

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0010330 Facility Name: REHAB & CARE CENTER - JACKSON COUNTY Address: 1411 NORTH 14TH STREET MURPHYSBORO 62966 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 Charitable Corp. Trust IRS Exemption Code PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other XGOVERNMENTAL State XCounty 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 12/01/2011 to 11/30/2012 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) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) MARK DALLAS CPA, PARTNER (Firm Name & Address) KERBER, ECK, & BRAECKEL, LLP 1116 W. MAIN STREET, CARBONDALE, IL 62901 (Telephone) (618) 529-1040 Fax # (618) 549-2311 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY# 0010330 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>178</u>	Skilled (SNF)	<u>178</u>	<u>65,148</u>	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	<u>178</u>	TOTALS	<u>178</u>	<u>65,148</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,992</u>	<u>1,451</u>	<u>5,548</u>	<u>14,991</u>	8
9	SNF/PED					9
10	ICF	<u>16,025</u>	<u>9,364</u>	<u>980</u>	<u>26,369</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,017</u>	<u>10,815</u>	<u>6,528</u>	<u>41,360</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 63.49%

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?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

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

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 5/01/1960

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 54 and days of care provided 3,840Medicare Intermediary WISCONSON PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: _____ Fiscal Year: 11/30/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	402,555	28,481	38,691	469,727		469,727		469,727		1
2	Food Purchase		267,104		267,104		267,104	(4,752)	262,352		2
3	Housekeeping	371,797	28,511	45,444	445,752	(163,884)	281,868		281,868		3
4	Laundry		11,049		11,049	163,884	174,933		174,933		4
5	Heat and Other Utilities			211,869	211,869		211,869		211,869		5
6	Maintenance	87,889	32,626	76,840	197,355		197,355		197,355		6
7	Other (specify):* WASTE REMOVAL			16,561	16,561		16,561		16,561		7
8	TOTAL General Services	862,241	367,771	389,405	1,619,417		1,619,417	(4,752)	1,614,665		8
	B. Health Care and Programs										
9	Medical Director			38,280	38,280		38,280		38,280		9
10	Nursing and Medical Records	2,623,429	26,510	583,943	3,233,882		3,233,882		3,233,882		10
10a	Therapy			622,255	622,255	(622,255)					10a
11	Activities	85,008		1,436	86,444		86,444		86,444		11
12	Social Services	82,292	2,729	1,041	86,062		86,062		86,062		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,790,729	29,239	1,246,955	4,066,923	(622,255)	3,444,668		3,444,668		16
	C. General Administration										
17	Administrative	66,483			66,483		66,483		66,483		17
18	Directors Fees										18
19	Professional Services			205,876	205,876		205,876		205,876		19
20	Dues, Fees, Subscriptions & Promotions			30,318	30,318		30,318	(11,918)	18,400		20
21	Clerical & General Office Expenses	166,978	29,130	40,255	236,363		236,363	(28,954)	207,409		21
22	Employee Benefits & Payroll Taxes			1,276,245	1,276,245	(5,371)	1,270,874		1,270,874		22
23	Inservice Training & Education										23
24	Travel and Seminar					5,371	5,371		5,371		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			345	345		345		345		26
27	Other (specify):*			152,750	152,750		152,750	(152,750)			27
28	TOTAL General Administration	233,461	29,130	1,705,789	1,968,380		1,968,380	(193,622)	1,774,758		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,886,431	426,140	3,342,149	7,654,720	(622,255)	7,032,465	(198,374)	6,834,091		29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			272,024	272,024		272,024	(80,126)	191,898			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			272,024	272,024		272,024	(80,126)	191,898			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			321,473	321,473	622,255	943,728		943,728			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			483,853	483,853		483,853		483,853			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			805,326	805,326	622,255	1,427,581		1,427,581			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,886,431	426,140	4,419,499	8,732,070		8,732,070	(278,500)	8,453,570			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,752)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,219)	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	(839)	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	(152,750)	27		24
25	Fund Raising, Advertising and Promotional	(11,850)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(68)	20		28
29	Other-Attach Schedule	(106,022)	21,30		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (278,500)		\$	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	2	
		Amount	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
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (278,500)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
REHAB & CARE CENTER - JACKSON COUNTY

Page 5A

Report Period Beginning: ID# 0010330
Ending: 12/01/2011
11/30/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,366)	21	1
2	Copies	(211)	21	2
3	Postage	(52)	21	3
4	Miscellaneous	(24,267)	21	4
5	Depreciable Non-Care Assets	(80,126)	30	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(106,022)		49

STATE OF ILLINOIS

Summary A

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

0010330

Report Period Beginning:

12/01/2011

Ending:

11/30/2012

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,752)	0	0	0	0	0	0	0	0	0	0	(4,752)	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	(4,752)	0	0	0	0	0	0	0	0	0	0	(4,752)	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	(11,918)	0	0	0	0	0	0	0	0	0	0	(11,918)	20
21	Clerical & General Office Expenses	(28,954)	0	0	0	0	0	0	0	0	0	0	(28,954)	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):*	(152,750)	0	0	0	0	0	0	0	0	0	0	(152,750)	27
28	TOTAL General Administration	(193,622)	0	0	0	0	0	0	0	0	0	0	(193,622)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(198,374)	0	0	0	0	0	0	0	0	0	0	(198,374)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
(to Sch V, col.7)														
30	Depreciation	(80,126)	0	0	0	0	0	0	0	0	0	0	(80,126)	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	(80,126)	0	0	0	0	0	0	0	0	0	0	(80,126)	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)	(278,500)	0	0	0	0	0	0	0	0	0	0	(278,500)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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 CENTER - JACKSON C # 0010330 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNTY # 0010330 Report Period Beginning: 12/01/2011 Ending: 1/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:	2007	N/A	8
	2008	N/A	9
	2009	N/A	10
	2010	N/A	11
	2011	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	REHAB & CARE CENTER - JACKSON COUNTY	COUNTY	JACKSON
---------------	--------------------------------------	--------	---------

FACILITY IDPH LICENSE NUMBER 0010330

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

A. Square Feet: 150,000

B. General Construction Type: Exterior BRICK

Frame CONCRETE/STEEL

Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76		1960	1960	\$ 1,069,483	\$	34.5	\$	\$	\$ 1,069,483	4
5			1966	1966	289,003		30			288,995	5
6	102		1972	1972	1,404,551		27			1,404,534	6
7											7
8											8
	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	126	VARIOUS	126		20,239	22
23	AGGREGATE		1991		49,356	4	VARIOUS	4		49,354	23
24	AGGREGATE		1992		324,871	7,422	VARIOUS	7,422		324,871	24
25	AGGREGATE		1993		208,954	7,411	VARIOUS	7,411		202,018	25
26	AGGREGATE		1994		117,102	2,698	VARIOUS	2,698		111,986	26
27	AGGREGATE		1995		29,398	1,115	VARIOUS	1,115		26,605	27
28	AGGREGATE		1996		12,441	604	VARIOUS	604		9,967	28
29	AGGREGATE		1997		707	35	VARIOUS	35		547	29
30	AGGREGATE		1998		95,496	4,631	VARIOUS	4,631		72,256	30
31	AGGREGATE		1999		3,738	34	VARIOUS	34		3,600	31
32	AGGREGATE		2000		2,045,586	136,142	VARIOUS	136,142		1,636,805	32
33	AGGREGATE		2001		76,704	2,349	VARIOUS	2,349		59,616	33
34	AGGREGATE		2002		283,429	26,588	VARIOUS	26,588		282,057	34
35	AGGREGATE		2003		1,543	56	VARIOUS	56		1,254	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	EZ FLUSH RETRO KIT	2004	\$ 2,405	\$ 120	20	\$ 120	\$	\$ 1,021	37
38	RE-WIRING-ADDITIONAL OUTLETS	2004	1,524	76	20	76		679	38
39	PATCHWORK AND PAINT	2004	5,860		5			5,860	39
40	UNDERGROUND CABLE	2004	8,148	326	25	326		2,716	40
41	PATCHWORK AND PAINT	2005	316		5			310	41
42	STEEL DOORS	2005	1,981	99	20	99		784	42
43	ROOF REPAIR	2005	422	42	30	42		309	43
44	OZONE GENERATOR/TANKLESS SYSTEM	2005	4,275		6			4,204	44
45	SEWER LINE	2006	3,935	157	25	157		996	45
46	ANNUNCIATOR RELOCATIOIN	2006	1,750	117	15	117		798	46
47	REMOTE ANNUNCIATOR	2006	2,250	150	15	150		1,025	47
48	FIRE DOOR SLEEVES	2006	554	55	10	55		382	48
49	LIGHTED EXIT/ACCESS PATHWAYS	2007	180,187	12,012	15	12,012		60,061	49
50	KITCHEN DRAIN LINE	2007	5,852	292	20	292		1,609	50
51	GREASE TRAP/DRAIN/KITCHEN FLOOR	2007	10,608	530	20	530		2,828	51
52	ALZHEIMER'S UNIT	2007	89,334	4,467	20	4,467		22,334	52
53	HEAT PUMP	2008	3,829	383	10	383		1,883	53
54	MOTOR	2008	3,197	400	5	400		1,933	54
55	BLINDS, FAUX, ALABASTER	2009	2,717	543	5	543		2,037	55
56	GARBAGE DISPOSAL	2009	3,139	628	5	628		2,198	56
57	TIMBER BLINDS	2009	5,098	1,019	5	1,019		3,228	57
58	FAUX ALABASTER BLINDS	2009	16,000	3,200	5	3,200		9,600	58
59	ROOFING SYSTEM	2010	6,225	622	10	622		1,815	59
60	SMOKE DETECTORS	2011	4,360	436	10	436		763	60
61	FIRE ALARM SYSTEM	2011	46,088	4,609	10	4,609		8,450	61
62	WINDOW REPLACEMENT	2012	273,216	7,969	20	7,969		7,969	62
63	SPRINKLER SYSTEM	2012	294,796	4,913	20	4,913		4,913	63
64	BOILER ROOM PLUMBING RE-ROUTE	2012	6,425	171	25	171		171	64
65									65
66									66
67									67
68	Non-Care Beds Adjustment (31.5%)		(2,848,393)	(73,254)		(73,254)		(2,438,098)	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,194,124	\$ 159,297		\$ 159,297	\$	\$ 5,301,896	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 6,194,124	\$ 159,297		\$ 159,297	\$	\$ 5,301,896	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,194,124	\$ 159,297		\$ 159,297	\$	\$ 5,301,896	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)									
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6		
71	Purchased in Prior Years	\$ 693,218	\$ 32,601	\$ 32,601	\$		\$ 564,002	71	
72	Current Year Purchases							72	
73	Fully Depreciated Assets	1,192,045					1,192,045	73	
74								74	
75	TOTALS	\$ 1,885,263	\$ 32,601	\$ 32,601	\$		\$ 1,756,047	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	2	
		Reference				Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)				\$ 8,089,387	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$ 191,898	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$ 191,898	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$ 7,057,943	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	82,453	87
88					88
89					89
90	Non-Care Beds Adjustments	2,848,393	73,254	2,438,098	90
91	TOTALS	\$ 3,058,721	\$ 80,126	\$ 2,627,827	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

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	\$	4,798	\$ 212,459	\$	4,798	\$ 212,459	1
2	Licensed Speech and Language Development Therapist		hrs		2,845	109,231		2,845	109,231	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		9,016	300,565		9,016	300,565	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			\$	16,659	\$ 622,255	\$	16,659	\$ 622,255	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.

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	\$ 663,624	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 359,000)	1,177,610		3
4	Supply Inventory (priced at)	9,097		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,277		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): A/R - IGA, Property Taxes, & O	839,092		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,697,700	\$	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	8,598,055		15
16	Equipment, at Historical Cost	2,199,283		16
17	Accumulated Depreciation (book methods)	(9,685,902)		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)	\$ 1,462,206	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,159,906	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 396,024	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,074		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	411,630		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	647,072		36
37	Due to third parties	205,454		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,679,254	\$	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	Deferred revenue-property taxes & advan	569,688		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 569,688	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,248,942	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,910,964	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,159,906	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,504,620	1
2	Restatements (describe):		2
3	Prior Year Audit Adjustment	(89,659)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,414,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(503,997)	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)	\$ (503,997)	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)	\$ 1,910,964	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number REHAB & CARE CENTER - JACKSON COUNT # 0010330 Report Period Beginning: 12/01/2011Ending: 11/30/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	1		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 8,875,027	1	
2 Discounts and Allowances for all Levels	(845,411)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,029,616	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	4,752	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space	2,219	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)	\$ 6,971	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	839	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 839	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 Copies, Postage, Vending	1,629	28	
28a Grants 164,751 & Miscellaneous	189,018	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 190,647	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,228,073	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	1,619,417	31	
32 Health Care	4,066,923	32	
33 General Administration	1,968,380	33	
B. Capital Expense			
34 Ownership	272,024	34	
C. Ancillary Expense			
35 Special Cost Centers	321,473	35	
36 Provider Participation Fee	483,853	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,732,070	40	
41 Income before Income Taxes (line 30 minus line 40)**	(503,997)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (503,997)	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.

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,248	\$ 73,411	\$ 32.66	1
2	Assistant Director of Nursing	2,154	2,390	61,250	25.63	2
3	Registered Nurses	12,954	13,970	346,733	24.82	3
4	Licensed Practical Nurses	30,298	33,174	601,797	18.14	4
5	CNAs & Orderlies	97,205	108,466	1,490,186	13.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,852	2,168	31,689	14.62	9
10	Activity Assistants	3,642	4,058	53,072	13.08	10
11	Social Service Workers	5,825	6,267	108,108	17.25	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,232	42,376	18.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,157	30,635	366,304	11.96	15
16	Dishwashers					16
17	Maintenance Workers	5,894	6,560	117,740	17.95	17
18	Housekeepers	12,444	14,240	170,932	12.00	18
19	Laundry	11,163	12,607	163,884	13.00	19
20	Administrator	1,876	2,112	66,483	31.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,744	2,136	45,700	21.40	23
24	Clerical	5,799	7,351	108,218	14.72	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	2,204	2,204	38,548	17.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	227,147	252,818	\$ 3,886,431 *	\$ 15.37	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 38,691		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,400		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psych		4,700		46
47	Dental		10,800		47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,591		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,506	\$ 97,359		50
51	Licensed Practical Nurses	8,341	253,996		51
52	Certified Nurse Assistants/Aides	10,552	205,228		52
53	TOTAL (lines 50 - 52)	21,399	\$ 556,583		53

STATE OF ILLINOIS

Facility Name & ID Number

REHAB & CARE CENTER - JACKSON COUNTY

0010330

Report Period Beginning:

12/01/2011

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Ending:

11/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Merle Taylor			\$ 66,483	Workers' Compensation Insurance	\$ 10,685	IDPH License Fee	\$	
				Unemployment Compensation Insurance	27,480	Advertising: Employee Recruitment	1,485	
				FICA Taxes	283,775	Health Care Worker Background Check		
				Employee Health Insurance	565,201	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	16 1,806	
				Illinois Municipal Retirement Fund (IMRF)*	378,648	Marketing	11,918	
				Employee Training	2,615	Subscription	837	
				Physical Exams	2,470	IHCA and CNHA dues	14,272	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,483			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(11,850)	
Description			Amount			Yellow page advertising	(68)	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,270,874	TOTAL (agree to Sch. V, line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
Kerber, Eck, & Braeckel	Cost Report/Audit		\$ 6,000				Out-of-State Travel	
FR&R Healthcare Consulting	Consulting		10,472					
Management Performance Assoc.	Management		189,404				In-State Travel	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 205,876	TOTAL		\$	Seminar Expense	
							Lodging	
							Meals	
							Entertainment Expense	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 5,371	

* Attach copy of IMRF notifications

**See instructions.

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$14,272

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 22

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 483,853
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 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.

Reclassify Laundry Salaries from Housekeeping	163,884
Reclassify Seminar and Travel Expense from Employee Benefits and Payroll Taxes	5,371
Reclassify Contracted Therapy from Therapy to Ancillary Service Centers	<u>622,255</u>
	<u>791,510</u>