

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0020131

Facility Name: JACKSONVILLE CONVALESCENT CENTER

Address: 1517 WEST WALNUT STREET JACKSONVILLE 62650
 Number City Zip Code

County: MORGAN

Telephone Number: (217) 243-6451 **Fax #** (217) 243-8295

HFS ID Number: 370983545001

Date of Initial License for Current Owners: AUGUST 1974

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/05 to 06/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JERRY W. JENNINGS</u>	
	(Title) <u>CONTROLLER</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER# 0020131 Report Period Beginning: 07/01/05 Ending: 06/30/06

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	42	5	3,550	3,597	8
9	SNF/PED					9
10	ICF	15,240	5,124		20,364	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,282	5,129	3,550	23,961	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.60%

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)

NONEF. 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 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 3,550Medicare 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: 6/30/06 Fiscal Year: 6/30/06

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	107,382	12,159	9,451	128,992		128,992		128,992		1
2	Food Purchase		113,901		113,901		113,901	(2,365)	111,536		2
3	Housekeeping	45,717	15,351		61,068		61,068		61,068		3
4	Laundry	28,290	9,580		37,870		37,870		37,870		4
5	Heat and Other Utilities			68,721	68,721		68,721		68,721		5
6	Maintenance	36,518	21,454	34,446	92,418		92,418	1,515	93,933		6
7	Other (specify):*										7
8	TOTAL General Services	217,907	172,445	112,618	502,970		502,970	(850)	502,120		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	582	12,582		9
10	Nursing and Medical Records	1,140,966	241,150	66,293	1,448,409	(147,676)	1,300,733	6,827	1,307,560		10
10a	Therapy	38,174	4,889	236,316	279,379	(236,316)	43,063		43,063		10a
11	Activities	50,435	3,335		53,770		53,770		53,770		11
12	Social Services	26,701		5,600	32,301		32,301		32,301		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,256,276	249,374	320,209	1,825,859	(383,992)	1,441,867	7,409	1,449,276		16
	C. General Administration										
17	Administrative	55,501		10,926	66,427	2,231	68,658	36,127	104,785		17
18	Directors Fees										18
19	Professional Services			251,032	251,032		251,032	(240,987)	10,045		19
20	Dues, Fees, Subscriptions & Promotions			15,208	15,208		15,208	(6,802)	8,406		20
21	Clerical & General Office Expenses	41,166	12,373	5,248	58,787		58,787	27,591	86,378		21
22	Employee Benefits & Payroll Taxes			303,400	303,400		303,400	18,270	321,670		22
23	Inservice Training & Education			2,990	2,990		2,990	1,872	4,862		23
24	Travel and Seminar			8,061	8,061	(6,199)	1,862	692	2,554		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			73,759	73,759		73,759	43	73,802		26
27	Other (specify):*			19,562	19,562		19,562	(19,562)			27
28	TOTAL General Administration	96,667	12,373	690,186	799,226	(3,968)	795,258	(182,756)	612,502		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,570,850	434,192	1,123,013	3,128,055	(387,960)	2,740,095	(176,197)	2,563,898		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER #0020131 Report Period Beginning: 07/01/05 Ending: 06/30/06

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			27,102	27,102		27,102	11,255	38,357			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,649	20,649		20,649	(11,606)	9,043			32
33	Real Estate Taxes			27,423	27,423		27,423		27,423			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(127,177)	4,823			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			207,174	207,174		207,174	(127,528)	79,646			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					387,960	387,960		387,960			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	387,960	436,140		436,140			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,570,850	434,192	1,378,367	3,383,409		3,383,409	(303,725)	3,079,684			45

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

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	(1,150)	2		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	7,284	30		9
10	Interest and Other Investment Income	(1,291)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,223)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,074)	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	(470)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(200)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(21,034)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,288)	27		24
25	Fund Raising, Advertising and Promotional	(6,736)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>VENDING</u>	(1,215)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,397)		\$	30

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)	(258,328)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (258,328)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (303,725)		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	Therapy	X		236,316	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		14,469	10	42
43	Prescription Drugs	X		105,664	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>Oxyg&Supp</u>	X		29,869	10	45
46	Other-Attach Schedule <u>Ambul&Oth</u>	X		1,642	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 387,960		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 JACKSONVILLE CONVALESCENT CENTER

ID# 0020131
 Report Period Beginning: 07/01/05
 Ending: 06/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/05

Ending:

06/30/06

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	(1,150)	0	0	0	0	0	0	0	0	0	0	(1,150)	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	(1,150)	0	0	0	0	0	0	0	0	0	0	(1,150)	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	311	0	0	0	0	0	0	0	0	0	311	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,034)	(220,100)	0	0	0	0	0	0	0	0	0	(241,134)	19
20	Fees, Subscriptions & Promotions	(7,206)	175	0	0	0	0	0	0	0	0	0	(7,031)	20
21	Clerical & General Office Expenses	(1,223)	0	0	0	0	0	0	0	0	0	0	(1,223)	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	(311)	0	0	0	0	0	0	0	0	0	(311)	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):*	(19,562)	0	0	0	0	0	0	0	0	0	0	(19,562)	27
28	TOTAL General Administration	(49,025)	(219,925)	0	(268,950)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,175)	(219,925)	0	(270,100)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/05 Ending:

06/30/06

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	7,284	2,062	0	0	0	0	0	0	0	0	0	9,346	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,291)	(10,315)	0	0	0	0	0	0	0	0	0	(11,606)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	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	5,993	(140,253)	0	(134,260)	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)	(44,182)	(360,178)	0	(404,360)	45								

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%	HILLTOP NURSING HOME, INC.	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
SAM KLEIN	25%	MEADOW MANOR, INC.	TAYLORVILLE	J'ville Land Trust	SPRINGFIELD	LAND TRUST
DORYS BERG, TRUSTEE	50%	MENARD CONVALESCENT CENTER, INC.	PETERSBURG			
		SUNRISE MANOR OF VIRDEN, INC.	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 LAND TRUST	100.00%	\$	\$ (132,000)	1
2	V	30 DEPRECIATION		JACKSONVILLE LAND TRUST	100.00%	2,062	2,062	2
3	V	20 TRUST FEES		JACKSONVILLE LAND TRUST	100.00%	175	175	3
4	V	32 INTEREST		JACKSONVILLE LAND TRUST	100.00%	(35)	(35)	4
5	V	32 INTEREST		JACKSONVILLE LAND TRUST	100.00%	(10,280)	(10,280)	5
6	V							6
7	V	19 MANAGEMENT FEES	229,689	NURSING HOME MANAGERS, INC	50.00%		(229,689)	7
8	V	VAR SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC	50.00%	101,850	101,850	8
9	V	19 ACCOUNTING		NURSING HOME MANAGERS - DIRECT ALLOCATION	50.00%	9,589	9,589	9
10	V	24 TRAVEL	311	TO TRANSFER 31% OF HOME OFFICE TRAVEL	50.00%		(311)	10
11	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW	50.00%	311	311	11
12	V							12
13	V							13
14	Total		\$ 362,000			\$ 103,672	\$ * (258,328)	14

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEN # 0020131 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	H. RAYMOND KLEIN	OWNER	MANAGEMENT	25.00					\$ 2,139	17 - 7	1
2											2
3											3
4	H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC. A RELATED										4
5	ORGANIZATION. TOTAL COMPENSATION OF \$10,010 WAS ALLOCATED AMONG THE										5
6	FIVE RELATED NURSING HOMES BASED UPON 10 HOURS PER WEEK FOR H. RAYMOND KLEIN.										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,139		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: 07/01/05 Ending: 06/30/06

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

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	SEE ATTACHED SCHEDULES				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/05 Ending: 06/30/06

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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	J'VILLE LAND TRUST	X		WORKING CAPITAL		8/27/04	70,000	389,000	DEMAND	4.0000	10,280	6								
7	BANK OF SPRINGFIELD		X	WORKING CAPITAL	INTEREST	5/25/06	112,000	192,355	05/25/07	8.2500	10,369	7								
8	STOCKHOLDER	X		WORKING CAPITAL		3/28/06	8,000	8,000	DEMAND			8								
9	TOTAL Facility Related						\$ 190,000	\$ 589,355			\$ 20,649	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 190,000	\$ 589,355			\$ 20,649	15								

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

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

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

Facility Name & ID Number **JACKSONVILLE CONVALESCENT CENTER**

0020131 Report Period Beginning: **07/01/05**

Ending: **06/30/06**

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 2005 report.		\$	38,928	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.)		\$	25,952	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(12,976)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	40,399	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.		\$	27,423	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	26,027	8
	2002	26,086	9
	2003	24,773	10
	2004	25,952	11
	2005	26,932	12

LINE 4: 2005 REAL ESTATE TAX BILL	\$ 26,932		
6/12 OF \$26,932 =	13,467		
TOTAL LINE 4	\$ 40,399		

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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 CONV. CTR.</u>	\$ <u>26,932.34</u>	\$ <u>26,932.34</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>26,932.34</u>	\$ <u>26,932.34</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131 Report Period Beginning:

07/01/05 Ending:

06/30/06

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>1974</u>	<u>\$ 35,003</u>	1
2	<u>TITLE WORK</u>		<u>1989</u>	<u>426</u>	2
3	TOTALS			\$ 35,429	3

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1974	1974	\$ 541,766	\$	30	\$	\$	\$ 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	18	30	25	7	632	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 CONDITIONING		1987	1,155		8			1,155	22
23		SIDEWALKS		1987	6,700	213	20	335	122	6,198	23
24		ROOF		1988	21,783	690	20	1,089	399	19,058	24
25		LIGHT DIFFUSER		1990	1,054	33	10		(33)	1,054	25
26		FLOORING		1990	1,030	33	15	33		1,030	26
27		WATER HEATER		1992	1,450	46	15	97	51	1,405	27
28		AIR CONDITIONING		1992	1,025		10			1,025	28
29		REWIRE FIXTURES		1992	1,110	35	10		(35)	1,110	29
30		COMPRESSOR		1993	1,479	38	10		(38)	1,479	30
31		DOOR STOPS		1993	2,168	56	15	145	89	1,805	31
32		ROOF		1993	34,178	875	20	1,709	834	21,361	32
33		FIRE DOORS		1996	1,011	26	15	67	41	704	33
34		WATER HEATER		1997	3,915	100	15	261	161	2,404	34
35		AIR CONDITIONING		1997	5,982	153	10	598	445	5,382	35
36		SWAMP COOLER		1998	1,125	29	8	115	86	1,125	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/05

Ending:

06/30/06

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	\$ 1,007	37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	1,202	38
39	SHUTTERS	1999	912	23	15	61	38	406	39
40	DOOR ENTRANCE	2000	4,507	116	15	301	185	1,852	40
41	DUCT SMOKE DETECTORS	2000	2,295	59	20	114	55	679	41
42	DOOR	2000	2,280	59	15	152	93	874	42
43	ROOFTOP AIR CONDITIONER	2001	7,619	195	10	762	567	3,683	43
44	COMBUSTION AIR DUCT	2002	710	18	15	48	30	213	44
45	SMOKE DETECTORS	2002	2,511	64	15	168	104	711	45
46	GARAGE	2002	11,636	298	15	776	478	3,233	46
47	SMOKE DETECTORS	2002	809	21	15	54	33	225	47
48	FIRE DAMPERS	2002	1,166	30	15	78	48	325	48
49	ROOFTOP AIR CONDITIONER & HEATING (2)	2002	9,766	250	8	1,221	971	4,298	49
50	GARAGE INSULATION	2003	1,652	42	15	110	68	367	50
51	ROOFTOP AIR CONDITIONER & HEATING	2003	5,300	136	8	663	527	2,098	51
52	PARKING LOT	2003	13,306	341	15	887	546	2,513	52
53	VENTILATION	2004	4,380	112	15	292	180	608	53
54	SIDEWALK & CONCRETE PAD	2003	5,900	505	20	295	(210)	832	54
55	FENCE	2004	1,453	124	8	182	58	425	55
56	FIRE ALARM SYSTEM	2004	5,540	142	15	369	227	690	56
57	WATER HEATER	2005	2,673	69	15	178	109	252	57
58	ALARM SYSTEM	2005	4,171	107	15	278	171	394	58
59	EXIT FIXTURES	2005	1,541	21	10	90	69	90	59
60	EXHAUST SYSTEM	2006	3,545	4	15		(4)		60
61	SIDEWALK & CONCRETE PATIO	2005	3,600	180	20	165	(15)	165	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 772,791	\$ 5,380		\$ 12,026	\$ 6,646	\$ 679,062	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: 07/01/05 Ending: 06/30/06

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	\$ 196,672	\$ 17,205	\$ 16,949	\$ (256)	Various	\$ 108,756	71
72	Current Year Purchases	12,456	1,779	422	(1,357)	Various	422	72
73	Fully Depreciated Assets	154,901					154,901	73
74	Assets No Longer in Service	(77,603)					(77,603)	74
75	TOTALS	\$ 286,426	\$ 18,984	\$ 17,371	\$ (1,613)		\$ 186,476	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	RESIDENT TRANSPORT	2003 FORD F350	2004	\$ 28,203	\$ 4,800	\$ 7,051	\$ 2,251	4	\$ 13,514	76
77										77
78										78
79										79
80	TOTALS			\$ 28,203	\$ 4,800	\$ 7,051	\$ 2,251		\$ 13,514	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,122,849	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,164	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,448	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,284	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 879,052	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 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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1974</u>	<u>88</u>	<u>08/01/74</u>	\$ <u>132,000</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		88		\$ 132,000			7

10. Effective dates of current rental agreement:

Beginning 07/01/05

Ending 06/30/06

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

Fiscal Year Ending Annual Rent

12.	<u>06/30/07</u>	\$ <u>132,000</u>
13.	<u>06/30/08</u>	\$ <u>132,000</u>
14.	<u>06/30/09</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.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/05 Ending: 06/30/06

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39 - 8	hrs	\$	2,434	\$ 116,595	\$	2,434	\$ 116,595	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		224	17,299		224	17,299	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		1,367	102,422		1,367	102,422	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 prescrpts				105,664		105,664	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab,O2,Amb,Other An	39 - 8					45,980		45,980	13
14	TOTAL			\$	4,025	\$ 236,316	\$ 151,644	4,025	\$ 387,960	14

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER# 0020131Report Period Beginning: 07/01/05

Ending:

06/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,765	\$ 16,782	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	623,796	623,796	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,443	18,443	6
7	Other Prepaid Expenses	1,314	1,314	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 646,318	\$ 660,335	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	112,916	112,916	15
16	Equipment, at Historical Cost	298,127	390,291	16
17	Accumulated Depreciation (book methods)	(246,627)	(958,097)	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)	\$ 164,416	\$ 239,383	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 810,734	\$ 899,718	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 393,223	\$ 393,223	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	589,355	200,355	29
30	Accrued Salaries Payable	40,450	40,450	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,321	32,321	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,399	40,399	32
33	Accrued Interest Payable	256	256	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,096,004	\$ 707,004	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)	\$ 1,096,004	\$ 707,004	46
47	TOTAL EQUITY(page 18, line 24)	\$ (285,270)	\$ 192,714	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 810,734	\$ 899,718	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 481,426	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 481,426	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(428,790)	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) JACKSONVILLE LAND TRUST INCOME	140,078	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (288,712)	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)	\$ 192,714	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/05Ending: 06/30/06**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	\$ 2,967,026	1
2	Discounts and Allowances for all Levels	(95,912)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,871,114	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,000	6
7	Oxygen	7,784	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 77,784	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	1,150	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	842	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,992	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,291	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,291	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending \$1215 Deposit Error \$2 W/A \$34	1,251	28
28a	Jury Duty \$15 Old Checks \$1172	1,187	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,438	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,954,619	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	502,970	31
32	Health Care	1,825,859	32
33	General Administration	799,226	33
B. Capital Expense			
34	Ownership	207,174	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)*	\$ 3,383,409	40
41	Income before Income Taxes (line 30 minus line 40)**	(428,790)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (428,790)	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: **07/01/05**

Ending:

06/30/06

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	2,080	2,120	\$ 46,948	\$ 22.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,720	5,992	125,392	20.93	3
4	Licensed Practical Nurses	23,132	24,148	427,146	17.69	4
5	CNAs & Orderlies	54,154	55,490	541,480	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,800	3,974	38,174	9.61	8
9	Activity Director	1,656	1,820	17,339	9.53	9
10	Activity Assistants	4,247	4,364	33,096	7.58	10
11	Social Service Workers	2,030	2,240	26,701	11.92	11
12	Dietician					12
13	Food Service Supervisor	2,085	2,200	27,725	12.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,616	9,958	79,657	8.00	15
16	Dishwashers					16
17	Maintenance Workers	3,640	3,814	36,518	9.57	17
18	Housekeepers	6,076	6,257	45,717	7.31	18
19	Laundry	4,100	4,202	28,290	6.73	19
20	Administrator	2,000	2,080	55,501	26.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,107	4,343	41,166	9.48	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)					33
34	TOTAL (lines 1 - 33)	128,443	133,002	\$ 1,570,850 *	\$ 11.81	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	280	\$ 9,451	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	18	558	10 - 3	37
38	Nurse Consultant	1,078	47,071	10 - 3	38
39	Pharmacist Consultant	96	1,800	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	93	5,600	12 - 3	45
46	Other(specify)				46
47	<u>SEE ATTACHED SCHEDULE</u>	457	27,790	VARIOUS	47
48					48
49	TOTAL (lines 35 - 48)	2,142	\$ 104,270		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning: 07/01/05

Ending: 06/30/06

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? 13 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,442 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 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, 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? YES Indicate the amount. \$ 1,150
- (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? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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? 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? YES
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 3 & 4 - SCHEDULE V

LINE 27 - GENERAL ADMINISTRATION - OTHER		
SALES TAX	\$	6,074
BAD DEBTS		13,288
CONTRIBUTIONS		200
TOTAL LINE 27 - COLUMN 3	\$	<u>19,562</u>

PAGE 3 & 4 - SCHEDULE V

DETAIL COLUMN 5 - RECLASSIFICATIONS

		LINE #
RECLASS TO:		
NURSE CONSULTANT TRAVEL:	\$	3,968 10
ADMINISTRATIVE CONSULTANT TRAVEL		2,231 17
RECLASS FROM: TRAVEL	\$	(6,199) 24
RECLASS FROM:		
MEDICARE SUPPLIES	\$	(10,098) 10
MEDICARE X-RAYS		(4,870) 10
MEDICARE DRUGS		(85,742) 10
MEDICARE LABORATORY FEES		(9,599) 10
MEDICARE I.V. THERAPY		(19,922) 10
MEDICARE AMBULANCE		(103) 10
OXYGEN		(19,771) 10
MEDICARE OTHER ANCILLARY SERVICES		(1,539) 10
PHYSICAL THERAPY		(102,422) 10A
SPEECH THERAPY		(17,299) 10A
OCCUPATIONAL THERAPY		(116,595) 10A
RECLASS TO: ANCILLARY SERVICES	\$	387,960 39

PAGE 2 - SCHEDULE III - K

NUMBER OF BEDS CERTIFIED FOR MEDICARE	
07/01/05 - 12/31/05	61 BEDS
01/01/06 - 06/30/06	27 BEDS

PAGE 9 - SCHEDULE IX - LINE 6

INTEREST PAID TO JACKSONVILLE LAND TRUST IS OFFSET ON PAGE 6 SCHEDULE VII - SECTION B - LINE 5 - RELATED ORGANIZATION TRANSACTIONS AS PART OF JACKSONVILLE LAND TRUST INTEREST INCOME.

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION	
LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 36,448
NURSING HOME MANAGERS ALLOCATION	1,909
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 38,357</u>

DNS

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME		
NET INCOME - LINE 43	\$	(428,790)
* MANAGEMENT FEE 6/30/05		(24,266)
* MANAGEMENT FEE 6/30/06		36,682
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS		(1,291)
TAXABLE INCOME	\$	<u>(417,665)</u>

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

PAGE 20 - SCHEDULE XVIII - SECTION B

CONSULTANT SERVICES	HOURS	COST	LINE & COL
PSYCHIATRIC CONSULTANT	8	\$ 2,000	10 - 3
MEDICARE CONSULTANT	96	12,739	10 - 3
ADMINISTRATIVE CONSULTANT	332	10,926	17 - 3
UTILIZATION REVIEW	21	2,125	10 - 3
	<u>457</u>	<u>\$ 27,790</u>	

PAGE 23 - SCHEDULE XX

QUESTION #12
SALARY COSTS ARE ALLOCATED TO DEPARTMENT BASED UPON HOURS WORKED PER TIME CARDS.

PAGE 21 - SCHEDULE XIX - SECTION F

DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS		
PUBLIC RELATIONS	\$	6736
CHAMBER OF COMMERCE DUES		295
FRANCHISE FEES		160
LTCNA DUES		105
CLIA LAB WAIVER		150
AUTOMOBILE LICENSE		158
	\$	<u>7604</u>

PAGE 21 - SCHEDULE XIX - SECTION G

SCHEDULE OF TRAVEL & SEMINARS		
MAINTENANCE MILEAGE	\$	293
ADMINISTRATIVE MILEAGE		549
PATIENT SCREENING MILEAGE		324
MISCELLANEOUS REIMBURSEMENT		696
	\$	<u>1862</u>

CENTRAL OFFICE COST ALLOCATION
 JACKSONVILLE
 2005

	JULY 05	AUG	SEPT	OCT	NOV	DEC	JAN 06	FEB	MARCH	APRIL	MAY	JUNE	2005 TOTAL	LINE #
SALARIES-ADMIN	\$2,976	\$2,973	\$2,873	\$2,785	\$2,696	\$2,760	\$2,812	\$2,761	\$2,806	\$2,760	\$2,702	\$2,773	\$33,677	17
SALARIES-CLERIC	2,137	2,334	2,255	2,186	2,116	2,166	2,218	2,178	2,214	2,177	2,131	2,187	26,300	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	532	812	785	761	737	754	414	407	413	406	398	408	6,827	10
ACCOUNTING	9	16	16	15	15	15	10	10	10	10	10	10	147	19
WORK COMP INS	19	55	53	52	50	51	20	20	20	20	19	20	400	22
SUPPLIES	101	64	62	60	58	60	94	93	94	93	91	93	963	21
TELEPHONE	131	132	127	123	119	122	135	132	134	132	129	133	1,551	21
EMPL BENEFITS	1,030	1,172	1,133	1,098	1,063	1,088	1,077	1,058	1,075	1,058	1,035	1,063	12,952	22
PAYROLL TAXES	426	408	395	382	370	379	433	425	432	425	416	427	4,918	22
TRAVEL	77	114	110	106	103	106	66	64	65	64	63	65	1,003	24
IN SERVICE	330	103	100	97	94	96	178	175	178	175	171	176	1,872	23
MEDICAL CONSULT	0	0	0	0	0	0	98	97	98	97	95	97	582	9
MACHINE RENTAL	22	36	35	34	33	34	20	20	20	20	19	20	313	6
OWNERS COMP	181	188	182	176	171	175	180	177	180	177	173	178	2,139	17
INS-PROP,LIAB,WC	33	(34)	(33)	(32)	(31)	(32)	29	29	29	29	28	29	43	26
DEPRECIATION	152	167	161	156	151	155	163	161	163	160	157	161	1,909	30
RENT	407	413	399	386	374	383	416	409	416	409	400	411	4,823	34
MAINTENANCE	84	119	115	111	108	110	94	92	94	92	90	92	1,202	6
FEES & PUBLICAT	8	32	31	30	29	30	12	12	12	12	11	12	229	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	\$8,658	\$9,105	\$8,799	\$8,527	\$8,257	\$8,452	\$8,471	\$8,319	\$8,455	\$8,315	\$8,140	\$8,353	\$101,850	
FIXED ASSETS													101,850	
EQUIP - PRIOR	12,999	9,218	8,909	8,634	8,360	8,558	14,096	13,843	14,069	13,837	13,545	13,900	11,664	
EQUIP - CURR	384	5,105	4,933	4,781	4,630	4,739	0	0	131	129	126	217	2,098	
EQUIP - FULLY DEP	4,189	4,243	4,100	3,974	3,848	3,939	4,175	4,101	4,167	4,099	4,012	4,117	4,080	
BLDG - PRIOR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	1,476	1,495	1,444	1,400	1,355	1,387	1,471	1,444	1,468	1,444	1,413	1,450	1,437	

OCCUPIED DAYS 2005	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,230	2,499	1,744		1,682	1,970	10,125
FEBRUARY		1,998	2,290	1,533		1,485	1,797	9,103
MARCH		2,199	2,453	1,727		1,679	1,945	10,003
APRIL		2,085	2,215	1,594		1,566	1,994	9,454
MAY		2,095	2,132	1,655		1,500	2,054	9,436
JUNE		1,942	2,069	1,677		1,402	1,975	9,065
JULY		2,118	2,026	1,781		1,315	1,994	9,234
AUGUST		2,091	2,047	1,833		1,280	1,960	9,211
SEPTEMBER		2,059	1,881	1,778		1,163	1,877	8,758
OCTOBER		2,210	1,902	1,854		1,173	1,999	9,138
NOVEMBER		2,175	1,844	1,936		1,216	1,978	9,149
DECEMBER		2,329	2,001	2,007		1,332	2,030	9,699
TOTAL	0	25,531	25,359	21,119	0	16,793	23,573	112,375 112,375

OCCUPIED DAYS 2006	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,331	2,170	2,010		1,459	1,952	9,922
FEBRUARY	2,071	1,914	1,868		1,302	1,756	8,911
MARCH	2,411	2,193	2,142		1,383	1,917	10,046
APRIL	2,269	2,014	2,034		1,346	1,718	9,381
MAY	2,177	1,972	2,041		1,447	1,746	9,383
JUNE	2,081	1,987	2,014		1,386	1,745	9,213
JULY	2,181	2,119	2,133		1,338	1,765	9,536
AUGUST							
SEPTEMBER							
OCTOBER							
NOVEMBER							
DECEMBER							
TOTAL	15,521	14,369	14,242	0	9,661	12,599	66,392 66,392

ALLOCATION PERCENTAGE 2005	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
FEBRUARY	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
MARCH	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
APRIL	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
MAY	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
JUNE	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%
JULY	0.00%	22.94%	21.94%	19.29%	14.24%	21.59%	100.00%
AUGUST	0.00%	22.70%	22.22%	19.90%	13.90%	21.28%	100.00%
SEPTEMBER	0.00%	23.51%	21.48%	20.30%	13.28%	21.43%	100.00%
OCTOBER	0.00%	24.18%	20.81%	20.29%	12.84%	21.88%	100.00%
NOVEMBER	0.00%	23.77%	20.16%	21.16%	13.29%	21.62%	100.00%
DECEMBER	0.00%	24.01%	20.63%	20.69%	13.73%	20.93%	100.00%

ALLOCATION PERCENTAGE 2006	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	23.49%	21.87%	20.26%	14.70%	19.67%	100.00%
FEBRUARY	23.24%	21.48%	20.96%	14.61%	19.71%	100.00%
MARCH	24.00%	21.83%	21.32%	13.77%	19.08%	100.00%
APRIL	24.19%	21.47%	21.68%	14.35%	18.31%	100.00%
MAY	23.20%	21.02%	21.75%	15.42%	18.61%	100.00%
JUNE	22.59%	21.57%	21.86%	15.04%	18.94%	100.00%
JULY	22.87%	22.22%	22.37%	14.03%	18.51%	100.00%