FOR BHF USE

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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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0010330

Facility Name: REHAB & CARE CTR JACKSON CO

Address: 1441 NORTH 14TH ST (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 12/1/2013 to 10/22/2014 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) MICHELLE TWEEDY
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) MARK DALLAS, CPA, PARTNER
(Firm Name & Address) KERBER, ECK, & BRAECKEL, LLP, 1116 WEST 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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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	138	Skilled (SNF)	138	44,988	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	138	TOTALS	138	44,988	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	6,071	1,458	5,478	13,007	8
9	SNF/PED					9
10	ICF	11,341	6,728	1,023	19,092	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,412	8,186	6,501	32,099	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.35%

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 4,135

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: _____ Fiscal Year: 11/30/2014

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

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	370,784	33,050	17,548	421,382		421,382		421,382			1
2	Food Purchase		226,480		226,480		226,480	(2,919)	223,561			2
3	Housekeeping	304,963	27,008	40,629	372,600	(158,641)	213,959		213,959			3
4	Laundry		14,311		14,311	158,641	172,952		172,952			4
5	Heat and Other Utilities			160,128	160,128		160,128		160,128			5
6	Maintenance	77,163	16,635	56,319	150,117		150,117		150,117			6
7	Other (specify):* WASTE REMOVAL			24,611	24,611		24,611		24,611			7
8	**TOTAL General Services**	752,910	317,484	299,235	1,369,629		1,369,629	(2,919)	1,366,710			8
	B. Health Care and Programs											
9	Medical Director			34,164	34,164		34,164		34,164			9
10	Nursing and Medical Records	2,040,347	15,323	741,344	2,797,014		2,797,014		2,797,014			10
10a	Therapy		105	474,476	474,581	(474,581)						10a
11	Activities	82,740		1,298	84,038		84,038		84,038			11
12	Social Services	51,039	4,643	1,699	57,381		57,381		57,381			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,174,126	20,071	1,252,981	3,447,178	(474,581)	2,972,597		2,972,597			16
	C. General Administration											
17	Administrative	62,174			62,174		62,174		62,174			17
18	Directors Fees											18
19	Professional Services			10,867	10,867		10,867		10,867			19
20	Dues, Fees, Subscriptions & Promotions			14,255	14,255		14,255	(11,763)	2,492			20
21	Clerical & General Office Expenses	155,775	21,037	50,677	227,489		227,489	(34,626)	192,863			21
22	Employee Benefits & Payroll Taxes			1,237,525	1,237,525	(3,152)	1,234,373		1,234,373			22
23	Inservice Training & Education											23
24	Travel and Seminar					3,152	3,152		3,152			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			300	300		300		300			26
27	Other (specify):* BAD DEBT			53,095	53,095		53,095	(53,095)				27
28	**TOTAL General Administration**	217,949	21,037	1,366,719	1,605,705		1,605,705	(99,484)	1,506,221			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,144,985	358,592	2,918,935	6,422,512	(474,581)	5,947,931	(102,403)	5,845,528			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 CTR JACKSON CO #0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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			217,016	217,016		217,016	(95,201)	121,815			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**			217,016	217,016		217,016	(95,201)	121,815			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			242,647	242,647	474,581	717,228		717,228			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			236,562	236,562		236,562		236,562			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			479,209	479,209	474,581	953,790		953,790			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,144,985	358,592	3,615,160	7,118,737		7,118,737	(197,604)	6,921,133			45

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

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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	(2,919)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,559)	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	(240)	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	(53,095)	27		24
25	Fund Raising, Advertising and Promotional	(7,149)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,614)	20		28
29	Other-Attach Schedule	(128,028)	21,31		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (197,604)		$	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))**	$ (197,604)		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

REHAB & CARE CTR JACKSON CO

ID# 0010330

Report Period Beginning: 12/1/2013

Ending: 10/22/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ (4,693)	21	1
2	POSTAGE	(14)	21	2
3	MISCELLANEOUS	(28,120)	21	3
4	DEPRECIABLE NON-CARE ASSETS	(95,201)	30	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**	(128,028)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number REHAB & CARE CTR JACKSON CO **#** 0010330 **Report Period Beginning:** 12/1/2013 **Ending:** 10/22/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,919)	0	0	0	0	0	0	0	0	0	0	(2,919)	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**	(2,919)	0	0	0	0	0	0	0	0	0	0	(2,919)	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	(11,763)	0	0	0	0	0	0	0	0	0	0	(11,763)	20
21	Clerical & General Office Expenses	(34,626)	0	0	0	0	0	0	0	0	0	0	(34,626)	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):*	(53,095)	0	0	0	0	0	0	0	0	0	0	(53,095)	27
28	**TOTAL General Administration**	(99,484)	0	0	0	0	0	0	0	0	0	0	(99,484)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(102,403)	0	0	0	0	0	0	0	0	0	0	(102,403)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number REHAB & CARE CTR JACKSON CO **#** 0010330 **Report Period Beginning:** 12/1/2013 **Ending:** 10/22/2014

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

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(95,201)	0	0	0	0	0	0	0	0	0	0	(95,201)	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**	(95,201)	0	0	0	0	0	0	0	0	0	0	(95,201)	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)**	(197,604)	0	0	0	0	0	0	0	0	0	0	(197,604)	45

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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

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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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

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

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

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 0/22/2014

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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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												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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009	N/A	8
	2010	N/A	9
	2011	N/A	10
	2012	N/A	11
	2013	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REHAB & CARE CTR JACKSON CO COUNTY JACKSON

FACILITY IDPH LICENSE NUMBER 0010330

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

X. BUILDING AND GENERAL INFORMATION:

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

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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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	76		1960	1960	$ 1,069,483	$	34.5	$	$	$ 1,069,483	4
5			1966	1966	289,003		30			288,995	5
6	102		1972	1972	1,404,551		27			1,404,534	6
7											7
8											8
	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			32,961	11
12	AGGREGATE			1979	16,053		VARIOUS			16,053	12
13	AGGREGATE			1981	24,389		VARIOUS			24,389	13
14	AGGREGATE			1982	343,459		VARIOUS			343,459	14
15	AGGREGATE			1983	141,163		VARIOUS			141,163	15
16	AGGREGATE			1984	178,226		VARIOUS			178,226	16
17	AGGREGATE			1985	168,428		VARIOUS			168,291	17
18	AGGREGATE			1986	46,364		VARIOUS			46,364	18
19	AGGREGATE			1987	673,140		VARIOUS			673,130	19
20	AGGREGATE			1988	2,336		VARIOUS			2,336	20
21	AGGREGATE			1989	212,154		VARIOUS			212,148	21
22	AGGREGATE			1990	20,558	115	VARIOUS	115		20,480	22
23	AGGREGATE			1991	49,356		VARIOUS			49,354	23
24	AGGREGATE			1992	324,871		VARIOUS			324,871	24
25	AGGREGATE			1993	208,954	762	VARIOUS	762		206,637	25
26	AGGREGATE			1994	117,102	1,338	VARIOUS	1,338		115,962	26
27	AGGREGATE			1995	29,398	1,023	VARIOUS	1,023		28,743	27
28	AGGREGATE			1996	12,441	554	VARIOUS	554		11,125	28
29	AGGREGATE			1997	707	32	VARIOUS	32		614	29
30	AGGREGATE			1998	95,496	4,057	VARIOUS	4,057		80,778	30
31	AGGREGATE			1999	3,738	16	VARIOUS	16		3,650	31
32	AGGREGATE			2000	2,045,586	124,644	VARIOUS	124,644		1,892,715	32
33	AGGREGATE			2001	76,704	2,105	VARIOUS	2,105		64,018	33
34	AGGREGATE			2002	283,429	165	VARIOUS	165		282,402	34
35	AGGREGATE			2003	1,543	51	VARIOUS	51		1,361	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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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	$ 110	20	$ 110	$	$ 1,251	37
38	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	70	20	70		825	38
39	PATCHWORK AND PAINT	2004	5,860		5			5,860	39
40	UNDERGROUND CABLE	2004	8,148	299	25	299		3,341	40
41	PATCHWORK AND PAINT	2005	316		5			310	41
42	STEEL DOORS	2005	1,981	91	20	91		974	42
43	ROOF REPAIR	2005	422	39	30	39		390	43
44	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275		6			4,204	44
45	SEWER LINE	2006	3,935	144	25	144		1,297	45
46	ANNUNCIATOR RELOCATION	2006	1,750	107	15	107		1,022	46
47	REMOTE ANNUNCIATOR	2006	2,250	138	15	138		1,313	47
48	FIRE DOOR SLEEVES	2006	554	51	10	51		488	48
49	LIGHTED EXIT/ACCESS PATHWAYS	2007	180,187	11,011	15	11,011		83,084	49
50	KITCHEN DRAIN LINE	2007	5,852	268	20	268		2,169	50
51	GREASE TRAP/DRAIN/KITCHEN FLOOR	2007	10,608	486	20	486		2,844	51
52	ALZHEIMER'S UNIT	2007	89,334	4,094	20	4,094		30,895	52
53	HEAT PUMP	2008	3,829	351	10	351		2,617	53
54	MOTOR	2008	3,197	366	5	366		2,699	54
55	BLINDS, FAUX, ALABASTER	2009	2,717	125	5	125		2,705	55
56	GARBAGE DISPOSAL	2009	3,139	288	5	288		3,114	56
57	TIMBER BLINDS	2009	5,098	701	5	701		4,948	57
58	FAUX, ALABASTER BLINDS	2009	16,000	2,933	5	2,933		15,733	58
59	ROOFING SYSTEM	2010	6,225	571	10	571		3,008	59
60	SMOKE DETECTORS	2011	4,360	400	10	400		1,599	60
61	FIRE ALARM SYSTEM	2011	46,088	4,225	10	4,225		17,284	61
62	WINDOW REPLACEMENT	2012	273,216	12,522	20	12,522		34,152	62
63	SPRINKLER SYSTEM	2012	294,796	13,512	20	13,512		33,165	63
64	BOILER ROOM PLUMBING RE-ROUTE	2012	6,425	236	25	236		664	64
65	DUCT WORK INSTALLATION	2013	2,941	135	20	135		221	65
66	SLMM	2013	3,449	158	20	158		21	66
67	DUCT WORK INSTALLATION	2014	10,000	42	10	42		42	67
68									68
69	NON-CARE BEDS ADJUSTMENT (46.9%)		(4,248,627)	(88,329)		(88,329)		(3,814,326)	69
70	TOTAL (lines 4 thru 69)		$ 4,810,280	$ 100,006		$ 100,006	$	$ 4,318,566	70

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

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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	$ 241,709	$ 21,659	$ 21,659	$		$ 149,361	71
72	Current Year Purchases	5,610	150	150			187	72
73	Fully Depreciated Assets	1,659,116					1,659,116	73
74								74
75	TOTALS	$ 1,906,435	$ 21,809	$ 21,809	$		$ 1,808,664	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)	$ 6,726,715	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 121,815	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 121,815	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)	$ 6,127,230	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	MEDICAL ANCILLARY COMPLEX	$ 107,276	$	$ 107,276	86
87	HVAC PROJECT	103,052	6,872	96,197	87
88					88
89	NON-CARE BEDS ADJUSTMENT	4,248,627	88,329	3,814,326	89
90					90
91	TOTALS	$ 4,458,955	$ 95,201	$ 4,017,799	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	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.	/2015	$
13.	/2016	$
14.	/2017	$

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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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	$	5,733	$ 157,664	$	5,733	$ 157,664	1
2	Licensed Speech and Language Development Therapist		hrs		2,752	93,421		2,752	93,421	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,845	223,497		5,845	223,497	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			$	14,330	$ 474,582	$	14,330	$ 474,582	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/22/2014 (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	$ 427,077	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 345,895)	527,949		3
4	Supply Inventory (priced at)	8,755		4
5	Short-Term Investments			5
6	Prepaid Insurance	(2,212)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): IGA, PROPERTY TAXES	503,578		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,465,147	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	350,770		13
14	Buildings, at Historical Cost	8,614,445		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,220,455		16
17	Accumulated Depreciation (book methods)	(10,145,029)		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)**	$ 1,040,641	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,505,788	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 168,332	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,045		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	291,151		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	DUE TO OTHER FUNDS	839,406		36
37	DUE TO THIRD PARTIES	98,872		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,403,806	$	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	DEFERED REVENUE - PROPERTY TA	503,008		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 503,008	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,906,814	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 598,974	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,505,788	$	48

***(See instructions.)**

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,291,386	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,291,386	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(692,412)	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)**	$ (692,412)	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)**	$ 598,974	24	*

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

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,511,388	1
2	Discounts and Allowances for all Levels	(1,122,608)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,388,780	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	2,919	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,559	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)**	$ 4,478	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	240	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 240	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	COPIES, POSTAGE, VENDING	4,707	28
28a	MISCELLANEOUS	28,120	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,827	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,426,325	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,369,629	31
32	Health Care	3,447,178	32
33	General Administration	1,605,705	33
	B. Capital Expense		
34	Ownership	217,016	34
	C. Ancillary Expense		
35	Special Cost Centers	242,647	35
36	Provider Participation Fee	236,562	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,118,737	40
41	**Income before Income Taxes (line 30 minus line 40)****	(692,412)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (692,412)	43

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

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

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

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

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

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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	1,795	1,941	$ 67,005	$ 34.52	1
2	Assistant Director of Nursing	1,886	2,100	60,403	28.76	2
3	Registered Nurses	10,583	11,563	286,141	24.75	3
4	Licensed Practical Nurses	27,542	29,914	598,630	20.01	4
5	CNAs & Orderlies	68,751	74,859	984,437	13.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,778	1,954	28,662	14.67	9
10	Activity Assistants	3,303	3,719	48,090	12.93	10
11	Social Service Workers	3,844	4,119	67,194	16.31	11
12	Dietician					12
13	Food Service Supervisor	1,844	1,984	44,071	22.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,836	26,599	337,114	12.67	15
16	Dishwashers					16
17	Maintenance Workers	4,779	5,271	100,335	19.04	17
18	Housekeepers	8,431	9,396	117,111	12.46	18
19	Laundry	12,209	13,398	158,641	11.84	19
20	Administrator	1,809	2,001	62,506	31.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,849	2,001	44,136	22.06	23
24	Clerical	10,909	12,841	113,386	8.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,544	1,544	27,123	17.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,692	205,204	$ 3,144,985 *	$ 15.33	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		$ 17,548		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,736		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) PSYCH		2,600		46
47	DENTAL		8,397		47
48					48
49	TOTAL (lines 35 - 48)		$ 31,281		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,392	$ 54,085		50
51	Licensed Practical Nurses	5,895	179,504		51
52	Certified Nurse Assistants/Aides	25,141	489,009		52
53	TOTAL (lines 50 - 52)	32,428	$ 722,598		53

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MERLE TALOR	DIRECTOR		$ 62,174
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,174

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	$ 5,042
FR&R HEALTHCARE CONULT.	CONSULTING	5,445
ANNETTE MILLER	STAFF TRAINING	380
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 10,867

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,818
Unemployment Compensation Insurance	28,026
FICA Taxes	240,463
Employee Health Insurance	495,590
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	370,296
EMPLOYEE TRAINING	7,104
PHYSICAL EXAMS	3,076
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,234,373

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	672
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 107	1,712
MARKETING	11,763
SUBSCRIPTION	108
Less: Public Relations Expense	( )
Non-allowable advertising	(7,149)
Yellow page advertising	(4,614)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,492

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	328
Seminar Expense	2,300
LODGING	332
MEALS	192
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,152

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number REHAB & CARE CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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			$		$	$	$	$	$	$	$	$	$
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 CTR JACKSON CO # 0010330 Report Period Beginning: 12/1/2013 Ending: 10/22/2014

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? **NO**
If YES, give association name and amount.

(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? **10**

(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. $ **236,562**
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**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Reclassification for Column 5 from Schedule V:

Reclassify Laundry Salaries from Housekeeping	158,641
Reclassify Seminar and Travel Expense from Employee Benefits and Payroll Taxes	3,152
Reclassify Contracted Therapy from Therapy to Ancillary Service Centers	474,581
	636,374

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