

		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: 0047597

Facility Name: Jerseyville Manor

Address: 1251 North State Street Jerseyville 62052
 Number City Zip Code

County: Jersey

Telephone Number: (618) 498-6441 **Fax #** (618) 498-9025

HFS ID Number: 37-1504181001

Date of Initial License for Current Owners: 09/28/05

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" 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 <u>501 (c) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input 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: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2005 to 09/30/2006 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.

(Signed) _____ (Date) _____

Officer or Administrator of Provider (Type or Print Name) Ron Bishop

(Title) Director of Operations

(Signed) See Attached Independent Accountant's Report (Date) _____

Paid Preparer (Print Name and Title) McGladrey & Pullen, LLP
117 E. Main Street, Suite 210

(Firm Name & Address) P.O. Box 1070
Galesburg, IL 61401

(Telephone) (309)342-1175 Fax # (309)342-7816

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 Jerseyville Manor# 0047597 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	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	<u>13,494</u>	<u>13,248</u>	<u>3,679</u>	<u>30,421</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>0</u>			12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,494</u>	<u>13,248</u>	<u>3,679</u>	<u>30,421</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.59%

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 10/01/05

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

YES Date 09/28/05 NO

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

YES NO If YES, enter number
of beds certified 92 and days of care provided 3,679Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 09/30/06 Fiscal Year: 09/30/06

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

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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	143,542	10,496	7,200	161,238		161,238		161,238			1
2	Food Purchase		156,839		156,839		156,839		156,839			2
3	Housekeeping	81,082	25,560		106,642		106,642		106,642			3
4	Laundry	43,180	10,260		53,440		53,440		53,440			4
5	Heat and Other Utilities			79,470	79,470		79,470		79,470			5
6	Maintenance	36,688	29,300	32,005	97,993		97,993		97,993			6
7	Other (specify):*											7
8	TOTAL General Services	304,492	232,455	118,675	655,622		655,622		655,622			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,072,190	229,169	1,764	1,303,123		1,303,123		1,303,123			10
10a	Therapy	4,061		220,212	224,273		224,273		224,273			10a
11	Activities	60,195	2,816		63,011		63,011		63,011			11
12	Social Services	14,700			14,700		14,700		14,700			12
13	CNA Training			994	994		994		994			13
14	Program Transportation			165	165	1,775	1,940		1,940			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,151,146	231,985	229,135	1,612,266	1,775	1,614,041		1,614,041			16
	C. General Administration											
17	Administrative	111,577			111,577		111,577		111,577			17
18	Directors Fees							1,409	1,409			18
19	Professional Services			175,903	175,903		175,903	702	176,605			19
20	Dues, Fees, Subscriptions & Promotions			47,058	47,058		47,058	(34,364)	12,694			20
21	Clerical & General Office Expenses	27,529	23,782	25,133	76,444		76,444	1,025	77,469			21
22	Employee Benefits & Payroll Taxes			271,637	271,637		271,637	6,171	277,808			22
23	Inservice Training & Education			2,927	2,927		2,927		2,927			23
24	Travel and Seminar			1,674	1,674		1,674	1,374	3,048			24
25	Other Admin. Staff Transportation			3,549	3,549	(1,775)	1,774	1,236	3,010			25
26	Insurance-Prop.Liab.Malpractice			85,609	85,609		85,609	51,913	137,522			26
27	Other (specify):* See Att Sch VI	14,448		1,758	16,206		16,206	(16,206)				27
28	TOTAL General Administration	153,554	23,782	615,248	792,584	(1,775)	790,809	13,260	804,069			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,609,192	488,222	963,058	3,060,472		3,060,472	13,260	3,073,732			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 Jerseyville Manor #0047597 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			14,200	14,200		14,200	137,463	151,663			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							232,687	232,687			32
33	Real Estate Taxes							50,328	50,328			33
34	Rent-Facility & Grounds			382,582	382,582		382,582	(382,582)				34
35	Rent-Equipment & Vehicles			1,438	1,438		1,438		1,438			35
36	Other (specify):* See Att Sch IV							4,927	4,927			36
37	TOTAL Ownership			398,220	398,220		398,220	42,823	441,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			19,339	19,339		19,339		19,339			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,904	3,904		3,904		3,904			41
42	Provider Participation Fee			50,370	50,370		50,370		50,370			42
43	Other (specify):*			66	66		66		66			43
44	TOTAL Special Cost Centers			73,679	73,679		73,679		73,679			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,609,192	488,222	1,434,957	3,532,371		3,532,371	56,083	3,588,454			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 Jerseyville Manor

0047597

Report Period Beginning: 10/01/2005

Ending: 09/30/2006

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	(622)	V-30		9
10	Interest and Other Investment Income	(752)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(34,548)	V-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 See Att Sch VII	(16,206)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,128)		\$	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)	96,086		34
35	Other- Attach Schedule See Att Sch III	12,125		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 108,211		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 56,083		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

Jerseyville Manor

ID# 0047597
 Report Period Beginning: 10/01/2005
 Ending: 09/30/2006

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

Facility Name & ID Number Jerseyville Manor

0047597

Report Period Beginning:

10/01/2005 Ending:

Summary B

09/30/2006

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	96,086	0	0	0	0	0	0	0	0	0	96,086	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	96,086	0	96,086	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)	0	96,086	0	96,086	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
See Attached Schedule I		See Attached Schedule I		See Attached Schedule I		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility rent	\$ 382,582	Jerseyville North State, LLC	N/A	\$ 478,668	\$ 96,086	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 382,582			\$ 478,668	\$ * 96,086	14

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

Facility Name & ID Number

Jerseyville Manor

#

0047597

Report Period Beginning:

10/01/2005

Ending:

09/30/2006

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	See Attached Schedules II & III								\$ 1,409	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,409		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 Jerseyville Manor

0047597

Report Period Beginning: 10/01/2005

Ending: 9/30/2006

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 Unlimited Development, Inc.
 Street Address 115 East South St
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309)343-1550
 Fax Number (309)343-2857

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Attached Schedule II & III							49,585	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				\$	\$		\$	49,585

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Realty Capital		X	Facility purchase	\$73,012.50	09/01/05	\$ 4,173,000	\$ 4,134,041	7/1/39	5.6200	\$ 233,439	1
2	LTD. Of Illinois											2
3												3
4												4
5												5
	Working Capital											
6	Miscellaneous											6
7												7
8	Less Interest Income										(752)	8
9	TOTAL Facility Related				\$73,012.50		\$ 4,173,000	\$ 4,134,041			\$ 232,687	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 4,173,000	\$ 4,134,041			\$ 232,687	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 45,389 Line # 26

* 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.)

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 Jerseyville Manor COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0047597

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

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>04-127-014-00</u>	<u>S17T8R11 Unplatted Parcels</u>	<u>\$ 50,292.00</u>	<u>\$ 50,292.00</u>
2. _____	<u>PT SE 1/4 TRACT 1</u>	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
4. <u>04-127-015-00</u>	<u>S17T8R11 Unplatted Parcels</u>	<u>\$ 841.00</u>	<u>\$ 841.00</u>
5. _____	<u>PT SE 1/4 TRACT 2</u>	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
TOTALS		<u>\$ 51,133.00</u>	<u>\$ 51,133.00</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 Jerseyville Manor# 0047597 Report Period Beginning:10/01/2005 Ending:09/30/2006**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 27,762 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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>Facility</u>	<u>3.5 Acres</u>	<u>2005</u>	<u>\$ 160,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 160,000	3

Facility Name & ID Number Jerseyville Manor

0047597

Report Period Beginning:

10/01/2005 Ending:

09/30/2006

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	92		2005		\$ 4,578,867	\$ 114,472	40	\$ 114,472	\$	\$ 124,011	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Attic Insulation		2005		5,952	397	15	397		397	9
10	Water Heater		2005		3,442	315	10	315		315	10
11	Parking Lot Lighting		2006		5,355	178	15	178		178	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

*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 Jerseyville Manor

0047597

Report Period Beginning:

10/01/2005

Ending:

09/30/2006

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								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)	\$ 4,593,616	\$ 115,362		\$ 115,362	\$	\$ 124,901	70

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

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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	\$ 236,133	\$ 23,613	\$ 23,613	\$	10 yrs	\$ 25,581	71
72	Current Year Purchases	14,906	910	910		5-15 yrs	910	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (see Attached Sch III)							74
75	TOTALS	\$ 251,039	\$ 24,523	\$ 24,523	\$		\$ 26,491	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	Patient Care	2005 Ford E 350	2005	\$ 47,110	\$ 11,778	\$ 11,778	\$	4 yrs	\$ 11,778	76
77										77
78										78
79										79
80	TOTALS			\$ 47,110	\$ 11,778	\$ 11,778	\$		\$ 11,778	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)	\$ 5,051,765	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,663	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 151,663	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 163,170	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	2003 GMC G3500 Van - 2006	\$ 29,848	\$ 622	\$ 622	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 29,848	\$ 622	\$ 622	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Jerseyville Manor

0047597

Report Period Beginning: 10/01/2005

Ending: 09/30/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Jerseyville North State, LLC

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>See Attached</u>			3
4	Additions				<u>Schedule IV - Related Party Lease</u>			4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</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 N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ Amount not determin Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.

Facility Name & ID Number Jerseyville Manor# 0047597

Report Period Beginning:

10/01/2005 Ending:

09/30/2006

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 Jerseyville Manor# 0047597Report Period Beginning: 10/01/2005

Ending:

09/30/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 09/30/2006

(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	\$ 174,518	\$ 185,797	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>62,319</u>)	533,743	533,743	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,250	1,250	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VIII</u>	80,336	482,945	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 789,847	\$ 1,203,735	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		160,000	13
14	Buildings, at Historical Cost		4,578,867	14
15	Leasehold Improvements, at Historical Cost	14,749	14,749	15
16	Equipment, at Historical Cost	91,864	327,997	16
17	Accumulated Depreciation (book methods)	(14,200)	(163,792)	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)	\$ 92,413	\$ 4,917,821	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 882,260	\$ 6,121,556	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 98,368	\$ 127,382	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,345	26,345	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,624	4,624	31
32	Accrued Real Estate Taxes(Sch.IX-B)		37,755	32
33	Accrued Interest Payable		19,360	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision payable</u>	141,296	1,282,471	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 270,633	\$ 1,497,937	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,134,041	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Security deposits</u>	46,500	46,500	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 46,500	\$ 4,180,541	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 317,133	\$ 5,678,478	46
47	TOTAL EQUITY (page 18, line 24)	\$ 565,127	\$ 443,078	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 882,260	\$ 6,121,556	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,041)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,041)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	566,168	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 566,168	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)	\$ 565,127	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Jerseyville Manor# 0047597Report Period Beginning: 10/01/2005Ending: 09/30/2006**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	\$ 4,048,410	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,048,410	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,476	12
13	Barber and Beauty Care	4,916	13
14	Non-Patient Meals	269	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)	\$ 11,661	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	752	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 752	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Att. Sch X</u>	256	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 256	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,061,079	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	655,622	31
32	Health Care	1,612,266	32
33	General Administration	755,124	33
B. Capital Expense			
34	Ownership	398,220	34
C. Ancillary Expense			
35	Special Cost Centers	23,309	35
36	Provider Participation Fee	50,370	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,494,911	40
41	Income before Income Taxes (line 30 minus line 40)**	566,168	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 566,168	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Jerseyville Manor

0047597

Report Period Beginning: 10/01/2005

Ending:

09/30/2006

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	1,859	1,978	\$ 45,641	\$ 23.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,953	2,078	41,550	20.00	3
4	Licensed Practical Nurses	16,332	17,374	269,302	15.50	4
5	CNAs & Orderlies	70,968	75,498	650,034	8.61	5
6	CNA Trainees					6
7	Licensed Therapist	30	30	1,340	44.67	7
8	Rehab/Therapy Aides	120	120	2,721	22.68	8
9	Activity Director	1,779	1,892	21,761	11.50	9
10	Activity Assistants	5,039	5,360	38,434	7.17	10
11	Social Service Workers	1,152	1,225	14,700	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,408	19,583	143,542	7.33	15
16	Dishwashers					16
17	Maintenance Workers	2,508	2,668	36,688	13.75	17
18	Housekeepers	9,623	10,238	81,082	7.92	18
19	Laundry	5,653	6,014	43,180	7.18	19
20	Administrator	1,756	1,868	55,677	29.81	20
21	Assistant Administrator	1,387	1,475	18,440	12.50	21
22	Other Administrative	1,045	1,111	14,448	13.00	22
23	Office Manager					23
24	Clerical	1,917	2,039	27,529	13.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,446	1,538	10,767	7.00	31
32	Other Health Care(specify)	3,571	3,799	54,896	14.45	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,546	155,888	\$ 1,571,732 *	\$ 10.08	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	***	\$ 7,200	1-3	35
36	Medical Director	***	6,000	9-3	36
37	Medical Records Consultant	***	213	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,506	10-3	39
40	Physical Therapy Consultant	***	180,581	10a-3	40
41	Occupational Therapy Consultant	***	38,134	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	1,497	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	45	10-3	46
47					47
48	<u>*** Monthly Fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 235,176		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 Jerseyville Manor

0047597

Report Period Beginning: 10/01/2005

Ending: 09/30/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Dana Seymour	Administrator		\$ 55,677	Workers' Compensation Insurance	\$ 95,872	IDPH License Fee	\$ 0		
Mary Mosby	Asst. Admin.		18,440	Unemployment Compensation Insurance	2,890	Advertising: Employee Recruitment	2,647		
				FICA Taxes	119,918	Health Care Worker Background Check			
				Employee Health Insurance	49,253	(Indicate # of checks performed <u>231</u>)	2,310		
				Employee Meals	0	Patient Background Checks	0		
				Illinois Municipal Retirement Fund (IMRF)*	0	IHCA Dues	3,913		
				401(k) Plan Contributions	1,873	Advertising - Promotion	33,283		
Indirect costs - see Att. Sch III			37,460	Other Employee Benefits	1,526	Other Subscriptions Licenses and Fees	3,640		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 111,577	Employee Appreciation	305	Advertising - Yellow Page	1,265		
(List each licensed administrator separately.)						Indirect Costs - See Att Sch III	184		
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount	Indirect costs - see Att. Sch III			6,171	Non-allowable advertising (33,283)	
			\$				Yellow page advertising (1,265)		
				TOTAL (agree to Schedule V, line 22, col.8)			\$ 277,808	TOTAL (agree to Sch. V, line 20, col. 8)	
								\$ 12,694	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services							Out-of-State Travel		
Vendor/Payee	Type		Amount					\$	
RFMS, Inc.	Administrative Services		\$ 171,600				In-State Travel		
McGladrey & Pullen	Accounting Services		4,259				Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)		
Davis & Campbell	Legal Fees		44				Seminar Expense		
							Less: Non-allowable out-of-sate travel		
							Indirect costs - See Att Sch III		
							1,374		
							Entertainment Expense ()		
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 175,903	TOTAL			\$	3,048	
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

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? Yes
If YES, give association name and amount. See Page 21, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA Dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,867 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 269
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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? 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed
- (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.