		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0010330

Facility Name: REHAB & CARE CENTER - JACKSON COUNTY

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

County: JACKSON

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

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[X]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[X]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/09 to 11/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) MARK DALLAS, CPA, PARTNER
(Firm Name & Address) KERBER, ECK, & BRAECKEL, LLP, 1116 W. MAIN STREET, CARBONDALE, IL 62901
(Telephone) (618)529-1040 Fax # (618)549-2311

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,486	2,005	6,512	12,003	8
9	SNF/PED					9
10	ICF	23,496	12,037	1,125	36,658	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,982	14,042	7,637	48,661	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.90%

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 54 and days of care provided 5,750

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: _____ Fiscal Year: 11/30/10

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON CO # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	433,299	20,955	41,125	495,379		495,379		495,379			1
2	Food Purchase		258,181		258,181		258,181	(2,865)	255,316			2
3	Housekeeping	395,623	29,497	34,143	459,263	(189,381)	269,882		269,882			3
4	Laundry		14,467		14,467	189,381	203,848		203,848			4
5	Heat and Other Utilities			227,585	227,585		227,585		227,585			5
6	Maintenance	77,079	41,233	98,946	217,258		217,258		217,258			6
7	Other (specify):* WASTE REMOVAL			21,323	21,323		21,323		21,323			7
8	TOTAL General Services	906,001	364,333	423,122	1,693,456		1,693,456	(2,865)	1,690,591			8
	B. Health Care and Programs											
9	Medical Director			38,280	38,280		38,280		38,280			9
10	Nursing and Medical Records	3,205,927	35,380	478,775	3,720,082		3,720,082		3,720,082			10
10a	Therapy	143,410	707	140,038	284,155		284,155		284,155			10a
11	Activities	124,781		748	125,529		125,529		125,529			11
12	Social Services	63,382	2,928	791	67,101		67,101		67,101			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,537,500	39,015	658,632	4,235,147		4,235,147		4,235,147			16
	C. General Administration											
17	Administrative	66,704			66,704		66,704		66,704			17
18	Directors Fees											18
19	Professional Services			46,025	46,025		46,025		46,025			19
20	Dues, Fees, Subscriptions & Promotions			40,486	40,486		40,486	(21,862)	18,624			20
21	Clerical & General Office Expenses	222,950	28,912	40,662	292,524		292,524	(8,674)	283,850			21
22	Employee Benefits & Payroll Taxes			1,428,199	1,428,199	(11,016)	1,417,183		1,417,183			22
23	Inservice Training & Education											23
24	Travel and Seminar					11,016	11,016		11,016			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			300	300		300		300			26
27	Other (specify):* BAD DEBT			316,562	316,562		316,562	(316,562)				27
28	TOTAL General Administration	289,654	28,912	1,872,234	2,190,800		2,190,800	(347,098)	1,843,702			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,733,155	432,260	2,953,988	8,119,403		8,119,403	(349,963)	7,769,440			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY #0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			280,465	280,465		280,465	(6,870)	273,595			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			280,465	280,465		280,465	(6,870)	273,595			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		365,762		365,762		365,762		365,762			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	**TOTAL Special Cost Centers**		365,762	97,455	463,217		463,217		463,217			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,733,155	798,022	3,331,908	8,863,085		8,863,085	(356,833)	8,506,252			45

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,865)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,118)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,870)	30		9
10	Interest and Other Investment Income	(894)	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	(316,562)	27		24
25	Fund Raising, Advertising and Promotional	(14,552)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,310)	20		28
29	Other-Attach Schedule P5a	(5,662)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (356,833)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (356,833)		37

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

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

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

STATE OF ILLINOIS
REHAB & CARE CENTER - JACKSON COUNTY
ID# 0010330
Report Period Beginning: 12/1/09
Ending: 11/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (3,678)		1
2	Copies	(392)		2
3	Postage	(159)		3
4	Miscellaneous	(1,433)		4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,662)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY **#** 0010330 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,865)	0	0	0	0	0	0	0	0	0	0	(2,865)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,865)	0	0	0	0	0	0	0	0	0	0	(2,865)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(21,862)	0	0	0	0	0	0	0	0	0	0	(21,862)	20
21	Clerical & General Office Expenses	(3,012)	0	0	0	0	0	0	0	0	0	0	(3,012)	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):*	(316,562)	0	0	0	0	0	0	0	0	0	0	(316,562)	27
28	**TOTAL General Administration**	(341,436)	0	0	0	0	0	0	0	0	0	0	(341,436)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(344,301)	0	0	0	0	0	0	0	0	0	0	(344,301)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY **#** 0010330 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(6,870)	0	0	0	0	0	0	0	0	0	0	(6,870)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,870)	0	0	0	0	0	0	0	0	0	0	(6,870)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(351,171)	0	0	0	0	0	0	0	0	0	0	(351,171)	45

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON C(# 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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: 12/1/09 Ending: 11/30/10

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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: 12/1/09 Ending: 11/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	N/A	8
	2006	N/A	9
	2007	N/A	10
	2008	N/A	11
	2009	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REHAB & CARE CENTER - JACKSON COUNTY COUNTY JACKSON

FACILITY IDPH LICENSE NUMBER 0010330

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		871,200	1960	$ 10,000	1
2					2
3	TOTALS	871,200		$ 10,000	3

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1978	1978	$ 7,390	$	14	$	$	$ 7,390	4
5	98		1986	1986	48,436	454	15	454		47,746	5
6	109		1996	1996	85,943	5,693	15	5,693		83,112	6
7	9		2005	2005	8,810	733	15	733		2,496	7
8					197,960	5,597	15	5,597		156,143	8
	Improvement Type**										
9	AGGREGATE			1972	63,650		VARIOUS			63,650	9
10	AGGREGATE			1977	122,761		VARIOUS			122,761	10
11	AGGREGATE			1978	32,983		VARIOUS			32,983	11
12	AGGREGATE			1979	16,053		VARIOUS			16,053	12
13	AGGREGATE			1981	24,389		VARIOUS			24,389	13
14	AGGREGATE			1982	343,459		VARIOUS			343,459	14
15	AGGREGATE			1983	141,163		VARIOUS			141,163	15
16	AGGREGATE			1984	178,226		VARIOUS			178,226	16
17	AGGREGATE			1985	168,428		VARIOUS			168,428	17
18	AGGREGATE			1986	46,364		VARIOUS			46,364	18
19	AGGREGATE			1987	673,140		VARIOUS			673,140	19
20	AGGREGATE			1988	2,336		VARIOUS			2,336	20
21	AGGREGATE			1989	212,154	4,399	VARIOUS	4,399		212,154	21
22	AGGREGATE			1990	20,558	374	VARIOUS	374		19,991	22
23	AGGREGATE			1991	49,356	975	VARIOUS	975		48,864	23
24	AGGREGATE			1992	324,871	15,346	VARIOUS	15,346		302,106	24
25	AGGREGATE			1993	208,954	7,410	VARIOUS	7,410		187,199	25
26	AGGREGATE			1994	117,102	2,698	VARIOUS	2,698		106,538	26
27	AGGREGATE			1995	29,398	1,205	VARIOUS	1,205		24,374	27
28	AGGREGATE			1996	12,441	604	VARIOUS	604		8,759	28
29	AGGREGATE			1997	707	35	VARIOUS	35		474	29
30	AGGREGATE			1998	95,496	4,631	VARIOUS	4,631		63,000	30
31	AGGREGATE			1999	3,738	34	VARIOUS	34		3,616	31
32	AGGREGATE			2000	2,045,586	134,782	VARIOUS	134,782		1,249,922	32
33	AGGREGATE			2001	76,704	5,671	VARIOUS	5,671		54,089	33
34	AGGREGATE			2002	283,429	28,143	VARIOUS	28,143		233,455	34
35	AGGREGATE			2003	1,543	56	VARIOUS	56		1,142	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	EZ FLUSH RETRO KIT	2004	$ 2,405	$ 120	20	$ 120	$	$ 780	37
38	UNIMAC 125LB WASHER	2004	7,000	700	10	700		4,433	38
39	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	70	20	70		490	39
40	PATCHWORK AND PAINT	2004	5,860	293	5	293		2,051	40
41	UNDERGROUND CABLE	2004	8,148	109	25	109		763	41
42	PATCHWORK AND PAINT	2005	316	1	5	1		316	42
43	STEEL DOORS	2005	1,981	91	20	91		546	43
44	ROOF REPAIR	2005	422	14	30	14		84	44
45	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275	214	6	214		4,275	45
46	SEWER LINE	2006	3,935	53	25	53		265	46
47	ANNUNIATOR RELOCATION	2006	1,750	97	15	97		485	47
48	REMOTE ANNUNCIATOR	2006	2,250	125	15	125		625	48
49	FIRE DOOR SLEEVES	2006	554	55	10	55		271	49
50	LIGHTED EXIT/ACCESS PATHWAYS	2007	180,187	12,012	15	12,012		36,036	50
51	KITCHEN DRAIN LINE	2007	5,852	293	20	293		1,025	51
52	GREASE TRAP/DRAIN/KITCHEN FLOOR	2007	10,608	530	20	530		1,767	52
53	ALZHEIMER'S UNIT	2007	89,334	4,467	20	4,467		13,401	53
54	HEAT PUMP	2008	3,829	383	10	383		1,117	54
55	RETAINING WALL	2008	975	195	5	195		423	55
56	CARPET	2008	1,693	339	5	339		734	56
57	FIRE PROOF DOORS - LAUNDRY	2008	2,215	111	20	111		222	57
58	MOTOR	2008	3,197	400	5	400		800	58
59	CAN LIGHTS	2008	2,000	200	20	200		400	59
60	ROOF EXHAUST MOTORS	2008	2,191	146	15	146		292	60
61	SEWER LINE	2009	1,750	88	5	88		154	61
62	SEWER LINE	2009	1,800	90	5	90		165	62
63	BLINDS, FAUX ALABASTER	2009	2,717	543	5	543		951	63
64	GARBAGE DISPOSAL	2009	3,139	628	5	628		942	64
65	TIMBER BLINDS	2009	5,098	1,020	5	1,020		1,190	65
66	FAUX ALABASTER BLINDS	2009	16,000	3,200	5	3,200		3,200	66
67	ROOFING SYSTEM	2010	6,625	571	10	571		571	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,023,158	$ 245,998		$ 245,998	$	$ 4,704,296	70

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	$ 3,059,339	$ 25,052	$ 25,052	$		$ 2,946,887	71
72	Current Year Purchases	32,284	2,545	2,545			2,545	72
73	Fully Depreciated Assets	1,186,304					1,186,304	73
74								74
75	TOTALS	$ 4,277,927	$ 27,597	$ 27,597	$		$ 4,135,736	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,311,085	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 273,595	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 273,595	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)	$ 8,840,032	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	6,870	103,052	87
88					88
89					89
90					90
91	TOTALS	$ 210,328	$ 6,870	$ 210,328	91

G. Construction-in-Progress

	Description	Cost	
92	Fire Alarm, installation,	$	92
93	and electrical work	46,088	93
94			94
95		$ 46,088	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.

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

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

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist			hrs	$	548	$ 47,618	$	548	$ 47,618	1
2	Licensed Speech and Language Development Therapist			hrs		179	12,393		179	12,393	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 8	1543	hrs	64,112	1,347	80,026		2,890	144,138	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				$ 64,112	2,074	$ 140,037	$	3,617	$ 204,149	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: 12/1/09 Ending: 11/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 490,440	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 332,076)	1,038,819		3
4	Supply Inventory (priced at)	9,496		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,055		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,547,810	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	350,770		14
15	Leasehold Improvements, at Historical Cost	8,023,618		15
16	Equipment, at Historical Cost	2,193,113		16
17	Accumulated Depreciation (book methods)	(9,050,360)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,517,141	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,064,951	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 371,575	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,323		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	483,572		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 877,470	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 877,470	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,187,481	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,064,951	$	48

***(See instructions.)**

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,226,059	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,226,059	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,038,578)	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	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,038,578)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,187,481	24 *

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

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,751,053	1
2	Discounts and Allowances for all Levels	(980,621)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,770,432	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,865	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,118	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,983	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	894	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 894	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Copies, Postage, Vending	4,229	28
28a	Miscellaneous	43,969	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 48,198	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,824,507	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,693,456	31
32	Health Care	4,235,147	32
33	General Administration	2,190,800	33
	B. Capital Expense		
34	Ownership	280,465	34
	C. Ancillary Expense		
35	Special Cost Centers	365,762	35
36	Provider Participation Fee	97,455	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,863,085	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,038,578)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,038,578)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,932	2,107	$ 67,923	$ 32.24	1
2	Assistant Director of Nursing	2,191	2,335	60,756	26.02	2
3	Registered Nurses	21,525	23,299	500,212	21.47	3
4	Licensed Practical Nurses	36,663	39,915	703,101	17.61	4
5	CNAs & Orderlies	125,530	136,761	1,804,598	13.20	5
6	CNA Trainees					6
7	Licensed Therapist	1,543	1,739	64,112	36.87	7
8	Rehab/Therapy Aides	4,343	5,035	82,723	16.43	8
9	Activity Director	1,776	2,112	50,292	23.81	9
10	Activity Assistants	5,157	5,963	75,027	12.58	10
11	Social Service Workers	6,692	6,906	105,360	15.26	11
12	Dietician					12
13	Food Service Supervisor	2,031	2,207	41,161	18.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,485	34,005	397,559	11.69	15
16	Dishwashers					16
17	Maintenance Workers	3,616	4,157	73,596	17.70	17
18	Housekeepers	11,439	12,827	173,447	13.52	18
19	Laundry	13,928	15,466	189,381	12.24	19
20	Administrator	1,844	2,160	66,704	30.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,639	1,883	44,590	23.68	23
24	Clerical	8,246	9,514	151,228	15.90	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	4,514	4,654	81,385	17.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	286,094	313,045	$ 4,733,155 *	$ 15.12	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 41,125	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		748	11,3	44
45	Social Service Consultant		791	12,3	45
46	Other(specify) Psych Consultant		550	10,3	46
47	Dental Consultant		10,800	10,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 56,414		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,949	$ 114,567	10,3	50
51	Licensed Practical Nurses	3,937	119,894	10,3	51
52	Certified Nurse Assistants/Aides	11,716	227,882	10,3	52
53	TOTAL (lines 50 - 52)	18,602	$ 462,343		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Merle Taylor	Administrator		$ 66,704
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,704

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kerber, Eck & Braeckel	Cost Report/Audit	$ 4,950
FR&R Helathcare Consulting	Healthcare	23,390
Eggemeyer Associates	Architects	1,080
MPA	Various	15,000
Various	Various	1,605
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 46,025

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,804
Unemployment Compensation Insurance	21,384
FICA Taxes	352,345
Employee Health Insurance	588,201
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	356,197
Physical Examinations	3,997
Employee Training	4,255
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,417,183

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,644
Health Care Worker Background Check	
(Indicate # of checks performed 143)	
Patient Background Checks	2,288
Marketing	21,862
Subscriptions	2,389
IHCA and CNHA dues	12,303
Less: Public Relations Expense	( )
Non-allowable advertising	(14,552)
Yellow page advertising	(7,310)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,624

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 513
Lodging	1,225
In-State Travel	1,344
Seminar Expense	6,845
Meals	1,010
Seminar Misc	79
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,016

**See instructions.

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/1/09 Ending: 11/30/10

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 $12,303**

(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? **5 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.

Reclassifications for Column 5 from Schedule V.

Reclassify Laundry Salaries from Housekeeping	189,381
Reclassify Seminar and Travel Expenses from Employee Benefits and Payroll Taxes	11,016
	200,397