FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 010330

Facility Name: REHAB & CARE CENTER OF 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 12/1/10 to 11/30/11 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)559-1040 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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	5,538	860	6,276	12,674	8
9	SNF/PED					9
10	ICF	19,884	12,075	720	32,679	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,422	12,935	6,996	45,353	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.81%

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 5/01/1960

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 5,443

Medicare Intermediary WISCONSIN PHYSICIANS SERVICES

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON (# 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	412,463	27,670	42,688	482,821		482,821		482,821			1
2	Food Purchase		267,290		267,290		267,290	(7,848)	259,442			2
3	Housekeeping	369,119	30,077	36,087	435,283	(178,278)	257,005		257,005			3
4	Laundry		11,095		11,095	178,278	189,373		189,373			4
5	Heat and Other Utilities			228,039	228,039		228,039		228,039			5
6	Maintenance	91,871	29,176	100,517	221,564		221,564		221,564			6
7	Other (specify):* Waste Removal			14,622	14,622		14,622		14,622			7
8	TOTAL General Services	873,453	365,308	421,953	1,660,714		1,660,714	(7,848)	1,652,866			8
	B. Health Care and Programs											
9	Medical Director			38,280	38,280		38,280		38,280			9
10	Nursing and Medical Records	2,817,941	30,238	402,464	3,250,643		3,250,643		3,250,643			10
10a	Therapy	(3,768)	34	706,974	703,240		703,240		703,240			10a
11	Activities	96,649		907	97,556		97,556		97,556			11
12	Social Services	107,483	4,135	810	112,428		112,428		112,428			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,018,305	34,407	1,149,435	4,202,147		4,202,147		4,202,147			16
	C. General Administration											
17	Administrative	64,096			64,096		64,096		64,096			17
18	Directors Fees											18
19	Professional Services			213,206	213,206		213,206		213,206			19
20	Dues, Fees, Subscriptions & Promotions			38,136	38,136		38,136	(17,099)	21,037			20
21	Clerical & General Office Expenses	202,021	30,351	40,120	272,492		272,492	(11,486)	261,006			21
22	Employee Benefits & Payroll Taxes			1,386,212	1,386,212	(7,410)	1,378,802		1,378,802			22
23	Inservice Training & Education											23
24	Travel and Seminar					7,410	7,410		7,410			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			300	300		300		300			26
27	Other (specify):* Bad Debt			348,536	348,536		348,536	(348,546)	(10)			27
28	TOTAL General Administration	266,117	30,351	2,026,510	2,322,978		2,322,978	(377,131)	1,945,847			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,157,875	430,066	3,597,898	8,185,839		8,185,839	(384,979)	7,800,860			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 OF JACKSON COUNTY #010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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			274,933	274,933		274,933		274,933			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**			274,933	274,933		274,933		274,933			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			122	122		122		122			38
39	Ancillary Service Centers			405,366	405,366		405,366		405,366			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**			502,943	502,943		502,943		502,943			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,157,875	430,066	4,375,774	8,963,715		8,963,715	(384,979)	8,578,736			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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	(7,848)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,221)	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	(312)	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	(348,546)	27		24
25	Fund Raising, Advertising and Promotional	(12,942)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,157)	20		28
29	Other-Attach Schedule P5a	(8,953)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (384,979)		$	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))**	$ (384,979)		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 OF JACKSON COUNTY

ID# 010330

Report Period Beginning: 12/1/10

Ending: 11/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (2,887)	21	1
2	Copies	(545)	21	2
3	Postage	(106)	21	3
4	Miscellaneous	(5,415)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,953)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUNTY # 010330 **Report Period Beginning:** 12/1/10 **Ending:** 11/30/11

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	(7,848)	0	0	0	0	0	0	0	0	0	0	(7,848)	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**	(7,848)	0	0	0	0	0	0	0	0	0	0	(7,848)	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	(17,099)	0	0	0	0	0	0	0	0	0	0	(17,099)	20
21	Clerical & General Office Expenses	(11,486)	0	0	0	0	0	0	0	0	0	0	(11,486)	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):*	(348,546)	0	0	0	0	0	0	0	0	0	0	(348,546)	27
28	**TOTAL General Administration**	(377,131)	0	0	0	0	0	0	0	0	0	0	(377,131)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(384,979)	0	0	0	0	0	0	0	0	0	0	(384,979)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUNTY # 010330 **Report Period Beginning:** 12/1/10 **Ending:** 11/30/11

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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)**	(384,979)	0	0	0	0	0	0	0	0	0	0	(384,979)	45

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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 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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	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								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

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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 OF JACKSON C # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												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 OF JACKSON COUNTY **#** 010330 **Report Period Beginning:** 12/1/10 **Ending:** 11/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:			
	2006	N/A	8
	2007	N/A	9
	2008	N/A	10
	2009	N/A	11
	2010	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REHAB & CARE CENTER OF JACKSON COUNTY COUNTY JACKSON

FACILITY IDPH LICENSE NUMBER 010330

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 2010 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 2010.

	(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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	25	454		48,201	5
6	109		1996	1996	85,943	3,311	15	3,311		85,943	6
7	9		2005	2005	8,810	786	15	786		2,849	7
8					201,746	8,526	15	8,526		164,670	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		VARIOUS			212,154	21
22	AGGREGATE			1990	20,558	126	VARIOUS	126		20,117	22
23	AGGREGATE			1991	49,356	492	VARIOUS	492		49,356	23
24	AGGREGATE			1992	324,871	15,346	VARIOUS	15,346		317,452	24
25	AGGREGATE			1993	208,954	7,410	VARIOUS	7,410		194,609	25
26	AGGREGATE			1994	117,102	2,698	VARIOUS	2,698		109,236	26
27	AGGREGATE			1995	29,398	1,115	VARIOUS	1,115		25,489	27
28	AGGREGATE			1996	12,441	604	VARIOUS	604		9,363	28
29	AGGREGATE			1997	707	35	VARIOUS	35		509	29
30	AGGREGATE			1998	95,496	4,631	VARIOUS	4,631		67,631	30
31	AGGREGATE			1999	3,738	34	VARIOUS	34		3,650	31
32	AGGREGATE			2000	2,045,586	134,584	VARIOUS	134,584		1,384,506	32
33	AGGREGATE			2001	76,704	3,245	VARIOUS	3,245		57,334	33
34	AGGREGATE			2002	283,429	28,143	VARIOUS	28,143		261,598	34
35	AGGREGATE			2003	1,543	56	VARIOUS	56		1,198	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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 900	37
38	UNIMAC 125LB WASHER	2004	7,000	700	10	700		5,133	38
39	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	70	20	70		560	39
40	PATCHWORK AND PAINT	2004	5,860	293	5	293		2,344	40
41	UNDERGROUND CABLE	2004	8,148	109	25	109		872	41
42	PATCHWORK AND PAINT	2005	316		5			316	42
43	STEEL DOORS	2005	1,981	91	20	91		637	43
44	ROOF REPAIR	2005	422	14	30	14		98	44
45	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275		6			4,275	45
46	SEWER LINE	2006	3,935	53	25	53		318	46
47	ANNUNIATOR RELOCATION	2006	1,750	97	15	97		582	47
48	REMOTE ANNUNCIATOR	2006	2,250	125	15	125		750	48
49	FIRE DOOR SLEEVES	2006	554	55	10	55		326	49
50	LIGHTED EXIT/ACCESS PATHWAYS	2007	180,187	12,012	15	12,012		48,048	50
51	KITCHEN DRAIN LINE	2007	5,852	293	20	293		1,318	51
52	GREASE TRAP/DRAIN/KITCHEN FLOOR	2007	10,608	530	20	530		2,297	52
53	ALZHEIMER'S UNIT	2007	89,334	4,467	20	4,467		17,868	53
54	HEAT PUMP	2008	3,829	383	10	383		1,500	54
55	RETAINING WALL	2008	975	195	5	195		618	55
56	CARPET	2008	1,693	339	5	339		1,073	56
57	FIRE PROOF DOORS - LAUNDRY	2008	2,215	111	20	111		332	57
58	MOTOR	2008	3,197	400	5	400		1,200	58
59	CAN LIGHTS	2008	2,000	200	20	200		600	59
60	ROOF EXHAUST MOTORS	2008	2,191	146	15	146		438	60
61	SEWER LINE	2009	1,750	88	5	88		242	61
62	SEWER LINE	2009	1,800	90	5	90		255	62
63	BLINDS, FAUX ALABASTER	2009	2,717	543	5	543		1,494	63
64	GARBAGE DISPOSAL	2009	3,139	628	5	628		1,570	64
65	TIMBER BLINDS	2009	5,098	1,020	5	1,020		2,210	65
66	FAUX ALABASTER BLINDS	2009	16,000	3,200	5	3,200		6,400	66
67	ROOFING SYSTEM	2010	6,225	571	10	571		1,142	67
68	SMOKE DETECTORS	2011	4,360	327	10	327		327	68
69	FIRE ALARM	2011	46,088	3,841	10	3,841		3,841	69
70	TOTAL (lines 4 thru 69)		$ 6,076,992	$ 242,707		$ 242,707	$	$ 4,946,091	70

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

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUNT # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	$ 3,257,860	$ 32,078	$ 32,078	$		$ 3,151,305	71
72	Current Year Purchases	1,383	148	148			148	72
73	Fully Depreciated Assets	1,017,421					1,017,421	73
74								74
75	TOTALS	$ 4,276,664	$ 32,226	$ 32,226	$		$ 4,168,874	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)	$ 10,363,656	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 274,933	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 274,933	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)	$ 9,114,965	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		103,052	87
88					88
89					89
90					90
91	TOTALS	$ 210,328	$	$ 210,328	91

G. Construction-in-Progress

	Description	Cost	
92	Window replacemtn	$ 148,973	92
93	Sprinkle System	184,212	93
94			94
95		$ 333,185	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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	3,651	$ 234,904	$	3,651	$ 234,904	1
2	Licensed Speech and Language Development Therapist		hrs		1,841	154,511		1,841	154,511	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		6,290	317,559		6,290	317,559	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			$	11,782	$ 706,974	$	11,782	$ 706,974	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.

STATE OF ILLINOIS

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/11 (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	$ 192,019	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 525,000)	2,753,004		3
4	Supply Inventory (priced at)	9,355		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)**	$ 2,963,433	$	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	2,532,782		16
17	Accumulated Depreciation (book methods)	(9,325,293)		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)**	$ 1,581,877	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,545,310	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 525,912	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,655		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,494,123		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)**	$ 2,040,690	$	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)**	$ 2,040,690	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,504,620	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,545,310	$	48

***(See instructions.)**

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,187,481	1
2	Restatements (describe):		2
3	**Prior year audit adjustment**	(6,180)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,181,301	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	323,319	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)**	$ 323,319	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)**	$ 2,504,620	24 *

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

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUN # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	$ 9,607,236	1
2	Discounts and Allowances for all Levels	(356,635)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,250,601	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	7,848	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,221	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)**	$ 10,069	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	312	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 312	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Copies, Postage, Vending	3,538	28
28a	Miscellaneous	22,514	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,052	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,287,034	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,660,714	31
32	Health Care	4,202,147	32
33	General Administration	2,322,978	33
	B. Capital Expense		
34	Ownership	274,933	34
	C. Ancillary Expense		
35	Special Cost Centers	405,488	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)***	$ 8,963,715	40
41	**Income before Income Taxes (line 30 minus line 40)****	323,319	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 323,319	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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	1,888	2,057	$ 66,221	$ 32.19	1
2	Assistant Director of Nursing	1,628	1,964	53,988	27.49	2
3	Registered Nurses	14,886	16,154	410,074	25.39	3
4	Licensed Practical Nurses	30,468	33,368	607,590	18.21	4
5	CNAs & Orderlies	105,152	116,353	1,610,648	13.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	701	1,009	21,876	21.68	9
10	Activity Assistants	5,163	5,624	70,247	12.49	10
11	Social Service Workers	7,334	8,009	152,538	19.05	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,120	42,518	20.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,854	30,340	375,262	12.37	15
16	Dishwashers					16
17	Maintenance Workers	5,005	5,546	102,397	18.46	17
18	Housekeepers	12,107	13,940	172,438	12.37	18
19	Laundry	12,038	13,849	178,278	12.87	19
20	Administrator	1,728	2,112	64,096	30.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	316	376	9,779	26.01	23
24	Clerical	8,168	9,376	154,275	16.45	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	3,474	3,474	65,650	18.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	239,782	265,671	$ 4,157,875 *	$ 15.65	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		$ 42,688	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		907	11,3	44
45	Social Service Consultant		810	12,3	45
46	Other(specify) Psych		3,200	10,3	46
47	Dental		10,800	10,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 60,805		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,539	$ 98,636	10,3	50
51	Licensed Practical Nurses	5,875	178,880	10,3	51
52	Certified Nurse Assistants/Aides	5,495	106,871	10,3	52
53	TOTAL (lines 50 - 52)	13,909	$ 384,387		53

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUNT # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Merle Taylor			$ 64,096
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 64,096

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	$ 5,000
FR&R Healthcare Consulting	Collections	10,736
Management Proformance Assoc.	Management	183,424
IL Dept of Pub Health	Planned Review for grants	6,546
Pro-Com	Collections	7,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 213,206

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,708
Unemployment Compensation Insurance	22,056
FICA Taxes	296,819
Employee Health Insurance	587,670
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	369,455
Employee training	6,606
Physical Examinantions	2,488
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,378,802

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	3,253
Health Care Worker Background Check (Indicate # of checks performed 125)	
Patient Background Checks	1,991
Marketing	17,099
Subscriptions	1,183
IHCA and CNHA dues	14,610
Less: Public Relations Expense	( )
Non-allowable advertising	(12,942)
Yellow page advertising	(4,157)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,037

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,150
Seminar Expense	4,264
Lodging	1,118
Meals	878
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,410

**See instructions.

Facility Name & ID Number REHAB & CARE CENTER OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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 OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

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 $14,610**

(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 YEARS**

(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.

Facility Name & ID Nun REHAB & CARE CENTER OF JACKSON COUNTY # 010330 Report Period Beginning: 12/1/10 Ending: 11/30/11

Reclassification for Column 5 From Schedule V.

Reclassify Laudry Salaries from Housekeeping	178,278
Reclassify Seminar and Travel Expense from Employee Benefits and Payroll Taxes	7,410
	185,688