/08 Ending:

11/30/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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>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>(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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(309,820)	0	0	0	0	0	0	0	0	0	0	(309,820)	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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON C # 0010330 Report Period Beginning: 12/01/08 Ending: 11/30/09

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: 12/01/08 Ending: 11/30/09

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

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

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

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:

12/01/08

Ending:

11/30/09

**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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1					\$	\$			\$	1									
2										2									
3	N/A									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

1. Real Estate Tax accrual used on 2008 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 2009 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:	2004	N/A	8
	2005	N/A	9
	2006	N/A	10
	2007	N/A	11
	2008	N/A	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	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.**



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

# 0010330

Report Period Beginning:

12/01/08

Ending:

11/30/09

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? [X] (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? [X] (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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: 1, Use, 871,200, 1960, \$ 10,000, 1. Row 2: 2, 2, 2. Row 3: 3, TOTALS, 871,200, \$ 10,000, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	100	1960	1960	\$ 1,069,483	\$	34.5	\$	\$	\$ 1,069,483
5		1966	1966	289,003		30			289,003
6	102	1972	1972	1,404,551		27			1,404,551
7									
8									
Improvement Type**									
9	AGGREGATE		1972	63,650		VARIOUS			63,650
10	AGGREGATE		1977	122,761		VARIOUS			122,761
11	AGGREGATE		1978	32,983		VARIOUS			32,983
12	AGGREGATE		1979	16,053		VARIOUS			16,053
13	AGGREGATE		1981	24,389		VARIOUS			24,389
14	AGGREGATE		1982	343,459		VARIOUS			343,459
15	AGGREGATE		1983	141,163		VARIOUS			141,163
16	AGGREGATE		1984	178,226		VARIOUS			178,226
17	AGGREGATE		1985	168,428		VARIOUS			168,428
18	AGGREGATE		1986	46,364		VARIOUS			46,364
19	AGGREGATE		1987	673,140		VARIOUS			673,140
20	AGGREGATE		1988	2,336		VARIOUS			2,336
21	AGGREGATE		1989	212,154	453	VARIOUS	453		207,755
22	AGGREGATE		1990	20,558	620	VARIOUS	620		19,617
23	AGGREGATE		1991	49,356	975	VARIOUS	975		47,889
24	AGGREGATE		1992	324,871	15,346	VARIOUS	15,346		286,760
25	AGGREGATE		1993	208,954	7,410	VARIOUS	7,410		179,789
26	AGGREGATE		1994	117,102	4,765	VARIOUS	4,765		103,840
27	AGGREGATE		1995	29,398	1,288	VARIOUS	1,288		23,169
28	AGGREGATE		1996	12,441	604	VARIOUS	604		8,155
29	AGGREGATE		1997	707	35	VARIOUS	35		439
30	AGGREGATE		1998	95,496	4,631	VARIOUS	4,631		58,369
31	AGGREGATE		1999	3,738	239	VARIOUS	239		3,582
32	AGGREGATE		2000	2,045,586	134,845	VARIOUS	134,845		1,115,140
33	AGGREGATE		2001	76,704	5,671	VARIOUS	5,671		48,418
34	AGGREGATE		2002	283,429	28,143	VARIOUS	28,143		205,312
35	AGGREGATE		2003	1,543	56	VARIOUS	56		1,086
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:

12/01/08

Ending:

11/30/09

## 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		\$ 660	37
38	UNIMAC 125LB WASHER	2004	7,000	700	10	700		3,733	38
39	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	70	20	70		420	39
40	PATCHWORK AND PAINT	2004	5,860	293	5	293		1,758	40
41	UNDERGROUND CABLE	2004	8,148	109	25	109		654	41
42	PATCHWORK AND PAINT	2005	316	63	5	63		315	42
43	STEEL DOORS	2005	1,981	91	20	91		455	43
44	ROOF REPAIR	2005	422	14	30	14		70	44
45	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275	855	6	855		4,061	45
46	SEWER LINE	2006	3,935	53	25	53		212	46
47	ANNUNCIATOR RELOCATION	2006	1,750	97	15	97		388	47
48	REMOTE ANNUNCIATOR	2006	2,250	125	15	125		500	48
49	FIRE DOOR SLEEVES	2006	554	55	10	55		216	49
50	LIGHTED EXIT/ACCESS PATHWAYS	2007	180,187	12,012	15	12,012		24,024	50
51	KITCHEN DRAIN LINE	2007	5,852	293	20	293		732	51
52	GREASE TRAP/DRAIN/KITCHEN FLOOR	2007	10,608	530	20	530		1,237	52
53	ALZHEIMER'S UNIT	2007	89,334	4,467	20	4,467		8,934	53
54	HEAT PUMP	2008	3,829	383	10	383		734	54
55	RETAINING WALL	2008	975	195	5	195		228	55
56	CARPET	2008	1,693	339	5	339		395	56
57	FIRE PROOF DOORS - LAUNDRY	2008	2,215	111	20	111		111	57
58	MOTOR	2008	3,197	400	5	400		400	58
59	CAN LIGHTS	2008	2,000	200	20	200		200	59
60	ROOF EXHAUST MOTORS	2008	2,191	146	15	146		146	60
61	SEWER LINE	2009	1,750	66	5	66		66	61
62	SEWER LINE	2009	1,800	75	5	75		75	62
63	BLINDS, FAUX ALABASTER	2009	2,717	408	5	408		408	63
64	GARBAGE DISPOSAL	2009	3,139	314	5	314		314	64
65	TIMBER BLINDS	2009	5,098	170	5	170		170	65
66	FAUX ALABASTER BLINDS	2009	16,000		5				66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,431,031	\$ 227,835		\$ 227,835		\$ 6,936,925	70

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

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 753,711	\$ 47,592	\$ 47,592	\$		\$ 606,772	71
72	Current Year Purchases	33,563	2,434	2,434			2,481	72
73	Fully Depreciated Assets	1,054,271					1,054,271	73
74								74
75	<b>TOTALS</b>	\$ 1,841,545	\$ 50,026	\$ 50,026	\$		\$ 1,663,524	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 10,282,576	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 277,861	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 277,861	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)	\$ 8,600,449	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	\$ 107,276	\$ 5,364	\$ 107,597	86
87	HVAC Project	103,052	6,870	61,849	87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$ 210,328	\$ 12,234	\$ 169,446	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	432	\$ 14,518	\$	432	\$ 14,518	1
2	Licensed Speech and Language Development Therapist		hrs		173	7,781		173	7,781	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A/8	1870 hrs	71,993	404	11,096		2,274	83,089	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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>			\$ 71,993	1,009	\$ 33,395	\$	2,879	\$ 105,388	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: **12/01/08**

Ending: **11/30/09**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **11/30/09** (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	\$ 1,378,338	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>267,000</u> )	975,709		3
4	Supply Inventory (priced at )	9,540		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,203		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>	\$ 2,372,790	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	350,770		13
14	Buildings, at Historical Cost	8,017,393		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,114,741		16
17	Accumulated Depreciation (book methods)	(8,769,895)		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>	\$ 1,713,009	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,085,799	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 357,465	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,942		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	480,333		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				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 859,740	\$	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>	\$ 859,740	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,226,059	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,085,799	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,295,139</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>3,295,139</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,115,350</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>1,115,350</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>COUNTY CONTRIBUION TO MEDICAID</b>		<b>18</b>
<b>19</b>	<b>REIMBURSEMENT TRANSFERRED TO STATE</b>	<b>(1,184,430)</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>(1,184,430)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,226,059</b>	<b>24</b> *

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

Facility Name & ID Number **REHAB & CARE CENTER - JACKSON COUNTY # 0010330** Report Period Beginning: **12/01/08**Ending: **11/30/09**

**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	\$ 10,945,495	1
2	Discounts and Allowances for all Levels	(941,037)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 10,004,458</b>	<b>3</b>
<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>	<b>\$</b>	<b>8</b>
<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	4,515	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,248	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>	<b>\$ 6,763</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,925	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,925</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>COPIES, POSTAGE, VENDING</b>	<b>6,282</b>	<b>28</b>
28a	<b>MISCELLANEOUS</b>	<b>22,490</b>	<b>28a</b>
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 28,772</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 10,041,918</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,682,898	31
32	Health Care	4,595,763	32
33	General Administration	1,933,323	33
<b>B. Capital Expense</b>			
34	Ownership	290,095	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	327,034	35
36	Provider Participation Fee	97,455	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,926,568</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,115,350</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,115,350</b>	<b>43</b>

\* 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.

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# **0010330**

Report Period Beginning: **12/01/08**

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**11/30/09**

**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	1,849	1,873	\$ 59,579	\$ 31.81	1
2	Assistant Director of Nursing	2,068	2,640	84,121	31.86	2
3	Registered Nurses	26,588	28,158	562,094	19.96	3
4	Licensed Practical Nurses	30,883	33,345	536,103	16.08	4
5	CNAs & Orderlies	118,358	128,067	1,708,603	13.34	5
6	CNA Trainees					6
7	Licensed Therapist	1,870	2,162	71,993	33.30	7
8	Rehab/Therapy Aides	15,321	17,094	262,434	15.35	8
9	Activity Director	1,824	2,128	51,198	24.06	9
10	Activity Assistants	5,374	6,083	79,554	13.08	10
11	Social Service Workers	6,365	6,930	88,151	12.72	11
12	Dietician					12
13	Food Service Supervisor	1,978	2,262	41,004	18.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,645	34,383	405,180	11.78	15
16	Dishwashers					16
17	Maintenance Workers	3,498	4,154	75,843	18.26	17
18	Housekeepers	14,088	15,926	201,283	12.64	18
19	Laundry	13,571	15,218	187,257	12.30	19
20	Administrator	1,856	2,128	66,019	31.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,713	2,041	48,576	23.80	23
24	Clerical	8,420	9,456	176,296	18.64	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	4,405	4,527	84,853	18.74	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	291,674	318,575	\$ 4,790,141 *	\$ 15.04	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	\$ 40,778	1,3	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	768	12,3	45
46	Other(specify) <u>Activity Consultant</u>	509	11,3	46
47	<u>Psych Consultant</u>	6,400	10,3	47
48	<u>Dental Consultant</u>	10,800	10,3	48
49	TOTAL (lines 35 - 48)	\$ 61,655		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,295	\$ 89,144	10,3	50
51	Licensed Practical Nurses	7,920	241,178	10,3	51
52	Certified Nurse Assistants/Aides	22,066	429,199	10,3	52
53	TOTAL (lines 50 - 52)	32,281	\$ 759,521		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		\$ 66,019	Workers' Compensation Insurance	\$ 150,381	IDPH License Fee	\$	
				Unemployment Compensation Insurance	25,976	Advertising: Employee Recruitment	3,536	
				FICA Taxes	350,906	Health Care Worker Background Check		
				Employee Health Insurance	572,880	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	175 2,800	
				Illinois Municipal Retirement Fund (IMRF)*	37,489	Marketing	18,407	
				Physical Examinations	3,542	IHCA and CNHA Dues	11,114	
				Employee Training	6,613	Other Dues and License	2,184	
						Subscriptions	2,190	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 66,019			Less: Public Relations Expense	(18,407)	
(List each licensed administrator separately.)						Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount		\$ 1,147,787			
			\$					
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
Kerber, Eck, & Braeckel	Cost Report/Audit		\$ 4,850			\$	Out-of-State Travel	\$ 742
Axis Pacific	Recruiting Service		12,500				Lodging	1,165
FR&R Healthcare Consulting Inc.			11,139					
Various	Various		137				In-State Travel	871
							Seminar Expense	3,941
							Meals	583
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)			\$ 28,626	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ 7,302

\* Attach copy of IMRF notifications

\*\*See instructions.



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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 \$11,114
- (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. \$ 97,445  
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? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: KERBER, ECK, & BRAECKEL, LLP
- (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.

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**Reclassifications for Column 5 from Schedule V.**

Reclassify Laundry Salaries from Housekeeping	187,257
Reclassify Seminar and Travel Expenses from Employee Benefits and Payroll Taxes	<u>7,302</u>
	194,559