

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131 Report Period Beginning: 07/01/01 Ending: 06/30/02

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	61	Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	354	61	2,972	3,387	8
9	SNF/PED					9
10	ICF	16,431	9,318		25,749	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,785	9,379	2,972	29,136	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.71%

D. How many bed-hold days during this year were paid by Public Aid? 233 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 8/1974

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 27 and days of care provided 2,972

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/02 Fiscal Year: 6/30/02

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

STATE OF ILLINOIS

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/01 Ending: 06/30/02

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	95,676	11,462	5,241	112,379		112,379		112,379		1
2	Food Purchase		102,021		102,021		102,021	(1,131)	100,890		2
3	Housekeeping	35,287	10,476		45,763		45,763		45,763		3
4	Laundry	22,574	10,430		33,004		33,004		33,004		4
5	Heat and Other Utilities			60,525	60,525		60,525		60,525		5
6	Maintenance	35,218	25,811	22,182	83,211		83,211	1,311	84,522		6
7	Other (specify):* Utility Workers	21,540			21,540		21,540		21,540		7
8	TOTAL General Services	210,295	160,200	87,948	458,443		458,443	180	458,623		8
B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	874,363	112,417	101,583	1,088,363	(60,592)	1,027,771	(86)	1,027,685		10
10a	Therapy	20,103	538	192,235	212,876	(192,235)	20,641		20,641		10a
11	Activities	33,227	917		34,144		34,144		34,144		11
12	Social Services	13,844		4,048	17,892		17,892		17,892		12
13	Nurse Aide Training	689	17	1,304	2,010		2,010		2,010		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	942,226	113,889	311,170	1,367,285	(252,827)	1,114,458	(86)	1,114,372		16
C. General Administration											
17	Administrative	54,575		14,980	69,555	2,968	72,523	39,311	111,834		17
18	Directors Fees										18
19	Professional Services			240,071	240,071		240,071	(231,776)	8,295		19
20	Dues, Fees, Subscriptions & Promotions			27,008	27,008		27,008	(5,796)	21,212		20
21	Clerical & General Office Expenses	23,172	11,444	4,522	39,138		39,138	22,834	61,972		21
22	Employee Benefits & Payroll Taxes			195,953	195,953		195,953	13,422	209,375		22
23	Inservice Training & Education			1,057	1,057		1,057	246	1,303		23
24	Travel and Seminar			8,716	8,716	(8,335)	381	508	889		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			105,281	105,281		105,281	489	105,770		26
27	Other (specify):*			20,915	20,915		20,915	(20,915)			27
28	TOTAL General Administration	77,747	11,444	618,503	707,694	(5,367)	702,327	(181,677)	520,650		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,230,268	285,533	1,017,621	2,533,422	(258,194)	2,275,228	(181,583)	2,093,645		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.

STATE OF ILLINOIS

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER #0020131 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation					15,462	15,462	5,761	21,223		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			26,381	26,381		26,381		26,381		33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(127,640)	4,360		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Depreciation			15,462	15,462	(15,462)					36
37	TOTAL Ownership			173,843	173,843		173,843	(121,879)	51,964		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					258,194	258,194		258,194		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			48,180	48,180		48,180		48,180		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			48,180	48,180	258,194	306,374		306,374		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,230,268	285,533	1,239,644	2,755,445		2,755,445	(303,462)	2,451,983		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 JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning: 07/01/01

Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,756)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(906)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,180)	27		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	(415)	20		17
18	Fines and Penalties	(8,353)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(326)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,354)	27		24
25	Fund Raising, Advertising and Promotional	(5,723)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,028)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,129)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,170)		\$	30

OHF 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)	(265,292)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (265,292)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (303,462)		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.		X	\$		38
39	<u>THERAPY</u>	X		192,235	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		775	10	42
43	Prescription Drugs	X		57,343	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>IV THER</u>	X		1,615	10	45
46	Other-Attach Schedule <u>OXYGEN</u>	X		6,226	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 258,194		47

STATE OF ILLINOIS
 JACKSONVILLE CONVALESCENT CENTER

ID# 0020131
 Report Period Beginning: 07/01/01
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING	\$ (1,131)	2	1
2	EXPENSE REIMBURSEMENT	(3,998)	10	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,129)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131 Report Period Beginning:

07/01/01

Ending:

06/30/02

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	(1,131)	0	0	0	0	0	0	0	0	0	0	(1,131)	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	(1,131)	0	0	0	0	0	0	0	0	0	0	(1,131)	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	(3,998)	0	0	0	0	0	0	0	0	0	0	(3,998)	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	Nurse Aide 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	(3,998)	0	0	0	0	0	0	0	0	0	0	(3,998)	16
	C. General Administration													
17	Administrative	0	228	0	0	0	0	0	0	0	0	0	228	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(326)	(231,938)	0	0	0	0	0	0	0	0	0	(232,264)	19
20	Fees, Subscriptions & Promotions	(6,138)	210	0	0	0	0	0	0	0	0	0	(5,928)	20
21	Clerical & General Office Expenses	(906)	0	0	0	0	0	0	0	0	0	0	(906)	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	(228)	0	0	0	0	0	0	0	0	0	(228)	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):*	(20,915)	0	0	0	0	0	0	0	0	0	0	(20,915)	27
28	TOTAL General Administration	(28,285)	(231,728)	0	(260,013)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,414)	(231,728)	0	(265,142)	29								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	25.00	D'ADRIAN CONVALESCENT CENTER	GODFREY	NursingHome Mngrs	SPRINGFIELD	MANAGEMENT
SAM KLEIN	25.00	HILLTOP NURSING HOME	CHARLESTON	J'ville Land Trust	SPRINGFIELD	LAND TRUST
DORYS BERG, TRUSTEE	50.00	MEADOW MANOR	TAYLORVILLE			
		MENARD CONVALESCENT CENTER	PETERSBURG			
		SUNRISE MANOR OF VIRDEN	VIRDEN			

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	34 RENT	\$ 132,000	JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	\$	\$(132,000)
2	V	30 DEPRECIATION		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	8,782	8,782
3	V	20 TRUST FEES		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	210	210
4	V						
5	V						
6	V	19 MANAGEMENT FEES	239,480	NURSING HOME MANAGERS, INC.	50.00%		(239,480)
7	V	VAR SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS, INC.	50.00%	89,654	89,654
8	V	19 ACCOUNTING		NURSING HOME MANAGERS, INC. DIRECT ALLOCATION	50.00%	7,542	7,542
9	V	24 TRAVEL	228	TO TRANSFER 31% OF HOME OFFICE TRAVEL	50.00%		(228)
10	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE PER DESK REVIEW	50.00%	228	228
11	V						
12	V						
13	V						
14	Total		\$ 371,708			\$ 106,416	\$ * (265,292)

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEN # 0020131 Report Period Beginning: 07/01/01 Ending: 06/30/02

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	SAM KLEIN	PRESIDENT	MANAGEMENT	25.00					\$ 852	17-7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	25.00					1,882	17-7	2
3											3
4											4
5	SAM KLIEN AND H. RAYMOND KLEIN WERE PAID BY NURSING HOME MANAGERS, INC., A RELATED										5
6	ORGANIZATION. TOTAL COMPENSATION OF \$4,098 FOR SAM KLEIN AND \$9,047 FOR H. RAYMOND										6
7	KLEIN WAS ALLOCATED AMONG THE SIX RELATED NURSING HOMES BASED UPON 10 HOURS PER										7
8	WEEK FOR SAM KLEIN AND 10 HOURS PER WEEK FOR H. RAYMOND KLEIN.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,734		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 JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization NURSING HOME MANAGERS, INC.
 Street Address 2653 W. LAWRENCE, SUITE B.
 City / State / Zip Code SPRINGFIELD, IL 62704
 Phone Number (217-787-8530
 Fax Number (217-787-9840

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

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	SEE ATTACHED SCHEDULES								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 JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			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								\$	\$			\$	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 # N/A

* 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

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1.	Real Estate Tax accrual used on 2001 report.			\$	37,978	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.)			\$	25,318	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	(12,660)	3																			
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	39,041	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.			\$	26,381	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		1997	31,641	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2001</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2001	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		1998	31,046	9																					
		1999	25,115	10																					
		2000	25,319	11																					
		2001	26,027	12																					
LINE 4: 2001 TAX BILL			\$ 26027																						
6/12 OF \$26027			13014																						
TOTAL			\$39041																						

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JACKSONVILLE CONVALESCENT CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0020131

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE 217-787-8530 FAX #: 217-787-9840

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(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. <u>09-18-301-002</u>	<u>Jacksonville Convalescent Center</u>	\$ <u>26,027.18</u>	\$ <u>26,027.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>26,027.18</u>	\$ <u>26,027.18</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131 Report Period Beginning:

07/01/01 Ending:

06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,061 B. General Construction Type: Exterior MASONRY Frame 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, nurse aide 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home		1974	\$ 35,003	1
2	Title Work		1989	426	2
3	TOTALS			\$ 35,429	3

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	88	1974	1974	\$ 541,766	\$ 6,712	30		\$ (6,712)	\$ 541,766	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	LANDSCAPING		1975	3,850		5			3,850	9
10	AIR CONDITIONING/HEATING		1974	14,470		8			14,470	10
11	MOTORS		1980	533		5			533	11
12	BIDS		1981	739	22	30	25	3	533	12
13	FURNACE		1981	678		8			678	13
14	FAN		1981	972		15			972	14
15	USED AIR CONDITIONER		1982	2,000		8			2,000	15
16	VACUUM REPAIR PER 1982 AUDIT		1982	1,031		10			1,031	16
17	FLOORING		1983	1,229		10			1,229	17
18	WATER HEATER		1983	1,498		8			1,498	18
19	WATER HEATER		1983	1,575		8			1,575	19
20	CEILING AND DOORS		1984	2,041		15			2,041	20
21	ASPHALT		1984	13,350		15			13,350	21
22	AIR CONDITIONER		1987	1,155		8			1,155	22
23	SIDEWALKS		1987	6,700	213	20	335	122	4,858	23
24	ROOF		1988	21,783	692	20	1,089	397	14,701	24
25	LIGHT DIFFUSER		1990	1,054	34	10		(34)	1,054	25
26	FLOORING		1990	1,030	33	15	69	36	792	26
27	WATER HEATER		1992	1,450	46	15	97	51	1,017	27
28	AIR CONDITIONER		1992	1,025		10	102	102	975	28
29	REWIRE FIXTURES		1992	1,110	35	10	111	76	1,055	29
30	COMPRESSOR		1993	1,479	38	10	148	110	1,257	30
31	DOOR STOPS		1993	2,168	56	15	144	88	1,225	31
32	ROOF		1993	34,178	876	20	1,709	833	14,525	32
33	FIRE DOORS		1996	1,011	26	15	67	41	436	33
34	WATER HEATER		1997	3,915	100	15	261	161	1,360	34
35	AIR CONDITIONER		1997	5,982	153	10	598	445	2,990	35
36	SWAMP COOLER		1998	1,125	29	8	141	112	587	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

STATE OF ILLINOIS

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/01

Ending:

Page 12A

06/30/02

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	WATER HEATER	1998	\$ 1,950	\$ 50	15	\$ 130	\$ 80	\$ 487		37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	490		38
39	SHUTTERS	1999	912	23	15	61	38	162		39
40	DOOR ENTRANCE	2000	4,507	116	15	300	184	650		40
41	DUCT SMOKE DETECTORS	2000	2,295	59	20	115	56	220		41
42	DOOR	2000	2,280	58	15	152	94	266		42
43	ROOFTOP AIR CONDITIONER	2001	7,619	155	10	635	480	635		43
44	COMBUSTION AIR DUCT	2002	710	8	15	24	16	24		44
45	SMOKE DETECTORS	2002	2,511	13	15	42	29	42		45
46	GARAGE	2002	11,636	37	15	129	92	129		46
47	SMOKE DETECTORS	2002	809	3	15	9	6	9		47
48	FIRE DAMPERS	2002	1,166	4	15	13	9	13		48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 709,964	\$ 9,660		\$ 6,684	\$ (2,976)	\$ 636,640		70

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 129,125	\$ 9,934	\$ 11,765	\$ 1,831	Various	\$ 73,340	71
72	Current Year Purchases	32,537	4,650	1,039	(3,611)	Various	1,039	72
73	Fully Depreciated Assets	122,791					122,791	73
74	Assets No Longer in Service	(77,603)					(77,603)	74
75	TOTALS	\$ 206,850	\$ 14,584	\$ 12,804	\$ (1,780)		\$ 119,567	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	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)	\$ 952,243	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,244	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,488	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,756)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 756,207	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		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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: **JACKSONVILLE CONVALESCENT CENTER LAND TRUST**

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building: 1974	88	8/1/74	\$ 132,000			3
4	Additions						4
5							5
6							6
7	TOTAL	88		\$ 132,000			7

10. Effective dates of current rental agreement:

Beginning 7/01/01
Ending 6/30/02

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

	Fiscal Year Ending	Annual Rent
12.	<u>6/30/2003</u>	\$ <u>132,000</u>
13.	<u>6/30/2004</u>	\$ <u>132,000</u>
14.	<u>6/30/2005</u>	\$ <u>132,000</u>

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: **INCLUDED IN THE ABOVE AMOUNT**

(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.**

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>84</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		17		17
3	Classroom Wages (a)		483		483
4	Clinical Wages (b)		206		206
5	In-House Trainer Wages (c)				
6	Transportation		276		276
7	Contractual Payments		978		978
8	Nurse Aide Competency Tests		50		50
9	TOTALS	\$	2,010	\$	2,010
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,010		

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Units	Cost						
					Units	Cost								
1	Licensed Occupational Therapist	39-8	hrs	\$	1,276	\$ 79,958						1,276	\$ 79,958	1
2	Licensed Speech and Language Development Therapist	39-8	hrs		61	3,610						61	3,610	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	39-8	hrs		1,867	108,667						1,867	108,667	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39-8	# of prescripts							57,343			57,343	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify): Oxygen, Lab, IV	39-8								8,616			8,616	13
14	TOTAL			\$	3,204	\$ 192,235				\$ 65,959		3,204	\$ 258,194	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning: 07/01/01

Ending:

06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/02

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 136,639	\$ 212,062	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	404,028	404,028	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,232	23,232	6
7	Other Prepaid Expenses	117,713	117,713	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 681,612	\$ 757,035	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		35,429	13
14	Buildings, at Historical Cost		658,844	14
15	Leasehold Improvements, at Historical Cost	50,089	50,089	15
16	Equipment, at Historical Cost	190,348	282,512	16
17	Accumulated Depreciation (book methods)	(146,857)	(835,500)	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)	\$ 93,580	\$ 191,374	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 775,192	\$ 948,409	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 154,949	\$ 154,949	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,606	64,606	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,809	10,809	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,041	39,041	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,028	5,028	35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 274,433	\$ 274,433	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 274,433	\$ 274,433	46
47	TOTAL EQUITY(page 18, line 24)	\$ 500,759	\$ 673,976	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 775,192	\$ 948,409	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 586,044	1
2	Restatements (describe):		2
3	ROUNDING ADJUSTMENT	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 586,045	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	314,814	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	(290,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) LAND TRUST INCOME	123,117	15
16	Other (describe) LAND TRUST DIST. TO OWNERS	(60,000)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 87,931	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)	\$ 673,976	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,001,146	1
2	Discounts and Allowances for all Levels	(7,642)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,993,504	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	61,465	6
7	Oxygen	602	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 62,067	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	619	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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)	\$ 619	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,034	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,034	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending 1131, Admit Fee 900	2,031	28
28a	Expense Reimbursement 3998 W/A 6	4,004	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,035	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,070,259	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	458,443	31
32	Health Care	1,367,285	32
33	General Administration	707,694	33
B. Capital Expense			
34	Ownership	173,843	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	48,180	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,755,445	40
41	Income before Income Taxes (line 30 minus line 40)**	314,814	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 314,814	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning: 07/01/01

Ending:

06/30/02

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,920	2,040	\$ 41,754	\$ 20.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,051	5,144	106,443	20.69	3
4	Licensed Practical Nurses	16,381	16,839	223,967	13.30	4
5	Nurse Aides & Orderlies	52,186	52,981	502,199	9.48	5
6	Nurse Aide Trainees	134	134	689	5.14	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,052	2,196	20,103	9.15	8
9	Activity Director	1,973	2,061	15,294	7.42	9
10	Activity Assistants	3,156	3,165	17,933	5.67	10
11	Social Service Workers	1,781	1,851	13,844	7.48	11
12	Dietician					12
13	Food Service Supervisor	2,339	2,445	29,359	12.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,480	9,813	66,317	6.76	15
16	Dishwashers					16
17	Maintenance Workers	3,306	3,557	35,218	9.90	17
18	Housekeepers	5,429	5,613	35,287	6.29	18
19	Laundry	2,810	3,027	22,574	7.46	19
20	Administrator	1,960	2,080	54,575	26.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,893	2,936	23,172	7.89	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					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	4,106	4,137	21,540	5.21	33
34	TOTAL (lines 1 - 33)	116,957	120,019	\$ 1,230,268 *	\$ 10.25	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	192	\$ 5,241	1-3	35
36	Medical Director	120	12,000	9-3	36
37	Medical Records Consultant	8	502	10-3	37
38	Nurse Consultant	781	24,945	10-3	38
39	Pharmacist Consultant	48	900	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	71	4,048	12-3	45
46	Other(specify)				46
47	ADMINISTRATIVE CONSULTANT	544	14,980	17-3	47
48					48
49	TOTAL (lines 35 - 48)	1,764	\$ 62,616		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	140	\$ 5,902	10-3	50
51	Licensed Practical Nurses	1,652	50,548	10-3	51
52	Nurse Aides	940	18,786	10-3	52
53	TOTAL (lines 50 - 52)	2,732	\$ 75,236		53

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	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT	7/90-6/91	\$ 1,384	3 YRS	\$	\$	\$	\$	\$	\$	\$	\$
2	INTERIOR PAINT	7/92-6/93	1,970	3 YRS								
3	WALLPAPER & PAINT	7/93-6/94	6,214	3 YRS								
4	WALLPAPER & PAINT	7/94-6/95	3,051	3 YRS								
5	WALLPAPER & PAINT	7/96-6/97	4,944	3 YRS	1,648	824						
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 17,563		\$ 1,648	\$ 824	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (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? 14 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,278 Line 10
- (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 of Public Aid during this cost report period. \$ 48,180
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? YES 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 of Public Aid, 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. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, 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.

SCHEDULE V - PAGE 3 & 4

LINE 27 - GENERAL ADMINISTRATION - OTHER

SALES TAX	\$ 3,180
BAD DEBTS	4,354
ILLINOIS RT TAX	5,028
FINES	8,353
TOTAL LINE 27 - COLUMN 3	<u>\$ 20,915</u>

DETAIL COLUMN 5 - RECLASSIFICATIONS

		LINE #
RECLASS TO:		
NURSE CONSULTANT TRAVEL	\$ 5,367	10
ADMINISTRATIVE CONSULTANT TRAVEL	<u>2,968</u>	17
RECLASS FROM: TRAVEL	\$ <u>-8,335</u>	24
RECLASS FROM:		
MEDICARE DRUGS	\$ -57,343	10
MEDICARE LABORATORY FEES	-775	10
MEDICARE I. V. THERAPY	-1,615	10
OXYGEN	-6,226	10
PHYSICAL THERAPY	-108,667	10A
SPEECH THERAPY	-3,610	10A
OCCUPATIONAL THERAPY	<u>-79,958</u>	10A
RECLASS TO:		
ANCILLARY SERVICES	\$ <u>258,194</u>	39

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 19,488
NURSING HOME MANAGERS ALLOCATION	<u>1,735</u>
SCHEDULE V - LINE 10 - COLUMN 8	\$ <u>21,223</u>

PAGE 15 - SCHEDULE XII

AIDES TRAINED AT: SUNRISE MANOR OF VIRDEN, INC
 333 S. WRIGHTSMAN
 VIRDEN, IL 62690

COST PER AIDE TRAINED: \$978.00

PAGE 23 - SCHEDULE XX

QUESTION # 12

SALARY COSTS ARE ALLOCATED TO DEPARTMENT
WORKED BASED UPON TIME CARDS.

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME

NET INCOME - LINE 43	\$ 314,814
* MANAGEMENT FEE 6/30/01	-22,916
* MANAGEMENT FEE 6/30/02	39,140
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	<u>-8,034</u>
TAXABLE INCOME	\$ <u>323,004</u>

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR
 PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR
 COST REPORTS AND TO CONFORM WITH ACCRUAL ACCOUNTING
 METHOD.

PAGE 21 - SCHEDULE XIX - SECTION F

DUES, FEES, SUBSCRIPTIONS, AND PROMOTIONS

PUBLIC RELATIONS	\$ 5,723
CHAMBER OF COMMERCE DUES	205
FRANCHISE FEES	100
HCFA LAB FEE	<u>150</u>
	\$ <u>6,178</u>

R TAX
IR YEAR
NTING

OCCUPIED DAYS 2001	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,278	1,698	2,136	1,630	595	1,701	2,074	12,112
FEBRUAR	2,100	1,570	2,067	1,408	518	1,538	1,875	11,076
MARCH	2,277	1,656	2,349	1,605	558	1,660	2,366	12,471
APRIL	2,198	1,578	2,311	1,461	560	1,563	2,419	12,090
MAY	2,210	1,727	2,404	1,535	543	1,568	2,491	12,478
JUNE	2,141	1,615	2,368	1,691	304	1,673	2,417	12,209
JULY	2,114	1,602	2,434	2,119	0	1,702	2,441	12,412
AUGUST	1,947	1,692	2,387	2,112	0	1,697	2,317	12,152
SEPTEMBER	1,768	1,761	2,359	2,027	0	1,652	2,193	11,760
OCTOBER	1,815	1,800	2,546	2,012	0	1,548	2,354	12,075
NOVEMBER	1,733	1,731	2,510	1,897	0	1,432	2,325	11,628
DECEMBER	1,777	1,581	2,529	1,845	0	1,421	2,430	11,583
TOTAL	24,358	20,011	28,400	21,342	3,078	19,155	27,702	144,046 144,046

OCCUPIED DAYS 2002	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1,809	1,594	2,447	1,759		1,501	2,396	11,506
FEBRUAR	1,598	1,477	2,246	1,597		1,527	2,172	10,617
MARCH	1,773	1,610	2,506	1,661		1,698	2,330	11,578
APRIL	1,793	1,645	2,422	1,630		1,613	2,281	11,384
MAY	1,910	1,497	2,430	1,734		1,605	2,409	11,585
JUNE	1,795	1,498	2,306	1,758		1,517	2,340	11,214
JULY	1,682	1,617	2,358	1,758		1,622	2,367	11,404
AUGUST								0
SEPTEMBER								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	12,360	10,938	16,715	11,897	0	11,083	16,295	79,288 79,288

ALLOCATION PERCENTAGE 2001	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
FEBRUARY	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
MARCH	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
APRIL	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
MAY	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
JUNE	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
JULY	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%
AUGUST	16.02%	13.92%	19.64%	17.38%	13.96%	19.07%	100.00%
SEPTEMBER	15.03%	14.97%	20.06%	17.24%	14.05%	18.65%	100.00%
OCTOBER	15.03%	14.91%	21.08%	16.66%	12.82%	19.49%	100.00%
NOVEMBER	14.90%	14.89%	21.59%	16.31%	12.32%	19.99%	100.00%
DECEMBER	15.34%	13.65%	21.83%	15.93%	12.27%	20.98%	100.00%

ALLOCATION PERCENTAGE 2002	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	15.72%	13.85%	21.27%	15.29%	13.05%	20.82%	100.00%
FEBRUARY	15.05%	13.91%	21.15%	15.04%	14.38%	20.46%	100.00%
MARCH	15.31%	13.91%	21.64%	14.35%	14.67%	20.12%	100.00%
APRIL	15.75%	14.45%	21.28%	14.32%	14.17%	20.04%	100.00%
MAY	16.49%	12.92%	20.98%	14.97%	13.85%	20.79%	100.00%
JUNE	16.01%	13.36%	20.56%	15.68%	13.53%	20.87%	100.00%
JULY	14.75%	14.18%	20.68%	15.42%	14.22%	20.76%	100.00%