



Facility Name & ID Number REHAB & CARE CTR-JACKSON CO

# 0010330 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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)	138	64,610	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	138	64,610	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	7,593	2,413	6,400	16,406	8
9	SNF/PED					9
10	ICF	15,243	8,523	940	24,706	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,836	10,936	7,340	41,112	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.63%

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 5/01/1960

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 4,929

Medicare Intermediary WISCONSON PHYSICIAN'S SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: 11/30/2013

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

Facility Name &amp; ID Number

REHAB &amp; CARE CTR-JACKSON CO

# 0010330

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

**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	417,553	34,817	24,436	476,806		476,806		476,806		1
2	Food Purchase		268,509		268,509		268,509	(7,460)	261,049		2
3	Housekeeping	360,552	30,917	54,149	445,618	(167,039)	278,579		278,579		3
4	Laundry		19,123		19,123	167,039	186,162		186,162		4
5	Heat and Other Utilities			206,030	206,030		206,030		206,030		5
6	Maintenance	90,512	24,851	101,552	216,915		216,915		216,915		6
7	Other (specify):* WASTE REMOVAL			22,059	22,059		22,059		22,059		7
8	<b>TOTAL General Services</b>	868,617	378,217	408,226	1,655,060		1,655,060	(7,460)	1,647,600		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	2,482,037	25,708	901,329	3,409,074		3,409,074		3,409,074		10
10a	Therapy		84	585,111	585,195	(585,195)					10a
11	Activities	85,263		1,636	86,899		86,899		86,899		11
12	Social Services	74,451	3,706	1,643	79,800		79,800		79,800		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,641,751	29,498	1,527,999	4,199,248	(585,195)	3,614,053		3,614,053		16
	<b>C. General Administration</b>										
17	Administrative	65,872			65,872		65,872		65,872		17
18	Directors Fees										18
19	Professional Services			24,620	24,620		24,620		24,620		19
20	Dues, Fees, Subscriptions & Promotions			32,875	32,875		32,875	(15,934)	16,941		20
21	Clerical & General Office Expenses	162,239	26,801	37,750	226,790		226,790	(31,530)	195,260		21
22	Employee Benefits & Payroll Taxes			1,498,477	1,498,477	(4,164)	1,494,313		1,494,313		22
23	Inservice Training & Education										23
24	Travel and Seminar					4,164	4,164		4,164		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			300	300		300		300		26
27	Other (specify):*			216,586	216,586		216,586	(216,589)	(3)		27
28	<b>TOTAL General Administration</b>	228,111	26,801	1,810,608	2,065,520		2,065,520	(264,053)	1,801,467		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,738,479	434,516	3,746,833	7,919,828	(585,195)	7,334,633	(271,513)	7,063,120		29

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

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

Facility Name &amp; ID Number

REHAB &amp; CARE CTR-JACKSON CO

#0010330

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

## 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			243,095	243,095		243,095	(77,591)	165,504			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>			243,095	243,095		243,095	(77,591)	165,504			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			326,533	326,533	585,195	911,728		911,728			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			316,599	316,599		316,599		316,599			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			643,132	643,132	585,195	1,228,327		1,228,327			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,738,479	434,516	4,633,060	8,806,055		8,806,055	(349,104)	8,456,951			45

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

Facility Name & ID Number REHAB & CARE CTR-JACKSON CO

# 0010330

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

**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	
	<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	(7,460)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,997)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(406)	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	(216,589)	27		24
25	Fund Raising, Advertising and Promotional	(10,998)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,936)	20		28
29	Other-Attach Schedule	(106,718)	21,30		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (349,104)</b>		<b>\$</b>	<b>30</b>

**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	
		<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>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (349,104)</b>		<b>37</b>

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

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

		1	2	3	4	
		<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>			<b>\$</b>		<b>47</b>

<b>BHF USE ONLY</b>						
48		49		50		51
						52

## REHAB &amp; CARE CTR-JACKSON CO

ID# 0010330

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING INCOME	\$ (4,105)	21	1
2	COPIES	(724)	21	2
3	POSTAGE	(31)	21	3
4	MISCELLANEOUS	(24,267)	21	4
5	DEPRECIABLE NON-CARE ASSETS	(77,591)	30	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>		(106,718)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number REHAB &amp; CARE CTR-JACKSON CO

# 0010330

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

## 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	(7,460)	0	0	0	0	0	0	0	0	0	0	(7,460)	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>(7,460)</b>	<b>0</b>	<b>(7,460)</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	(15,934)	0	0	0	0	0	0	0	0	0	0	(15,934)	20
21	Clerical & General Office Expenses	(31,530)	0	0	0	0	0	0	0	0	0	0	(31,530)	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):*	(216,589)	0	0	0	0	0	0	0	0	0	0	(216,589)	27
28	<b>TOTAL General Administration</b>	<b>(264,053)</b>	<b>0</b>	<b>(264,053)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(271,513)</b>	<b>0</b>	<b>(271,513)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number REHAB & CARE CTR-JACKSON CO# 0010330

Report Period Beginning:

12/01/2012 Ending:

11/30/2013

## 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	(77,591)	0	0	0	0	0	0	0	0	0	0	(77,591)	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>(77,591)</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>(77,591)</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)	(349,104)	0	0	0	0	0	0	0	0	0	0	(349,104)	45

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 CTR-JACKSON CO

# 0010330

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number REHAB & CARE CTR-JACKSON CO

# 0010330

Report Period Beginning:

12/01/2012

Ending: 1/30/2013

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

REHAB & CARE CTR-JACKSON CO

# 0010330

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

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

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2012 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 2013 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:	2008	N/A	8	<b>FOR BHF USE ONLY</b>		
	2009	N/A	9			
	2010	N/A	10			
	2011	N/A	11			
	2012	N/A	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REHAB & CARE CTR-JACKSON CO 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 2012 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 2012.

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

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

A division of the Ambulance service, which is owned by Jackson County, is located on the grounds of the Rehab & Care Center. This division houses two rigs

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	76	1960	1960	\$ 1,069,483	\$	34.5	\$	\$	\$ 1,069,483	4
5		1966	1966	289,003		30			288,995	5
6	102	1972	1972	1,404,551		27			1,404,534	6
7										7
8										8
<b>Improvement Type**</b>										
9	AGGREGATE		1972	63,650		VARIOUS			63,650	9
10	AGGREGATE		1977	122,761		VARIOUS			122,761	10
11	AGGREGATE		1978	32,983		VARIOUS			32,961	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			168,291	17
18	AGGREGATE		1986	46,364		VARIOUS			46,364	18
19	AGGREGATE		1987	673,140		VARIOUS			673,130	19
20	AGGREGATE		1988	2,336		VARIOUS			2,336	20
21	AGGREGATE		1989	212,154		VARIOUS			212,148	21
22	AGGREGATE		1990	20,558	126	VARIOUS	126		20,239	22
23	AGGREGATE		1991	49,356	4	VARIOUS	4		49,354	23
24	AGGREGATE		1992	324,871		VARIOUS			324,871	24
25	AGGREGATE		1993	208,954	4,198	VARIOUS	4,198		205,877	25
26	AGGREGATE		1994	117,102	2,698	VARIOUS	2,698		114,624	26
27	AGGREGATE		1995	29,398	1,115	VARIOUS	1,115		27,720	27
28	AGGREGATE		1996	12,441	604	VARIOUS	604		10,571	28
29	AGGREGATE		1997	707	35	VARIOUS	35		582	29
30	AGGREGATE		1998	95,496	4,464	VARIOUS	4,464		76,721	30
31	AGGREGATE		1999	3,738	34	VARIOUS	34		3,634	31
32	AGGREGATE		2000	2,045,586	136,142	VARIOUS	136,142		1,772,947	32
33	AGGREGATE		2001	76,704	2,348	VARIOUS	2,348		61,913	33
34	AGGREGATE		2002	283,429	180	VARIOUS	180		282,237	34
35	AGGREGATE		2003	1,543	56	VARIOUS	56		1,310	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 CTR-JACKSON CO

# 0010330

Report Period Beginning:

12/01/2012 Ending: 11/30/2013

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	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	\$	\$ 1,141	37
38	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	76	20	76		679	38
39	PATCHWORK AND PAINT	2004	5,860		5			5,860	39
40	UNDERGROUND CABLE	2004	8,148	326	25	326		3,042	40
41	PATCHWORK AND PAINT	2005	316		5			310	41
42	STEEL DOORS	2005	1,981	99	20	99		883	42
43	ROOF REPAIR	2005	422	42	30	42		351	43
44	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275		6			4,204	44
45	SEWER LINE	2006	3,935	157	25	157		1,153	45
46	ANNUNCIATOR RELOCATION	2006	1,750	117	15	117		915	46
47	REMOTE ANNUNCIATOR	2006	2,250	150	15	150		1,175	47
48	FIRE DOOR SLEEVES	2006	554	55	10	55		437	48
49	LIGHTED EXIT/ACCESS PATHWAYS	2007	180,187	12,012	15	12,012		72,073	49
50	KITCHEN DRAIN LINE	2007	5,852	292	20	292		1,901	50
51	GREASE TRAP/DRAIN/KITCHEN FLOOR	2007	10,608	530	20	530		3,358	51
52	ALZHEIMER'S UNIT	2007	89,334	4,467	20	4,467		26,801	52
53	HEAT PUMP	2008	3,829	383	10	383		2,266	53
54	MOTOR	2008	3,197	400	5	400		2,333	54
55	BLINDS, FAUX, ALABASTER	2009	2,717	543	5	543		2,580	55
56	GARBAGE DISPOSAL	2009	3,139	628	5	628		2,826	56
57	TIMBER BLINDS	2009	5,098	1,019	5	1,019		4,247	57
58	FAUX, ALABASTER BLINDS	2009	16,000	3,200	5	3,200		12,800	58
59	ROOFING SYSTEM	2010	6,225	622	10	622		2,437	59
60	SMOKE DETECTORS	2011	4,360	436	10	436		1,199	60
61	FIRE ALARM SYSTEM	2011	46,088	4,609	10	4,609		13,059	61
62	WINDOW REPLACEMENT	2012	273,216	13,661	20	13,661		21,630	62
63	SPRINKLER SYSTEM	2012	294,796	14,740	20	14,740		19,653	63
64	BOILER ROOM PLUMBING RE-ROUTE	2012	6,425	257	25	257		428	64
65	DUCT WORK INSTALLATION	2013	2,941	86	20	86		86	65
66	SLMM	2013	3,449	43	20	43		43	66
67									67
68	NON-CARE BEDS ADJUSTMENT (31.9%)		(2,886,601)	(67,333)		(67,333)		(2,536,182)	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,162,306	\$ 143,741		\$ 143,741	\$	\$ 5,414,231	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 656,702	\$ 24,504	\$ 24,504	\$		\$ 553,202	71
72	Current Year Purchases	16,545	645	645			645	72
73	Fully Depreciated Assets	1,227,578					1,227,152	73
74								74
75	TOTALS	\$ 1,900,825	\$ 25,149	\$ 25,149	\$		\$ 1,780,999	75

D. Vehicle Costs. (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)	\$ 8,073,131	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 168,890	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 168,890	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,195,230	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	\$	\$ 107,276	86
87	HVAC PROJECT	103,052	6,872	89,325	87
88					88
89					89
90	NON-CARE BEDS ADJUSTMENTS	2,886,601	67,333	2,536,182	90
91	TOTALS	\$ 3,096,929	\$ 74,205	\$ 2,732,783	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			7

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. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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

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

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

**A. TYPE OF TRAINING PROGRAM** (If 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	6,677	\$ 202,562	\$	6,677	\$ 202,562	1	
2	Licensed Speech and Language Development Therapist		hrs		4,462	109,377		4,462	109,377	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs		8,271	273,172		8,271	273,172	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>			\$	19,410	\$ 585,111	\$	19,410	\$ 585,111	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 CTR-JACKSON CO**

# **0010330**

Report Period Beginning: **12/01/2012**

Ending:

**11/30/2013**

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

As of **11/30/2013**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 265,917	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>346,000</u> )	1,310,367		3
4	Supply Inventory (priced at )	8,857		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,817		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R - IGA, PROPERTY TAXES</u>	578,590		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,172,548	\$	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	8,604,445		14
15	Leasehold Improvements, at Historical Cost	2,214,845		15
16	Equipment, at Historical Cost	(9,928,013)		16
17	Accumulated Depreciation (book methods)			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>	\$ 1,242,047	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,414,595	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 361,713	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,229		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	406,784		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>DUE TO OTHER FUNDS</u>	700,578		36
37	<u>DUE TO THIRD PARTIES</u>	253,696		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,741,000	\$	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	<u>DEFERRED REVENUE - PROPERTY T</u>	382,210		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 382,210	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,123,210	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,291,386	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,414,596	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,910,964	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,910,964	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(619,578)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (619,578)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,291,386	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,438,630	1
2	Discounts and Allowances for all Levels	(1,272,116)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 8,166,514</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	7,460	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,997	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>\$ 9,457</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	406	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 406</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>4,860</b>	<b>28</b>
28a	<b>MISCELLANEOUS</b>	<b>5,240</b>	<b>28a</b>
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 10,100</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,186,477</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,655,060	31
32	Health Care	4,199,248	32
33	General Administration	2,065,520	33
<b>B. Capital Expense</b>			
34	Ownership	243,095	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	326,533	35
36	Provider Participation Fee	316,599	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>\$ 8,806,055</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(619,578)</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>\$ (619,578)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$</b>	<b>49</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.

Facility Name & ID Number **REHAB & CARE CTR-JACKSON CO**

# **0010330**

Report Period Beginning: **12/01/2012**

Ending: **11/30/2013**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,032	2,168	\$ 76,583	\$ 35.32	1
2	Assistant Director of Nursing	2,131	2,343	59,984	25.60	2
3	Registered Nurses	12,919	14,067	346,195	24.61	3
4	Licensed Practical Nurses	31,705	34,347	588,415	17.13	4
5	CNAs & Orderlies	96,258	104,084	1,355,876	13.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,948	2,168	31,810	14.67	9
10	Activity Assistants	3,523	4,101	53,865	13.13	10
11	Social Service Workers	4,099	4,582	80,490	17.57	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,168	42,376	19.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,977	31,268	381,858	12.21	15
16	Dishwashers					16
17	Maintenance Workers	5,870	6,590	118,215	17.94	17
18	Housekeepers	11,142	12,615	161,554	12.81	18
19	Laundry	12,889	13,935	167,039	11.99	19
20	Administrator	1,864	2,112	66,872	31.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,168	48,000	22.14	23
24	Clerical	6,963	8,311	121,590	14.63	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	1,538	1,538	37,757	24.55	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	227,770	248,565	\$ 3,738,479 *	\$ 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	\$ 24,436		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,400		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Psych</u>	5,200		46
47	<u>Dental</u>	13,313		47
48				48
49	TOTAL (lines 35 - 48)	\$ 45,349		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,231	\$ 125,511	50
51	Licensed Practical Nurses	7,199	219,205	51
52	Certified Nurse Assistants/Aides	27,192	528,885	52
53	TOTAL (lines 50 - 52)	37,622	\$ 873,601	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 TAYLOR	ADMINISTRATOR		\$ 65,872	Workers' Compensation Insurance	\$ 183,801	IDPH License Fee	\$	
				Unemployment Compensation Insurance	30,650	Advertising: Employee Recruitment	2,791	
				FICA Taxes	273,218	Health Care Worker Background Check		
				Employee Health Insurance	605,308	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	16 2,352	
				Illinois Municipal Retirement Fund (IMRF)*	394,501	MARKETING	15,934	
				EMPLOYEE TRAINING	1,621	SUBSCRIPTION	1,469	
				PHYSICAL EXAMS	5,214	IHCA AND CNHA DUES	10,329	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,872	TOTAL (agree to Schedule V, line 22, col.8)		\$ 16,941		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising (10,998)	
			\$				Yellow page advertising (4,936)	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
KERBER, ECK, & BRAECKEL	COST REPORT/AUDIT		\$ 5,500			\$	Out-of-State Travel \$ 55	
FR&R HEALTHCARE CONSLT.	CONSULTING		3,751					
MANAGEMENT PERFORMANCE	MANAGEMENT		15,369				In-State Travel 645	
							Seminar Expense 2,970	
							LODGING 375	
							MEALS 119	
							Entertainment Expense ( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,620	TOTAL			\$ 4,164	

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$10,329
- (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? 22
- (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. \$ 316,599  
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? YES  
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.

**Reclassification for Column 5 from Schedule V:**

Reclassify Laundry Salaries from Housekeeping	167,039
Reclassify Seminar and Travel Expense from Employee Benefits and Payroll Taxes	4,164
Reclassify Contracted Therapy from Therapy to Ancillary Service Centers	<u>585,195</u>
	<u><u>756,398</u></u>

**Explanation for Schedule XX, line 16a:**

Out of state travel consists of \$55 in mileage to Cape Girardeau, MO to attend the "Managing Multiple Priorities, Projects, and Deadlines" Seminar on January 1, 2013.