

		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: 0039339

Facility Name: Jerseyville Nursing & Rehabilitation Center

Address: 101 South State Street Jerseyville 62052
 Number City Zip Code

County: Jersey

Telephone Number: (618) 498-6496 **Fax #** (618) 498-7435

HFS ID Number: 37-1323741

Date of Initial License for Current Owners: 04/01/1994

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: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>J. Terry Dooling</u>	
	(Title) <u>Treasurer</u>	
Paid Preparer	(Signed) <u>See Accountants Compilation Report</u>	(Date) _____
	(Print Name and Title) <u>J. Terry Dooling</u> <u>Partner</u>	
	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>	
	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	

**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**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>36,865</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>101</u>	TOTALS	<u>101</u>	<u>36,865</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>9,337</u>	<u>6,782</u>	<u>16,119</u>	8
9	SNF/PED					9
10	ICF	<u>17,774</u>			<u>17,774</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,774</u>	<u>9,337</u>	<u>6,782</u>	<u>33,893</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.94%

D. How many bed-hold days during this year were paid by the Department?

None (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)

Outpatient Therapy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 04/01/1994

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

YES Date 04/01/1994 NO

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

YES NO If YES, enter number of beds certified 101 and days of care provided 6,782

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	191,647	24,561	7,121	223,329		223,329		223,329		1
2	Food Purchase		190,300		190,300		190,300	(352)	189,948		2
3	Housekeeping	97,610	17,003		114,613		114,613		114,613		3
4	Laundry	88,561	20,069		108,630		108,630		108,630		4
5	Heat and Other Utilities			95,131	95,131		95,131	614	95,745		5
6	Maintenance	50,310	9,455	40,603	100,368		100,368	675	101,043		6
7	Other (specify):* Waste Removal			6,356	6,356		6,356		6,356		7
8	TOTAL General Services	428,128	261,388	149,211	838,727		838,727	937	839,664		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,285,948	143,426	34,674	1,464,048	349	1,464,397	(200)	1,464,197		10
10a	Therapy	32,143	2,276	450,059	484,478		484,478	(41,810)	442,668		10a
11	Activities	44,470	4,237	4,344	53,051	1,192	54,243		54,243		11
12	Social Services	59,624	37	1,599	61,260		61,260		61,260		12
13	CNA Training										13
14	Program Transportation		3,380		3,380		3,380		3,380		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,422,185	153,356	500,276	2,075,817	1,541	2,077,358	(42,010)	2,035,348		16
	C. General Administration										
17	Administrative	78,782	9,853	259,911	348,546	(2,501)	346,045	(219,700)	126,345		17
18	Directors Fees			60,000	60,000		60,000	(60,000)			18
19	Professional Services			70,882	70,882	392	71,274	21,407	92,681		19
20	Dues, Fees, Subscriptions & Promotions			28,763	28,763	187	28,950	(8,595)	20,355		20
21	Clerical & General Office Expenses	50,449	17,519	63,873	131,841		131,841	24,842	156,683		21
22	Employee Benefits & Payroll Taxes			293,460	293,460		293,460	11,078	304,538		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,334	11,334	381	11,715	7,299	19,014		24
25	Other Admin. Staff Transportation							1,463	1,463		25
26	Insurance-Prop.Liab.Malpractice			49,812	49,812		49,812	(8,036)	41,776		26
27	Other (specify):*										27
28	TOTAL General Administration	129,231	27,372	838,035	994,638	(1,541)	993,097	(230,242)	762,855		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,979,544	442,116	1,487,522	3,909,182		3,909,182	(271,315)	3,637,867		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Nursing & Rehabilitation Center #0039339 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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			165,412	165,412	165,412	3,856	169,268				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			578,963	578,963	578,963	(3,247)	575,716				32
33	Real Estate Taxes			51,547	51,547	51,547	909	52,456				33
34	Rent-Facility & Grounds						3,945	3,945				34
35	Rent-Equipment & Vehicles			2,936	2,936	2,936		2,936				35
36	Other (specify):* Mortgage Ins.			17,643	17,643	17,643		17,643				36
37	TOTAL Ownership			816,501	816,501	816,501	5,463	821,964				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		229,456	28,034	257,490	257,490		257,490				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,298	55,298	55,298		55,298				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		229,456	83,332	312,788	312,788		312,788				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,979,544	671,572	2,387,355	5,038,471	5,038,471	(265,852)	4,772,619				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(352)	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				9
10	Interest and Other Investment Income	(3,247)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,647)	20		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	(2,257)	24		19
20	Contributions	(50)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals	(10,247)	26		23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,132)	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	(4,375)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,307)		\$	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)	(237,545)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (237,545)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (265,852)		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						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Jerseyville Nursing & Rehabilitation Center

ID# 0039339

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Offset misc income against expense	\$ (476)	22 1
2	Offset misc income against expense	(67)	21 2
3	Offset misc income against expense	(200)	10 3
4	Eliminate PAC & lobbying dues	(1,749)	20 4
5	Eliminate promotional advertising	(234)	17 5
6	Eliminate non-allowable meals and entertainment	(424)	17 6
7	Eliminate employee advances	(230)	17 7
8	Eliminate expense for 2007 IDPH license paid in 2006	(995)	20 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	(4,375)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(352)	0	0	0	0	0	0	0	0	0	0	(352)	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	614	0	0	0	0	0	0	0	0	0	614	5
6	Maintenance	0	675	0	0	0	0	0	0	0	0	0	675	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(352)	1,289	0	0	0	0	0	0	0	0	0	937	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	(200)	0	0	0	0	0	0	0	0	0	0	(200)	10
10a	Therapy	0	0	(41,810)	0	0	0	0	0	0	0	0	(41,810)	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	(200)	0	(41,810)	0	(42,010)	16							
	C. General Administration													
17	Administrative	(938)	41,149	(259,911)	0	0	0	0	0	0	0	0	(219,700)	17
18	Directors Fees	0	0	(60,000)	0	0	0	0	0	0	0	0	(60,000)	18
19	Professional Services	0	2,400	19,007	0	0	0	0	0	0	0	0	21,407	19
20	Fees, Subscriptions & Promotions	(10,523)	1,928	0	0	0	0	0	0	0	0	0	(8,595)	20
21	Clerical & General Office Expenses	(67)	24,909	0	0	0	0	0	0	0	0	0	24,842	21
22	Employee Benefits & Payroll Taxes	(476)	11,554	0	0	0	0	0	0	0	0	0	11,078	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,257)	9,556	0	0	0	0	0	0	0	0	0	7,299	24
25	Other Admin. Staff Transportation	0	1,463	0	0	0	0	0	0	0	0	0	1,463	25
26	Insurance-Prop.Liab.Malpractice	(10,247)	2,211	0	0	0	0	0	0	0	0	0	(8,036)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(24,508)	95,170	(300,904)	0	(230,242)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,060)	96,459	(342,714)	0	(271,315)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	3,856	0	0	0	0	0	0	0	0	0	3,856	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,247)	0	0	0	0	0	0	0	0	0	0	(3,247)	32
33	Real Estate Taxes	0	909	0	0	0	0	0	0	0	0	0	909	33
34	Rent-Facility & Grounds	0	3,945	0	0	0	0	0	0	0	0	0	3,945	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	(3,247)	8,710	0	0	0	0	0	0	0	0	0	5,463	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)	(28,307)	105,169	(342,714)	0	(265,852)	45							

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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
John H. Rothert	60.00	Mongomery Nursing and Rehabilitation Ctr., Inc.	Hillsboro, IL	Wellington Mgt. Co.	Chesterfield, MO	Mangement Co.
David L. Kamler	15.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Mangement Co.
J. Terry Dooling	15.00	Spanish Lake Nursing and Rehabilitation Ctr.	Florissant, MO	C.J. Schlosser & Co.	Alton, IL	Public Accountants
Jack Yaeger	10.00			NW Reahb, L.L.C.	Alton, IL	Therapy Co.
				Three Amigos, L.L.C.	Alton, IL	Real Estate Co.

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	5 See Schedule VIII	\$	Wellington Management Co.	60.00%	\$ 614	\$ 614	1
2	V	6 See Schedule VIII		Wellington Management Co.	60.00%	675	675	2
3	V	17 See Schedule VIII		Wellington Management Co.	60.00%	41,149	41,149	3
4	V	19 See Schedule VIII		Wellington Management Co.	60.00%	2,400	2,400	4
5	V	20 See Schedule VIII		Wellington Management Co.	60.00%	1,928	1,928	5
6	V	21 See Schedule VIII		Wellington Management Co.	60.00%	24,909	24,909	6
7	V	22 See Schedule VIII		Wellington Management Co.	60.00%	11,554	11,554	7
8	V	24 See Schedule VIII		Wellington Management Co.	60.00%	9,556	9,556	8
9	V	25 See Schedule VIII		Wellington Management Co.	60.00%	1,463	1,463	9
10	V	26 See Schedule VIII		Wellington Management Co.	60.00%	2,211	2,211	10
11	V	30 See Schedule VIII		Wellington Management Co.	60.00%	3,856	3,856	11
12	V	33 See Schedule VIII		Wellington Management Co.	60.00%	909	909	12
13	V	34 See Schedule VIII		Wellington Management Co.	60.00%	3,945	3,945	13
14	Total		\$			\$ 105,169	\$ * 105,169	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)
15	V		\$			\$	\$
16	V	17 Management Fees	187,136	Wellington Management Co.	60.00%		(187,136)
17	V	17 Management Fees	72,775	Health Care Financial, L.L.C.	40.00%		(72,775)
18	V	19 Professional Services	52,883	C.J. Schlosser & Company, L.L.C.	40.00%	71,890	19,007
19	V	10a Therapy Services	450,059	NW Rehab, L.L.C.	100.00%	408,249	(41,810)
20	V	10 Nurse Consultant	28,624	Wellington Management Co.	60.00%	28,624	
21	V	18 Director's Fees	36,000	John H. Rothert	60.00%		(36,000)
22	V	18 Director's Fees	12,000	J. Terry Dooling	15.00%		(12,000)
23	V	18 Director's Fees	12,000	David L. Kamler	15.00%		(12,000)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 851,477			\$ 508,763	\$ * (342,714)

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	John H. Rothert	President	Administrative	60.00	139,180	9.07	22.68	Salary	\$ 40,820	17,8	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	\$ 40,820		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

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

Name of Related Organization Wellington Management Corporation
 Street Address 750 Spirit 40 Park Drive
 City / State / Zip Code Chesterfield, MO 63005
 Phone Number (636) 537-8447
 Fax Number (636) 537-8446

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	5	Heat and Other Utilities	Accumulated Costs	18,906,420	5	\$ 2,708	\$ 4,287,509	\$ 614	1	
2	6	Maintenance	Accumulated Costs	18,906,420	5	2,977	4,287,509	675	2	
3	17	Administrative	Accumulated Costs	18,906,420	5	181,451	181,451	4,287,509	41,149	3
4	19	Professional Services	Accumulated Costs	18,906,420	5	10,584	4,287,509	2,400	4	
5	20	Dues, Fees, Subs, & Promos	Accumulated Costs	18,906,420	5	8,500	4,287,509	1,928	5	
6	21	Clerical and General Office Exp.	Accumulated Costs	18,906,420	5	109,841	109,841	4,287,509	24,909	6
7	22	Employee Benefits and PR Taxes	Accumulated Costs	18,906,420	5	50,950	4,287,509	11,554	7	
8	24	Travel and Seminar	Accumulated Costs	18,906,420	5	42,140	4,287,509	9,556	8	
9	25	Other Admin Staff Transport	Accumulated Costs	18,906,420	5	6,451	4,287,509	1,463	9	
10	26	Insurance - Prop, Liab, Malprac.	Accumulated Costs	18,906,420	5	9,751	4,287,509	2,211	10	
11	30	Depreciation	Accumulated Costs	18,906,420	5	17,005	4,287,509	3,856	11	
12	33	Real Estate Taxes	Accumulated Costs	18,906,420	5	4,008	4,287,509	909	12	
13	34	Rent-Facility and Grounds	Accumulated Costs	18,906,420	5	17,395	4,287,509	3,945	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					\$ 463,761	\$ 291,292	\$ 105,169	25	

SEE ACCOUNTANTS' COMPILATION REPORT

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	GMAC Commercial Mortgage		X	Mortgage Loan	\$26,697.36	4/17/00	\$ 3,720,700	\$	5/1/2035	8.1000	\$ 390,813	1								
2	Capmark Finance, Inc.		X	Refinance Mortgage	\$20,841.58	10/31/06	3,720,700	3,715,280	10/31/41	5.8500	35,937	2								
3	Interest Income										(3,247)	3								
4	Loan Cost Amortization										151,976	4								
5												5								
Working Capital																				
6	First National Bank		X	Line of Credit	N/A	1/4/05	100,000		1/4/06			6								
7	First National Bank		X	Line of Credit	N/A	5/17/06	250,000		5/17/07		237	7								
8												8								
9	TOTAL Facility Related				\$47,538.94		\$ 7,791,400	\$ 3,715,280			\$ 575,716	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 7,791,400	\$ 3,715,280			\$ 575,716	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 17,643 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Nursing & Rehabilitation Center COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0039339

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

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>04-875-004-00</u>	<u>Outlots 59, 62, 63, & 64 S Pt. Outlot 6</u>	\$ <u>46,607.74</u>	\$ <u>46,607.74</u>
2. <u>04-208-017-00</u>	<u>S28 T8 R11 Unplatted Parcels</u>	\$ <u>3,439.20</u>	\$ <u>3,439.20</u>
3. _____	<u>S & W PT SE 1/4 NE 1/4 Less E PT</u>	\$ _____	\$ _____
4. _____	<u>Less .10 ACS for HWY</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>50,046.94</u>	\$ <u>50,046.94</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 Nursing & Rehabilitation Center

0039339 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,948 B. General Construction Type: Exterior Brick & Siding Frame Steel & Brick Number of Stories One

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).

None

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/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(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>158,994</u>	<u>1994</u>	<u>\$ 71,644</u>	1
2					2
3	TOTALS	158,994		\$ 71,644	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	101		1994		\$ 1,180,668	\$ 47,227	25	\$ 47,227		\$ 602,141	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Parking Lot		1994	26,304		5-10			26,304	9
10		Exterior Remodeling		1994	10,000	667	15	667		8,389	10
11		Flooring		1994	29,698		10			29,698	11
12		Electrical		1994	11,690	585	20	585		7,158	12
13		Air Conditioning		1994	25,830		10			25,830	13
14		Interior Remodeling		1994	40,265	1,359	5-20	1,359		36,331	14
15		Shed		1994	3,267		10			3,267	15
16		Nurses' Station		1994	6,055	303	20	303		3,810	16
17		Home Office Wallpapering/Flooring		1994	3,586		5			3,586	17
18		Painting		1995	7,392		5			7,392	18
19		Electrical		1995	3,382		10			3,382	19
20		Call Lights		1996	1,564	104	10	104		1,173	20
21		Storage Building		1996	3,500	350	10	350		3,500	21
22		2 Boilers		1996	7,400	370	20	370		4,039	22
23		Roof Repair & Drains Installed		1996	3,619	90	10	90		3,619	23
24		Ceiling Tile & End Caps		1996	3,506	292	12	292		2,970	24
25		Storage Building		1997	3,356	336	10	336		3,329	25
26		Alarm System		1997	1,750	175	10	175		1,735	26
27		Wallcovering		1997	6,355	318	5-10	318		6,249	27
28		Ceiling Tile & End Caps		1997	1,485	124	12	124		1,176	28
29		3 Windows & Sills & 1 Door Replaced		1997	4,108	274	15	274		2,556	29
30		Baseboards Remodeled		1997	1,166	117	10	117		1,089	30
31		Air Conditioner Unit		1997	2,185	219	10	219		2,071	31
32		Concrete Patio & Sidewalk		1997	1,842	123	15	123		1,146	32
33		Rock		1997	502		5			502	33
34		Landscaping		1997	1,075	107	10	107		1,039	34
35		Roofing		1998	2,592	259	10	259		2,311	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	Shower Room Remoded	1998	\$ 1,437	\$ 144	10	\$ 144	\$	\$ 1,282	37
38	Baseboard Remodeling	1998	1,919	192	10	192		1,655	38
39	Air Conditioning Units & Ducts	1998	13,420	1,280	10-20	1,280		10,859	39
40	Wallcoverings	1998	1,495	149	10	149		1,208	40
41	4 Air Conditioning Units	1999	2,840	284	10	284		2,107	41
42	Roofing	1999	35,386	3,539	10	3,539		27,424	42
43	Home Office Wallpapering	1999	603		5			603	43
44	3 Air Conditioning Units	2000	2,118	212	10	212		1,360	44
45	Wallcoverings	2000	2,231		5			2,231	45
46	Chair Railings	2000	6,267	418	15	418		2,539	46
47	Cove Base	2000	1,797	180	10	180		1,078	47
48	Constr. Of 400 Wing - Design, Architecture & Engineering	2001	67,723	2,709	25	2,709		14,899	48
49	Constr. Of 400 Wing - Contractor Costs	2001	943,708	37,748	25	37,748		207,615	49
50	Constr. Of 400 Wing - Drawing, Surety Bond, & Misc.	2001	11,223	449	25	449		2,469	50
51	Constr. Of 400 Wing - Interest & Mortgage Ins. Premiums	2001	89,316	3,573	25	3,573		19,650	51
52	400 Wing Nurse Call Station	2001	10,104	674	15	674		3,705	52
53	400 Wing Cable TV System Cabling	2001	1,962	196	10	196		1,079	53
54	400 Wing Fire Alarm System	2001	14,696	980	15	980		5,389	54
55	400 Wing Telecommunication System	2001	4,025	402	10	402		2,213	55
56	400 Wing Door Monitor system	2001	2,640	264	10	264		1,452	56
57	400 Wing TV Wall Mounts	2001	6,030	603	10	603		3,317	57
58	400 Wing Signage	2001	1,161	116	5	116		1,161	58
59	400 Wing Hand Rails & Wall Guards	2001	2,319	155	15	155		851	59
60	400 Wing Chair Rails, Wallpaper, & Border	2001	4,208	421	5	421		4,208	60
61	400 Wing Door Guard	2001	607	61	5	61		607	61
62	400 Wing Cubicle Tracks, Curtains, & Window Treatments	2001	15,188	1,160	5-20	1,160		9,990	62
63	Landscaping, Shrubs, & Trees	2001	11,744	1,174	10	1,174		6,752	63
64	Fencing	2001	4,200	525	8	525		2,975	64
65	Wallpaper & Border - Existing Facility	2001	55,671	702	5	702		55,671	65
66	Storage Building	2001	3,268	327	10	327		1,907	66
67	Carpet - Administrative Offices	2001	2,687	90	5	90		2,687	67
68	Nurse Call System - Existing Facility	2001	3,700	247	15	247		1,378	68
69	Alarm System Services - Existing Facility	2001	3,903	260	15	260		1,561	69
70	TOTAL (lines 4 thru 69)		\$ 2,723,738	\$ 112,633		\$ 112,633	\$	\$ 1,199,674	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	
1	Totals from Page 12A, Carried Forward		\$ 2,723,738	\$ 112,633		\$ 112,633	\$	\$ 1,199,674	1
2	Replacement Signage - Existing Facility	2001	3,656	122	5	122		3,656	2
3	Door Guards - Existing Facility	2001	1,979	165	5	165		1,979	3
4	Vinyl Flooring & Cove Base 400 Wing	2001	11,615	1,162	10	1,162		6,389	4
5	25 Overbed Lights	2001	1,625	162	10	162		880	5
6	Painting Door Frames	2001	8,932	446	5	446		8,932	6
7	2P 50 Amp Disconnect	2001	955	48	20	48		259	7
8	Mini Blinds, Balances & Rods	2001	14,744	2,458	5	2,458		14,744	8
9	Asphalt Paving of Parking Lot	2001	14,193	1,419	10	1,419		8,042	9
10	A/C Units	2001	3,424	342	10	342		1,899	10
11	Overbed Lights	2002	3,055	306	10	306		1,480	11
12	Cubicle Curtains	2002	6,155	1,231	5	1,231		5,864	12
13	A/C Units - 2	2002	1,398	140	10	140		653	13
14	Security Camera System	2002	1,010	202	5	202		909	14
15	Fire Doors	2002	1,543	103	15	103		463	15
16	Roofing - North Entrance	2002	1,680	168	10	168		700	16
17	Wall Guard & End Caps	2002	1,497	100	15	100		416	17
18	Door Canopy	2002	3,800	253	15	253		1,013	18
19	Landscaping	2002	1,729	173	10	173		735	19
20	Home Office Light Fixtures	2002	218		10	22	22	107	20
21	Landscaping, Plants, Trees	2003	18,903	1,890	10	1,890		6,449	21
22	A/C Units	2003	5,551	555	10	555		1,961	22
23	Home Office Cabinets	2003	946		10	94	94	331	23
24	Landscaping, Plants, Trees	2004	4,371	437	10	437		1,129	24
25	100 Amp Transfer Switch to Generator	2004	11,865	791	15	791		2,175	25
26	Smoke Detectors	2004	1,600	160	10	160		427	26
27	Extend Activities Wall/Replace Door	2004	2,002	133	15	133		355	27
28	Air Conditioners	2004	1,814	181	10	181		453	28
29	Cove Base	2004	2,188	219	10	219		547	29
30	Hollow Metal Double Doors	2004	8,520	426	20	426		888	30
31	Wall/Flooring Kitchen	2004	2,983	298	10	298		596	31
32	Landscaping	2005	1,142	114	10	114		190	32
33	Cubicle Curtains	2005	289	58	5	58		101	33
34	TOTAL (lines 1 thru 33)		\$ 2,869,120	\$ 126,895		\$ 127,011	\$ 116	\$ 1,274,396	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	
1	Totals from Page 12B, Carried Forward		\$ 2,869,120	\$ 126,895		\$ 127,011	\$ 116	\$ 1,274,396	1
2	Generator Control Panel	2005	3,689	307	12	307		384	2
3	Resident Room Doors	2005	19,393	1,293	15	1,293		1,691	3
4	Fire Doors	2005	4,955	492	5-15	492		964	4
5	Water Heater	2005	4,000	400	10	400		633	5
6	Generator	2005	5,690	474	12	474		513	6
7	3 A/C's	2005	1,753	175	10	175		175	7
8	Electrical Wiring	2005	4,862	243	20	243		283	8
9	Dishwasher Booster Heater	2005	1,766	177	10	177		176	9
10	Kitchen & Laundry Flooring	2005	2,556	255	10	255		276	10
11	4-Door Monitoring System	2006	2,696	112	10	112		112	11
12	2 Door Awnings	2006	1,671	37	15	37		37	12
13	Built-In Waterfall	2006	3,499	204	10	204		204	13
14	Drywall & Supplies - Lobby	2006	1,234	34	15	34		34	14
15	Wallpaper	2006	5,219	215	5	215		215	15
16	Labor for Lobby Remodel	2006	17,774	197	15	197		197	16
17	4 Ton Heat Pump	2006	5,580	47	10	47		47	17
18	Doors	2006	47,653	1,627	10-15	1,627		1,627	18
19	A/C Units	2006	9,474	322	15	322		322	19
20	Flooring	2006	6,924	422	10	422		422	20
21	Ceiling Tiles	2006	4,411	61	8-10	61		61	21
22	Sprinkler System	2006	5,025	141	25	141		141	22
23	Carpet	2006	3,419	168	5	168		168	23
24	Electrical Wiring	2006	15,869	124	20	124		124	24
25	Smoke Damper	2006	1,793	75	20	75		75	25
26	Vinyl Fencing	2006	12,359	206	10	206		206	26
27	Concrete Patios and Sidewalks	2006	10,744	119	15	119		119	27
28	Landscaping	2006	4,325	360	10	360		360	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,077,453	\$ 135,182		\$ 135,298	\$ 116	\$ 1,283,962	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	\$ 272,866	\$ 25,872	\$ 27,147	\$ 1,275	3-20	\$ 149,513	71
72	Current Year Purchases	51,462	1,402	1,413	11	3-20	1,413	72
73	Fully Depreciated Assets	311,546	1,456	1,461	5	5-10	311,547	73
74								74
75	TOTALS	\$ 635,874	\$ 28,730	\$ 30,021	\$ 1,291		\$ 462,473	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	Facility Use	2000 Dodge Caravan	2005	\$ 6,000	\$ 1,500	\$ 1,500		4	\$ 2,625	76
77	Home Office-Admin	2000 Ford Taurus	2000	5,401				4	5,401	77
78	Home Office-Admin	1998 Jaguar	2004	5,096		1,274	1,274	4	3,185	78
79	See Attached Schedule			8,515		1,175	1,175	4	2,817	79
80	TOTALS			\$ 25,012	\$ 1,500	\$ 3,949	\$ 2,449		\$ 14,028	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)		\$ 3,809,983	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 165,412	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 169,268	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 3,856	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,760,463	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	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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?

N/A YES N/A NO

16. Rental Amount for movable equipment: \$ 2,864 Description: Copier \$2271; Postage Machine \$593

(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	<u>Section N/A</u>		\$	\$	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? N/A - Only hire certified aides</p> <p><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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	10a,8	6148 hrs	\$ 163,070		\$	\$ 986	6,148	\$ 164,056	1
2	Licensed Speech and Language Development Therapist	10a,8	1887 hrs	82,687			222	1,887	82,909	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	6047 hrs	162,492			1,068	6,047	163,560	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				229,456		229,456	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory Fees	39,3				23,894				
	Other (specify): X-Rays	39,3				4,140			4,140	13
14	TOTAL			\$ 408,249		\$ 28,034	\$ 231,732	14,082	\$ 644,121	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339Report Period Beginning: 01/01/2006

Ending:

12/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2006

(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	\$ 591,828	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (43,902))	1,200,399		3
4	Supply Inventory (priced at)	10,904		4
5	Short-Term Investments			5
6	Prepaid Insurance	47,216		6
7	Other Prepaid Expenses	2,280		7
8	Accounts Receivable (owners or related parties)	207,690		8
9	Other(specify): <u>Resident Refunds Payable</u>	30		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,060,347	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	185,096		13
14	Buildings, at Historical Cost	2,958,668		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	625,757		16
17	Accumulated Depreciation (book methods)	(1,731,289)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	103,700		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	67,101		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,229,233	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,289,580	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 337,916	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1		29
30	Accrued Salaries Payable	95,881		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,418		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,500		32
33	Accrued Interest Payable			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)	\$ 512,716	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,783,554		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)	\$ 3,783,554	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,296,270	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,690)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,289,580	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (142,688)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (142,688)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	135,998	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)	\$ 135,998	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)	\$ (6,690)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339Report Period Beginning: 01/01/2006Ending: 12/31/2006**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	\$ 5,283,658	1
2	Discounts and Allowances for all Levels	(1,054,537)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,229,121	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	16,158	5
6	Therapy	850,320	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 866,478	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,693	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	66	13
14	Non-Patient Meals	352	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	20,597	19
20	Radiology and X-Ray	3,730	20
21	Other Medical Services	33,214	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 59,652	23
D. Non-Operating Revenue			
24	Contributions	600	24
25	Interest and Other Investment Income***	3,247	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,847	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	1,705	28
28a	Miscellaneous Income	13,666	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,371	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,174,469	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	838,727	31
32	Health Care	2,075,817	32
33	General Administration	994,638	33
B. Capital Expense			
34	Ownership	816,501	34
C. Ancillary Expense			
35	Special Cost Centers	257,490	35
36	Provider Participation Fee	55,298	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,038,471	40
41	Income before Income Taxes (line 30 minus line 40)**	135,998	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 135,998	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Attached 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

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	1,952	2,149	\$ 52,395	\$ 24.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,479	7,965	145,571	18.28	3
4	Licensed Practical Nurses	21,632	22,883	384,433	16.80	4
5	CNAs & Orderlies	70,882	75,441	679,316	9.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,004	3,390	32,143	9.48	8
9	Activity Director					9
10	Activity Assistants	4,744	4,965	44,470	8.96	10
11	Social Service Workers	4,893	4,953	59,624	12.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,433	25,865	191,647	7.41	15
16	Dishwashers					16
17	Maintenance Workers	4,103	4,564	50,310	11.02	17
18	Housekeepers	12,471	13,329	97,610	7.32	18
19	Laundry	10,596	11,166	88,561	7.93	19
20	Administrator	2,088	2,150	78,782	36.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,682	4,134	50,449	12.20	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	1,902	2,108	24,233	11.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,861	185,062	\$ 1,979,544 *	\$ 10.70	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	192	\$ 7,121	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	25	1,260	10,3	37
38	Nurse Consultant	N/A	27,906	10,3	38
39	Pharmacist Consultant	N/A	1,500	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	28	1,599	11,3	44
45	Social Service Consultant	28	1,599	12,3	45
46	Other(specify) <u>Survey Consultant</u>	N/A	1,090	10,3	46
47	<u>Quality Assurance Doctor</u>	N/A	2,200	10,3	47
48	<u>Rehabilitation Therapy</u>	N/A	718	10,3	48
49	TOTAL (lines 35 - 48)	273	\$ 54,593		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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			
<u>Terrie Weible</u>	<u>Administrator</u>	<u>0.00</u>	<u>\$ 78,782</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 67,858</u>	<u>IDPH License Fee</u>	<u>\$ 995</u>			
				<u>Unemployment Compensation Insurance</u>	<u>24,671</u>	<u>Advertising: Employee Recruitment</u>	<u>5,945</u>			
				<u>FICA Taxes</u>	<u>144,915</u>	<u>Health Care Worker Background Check</u>	<u>3,248</u>			
				<u>Employee Health Insurance</u>	<u>45,339</u>	(Indicate # of checks performed <u>203</u>)				
				<u>Employee Meals</u>		<u>Licenses & Fees</u>	<u>822</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>1,924</u>			
				<u>Employee Disability Insurance</u>	<u>685</u>	<u>Service Charges</u>	<u>751</u>			
				<u>Employee Dental Insurance</u>	<u>(232)</u>	<u>IHCA Dues</u>	<u>4,310</u>			
				<u>Staff Relations</u>	<u>9,504</u>	<u>Home Office Dues & Subscriptions</u>	<u>1,928</u>			
				<u>Home Office Employee Benefits</u>	<u>11,554</u>	<u>Resident Background Checks</u>	<u>432</u>			
				<u>Employee Physicals</u>	<u>244</u>	<u>Less: Public Relations Expense</u>	()			
						<u>Non-allowable advertising</u>	()			
						<u>Yellow page advertising</u>	()			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 78,782	TOTAL (agree to Schedule V, line 22, col.8)	\$ 304,538	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,355			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
Description			Amount	Description		Line #	Amount	Description		Amount
<u>Wellington Mgt Co.- Management Fees</u>			<u>\$ 187,136</u>	<u>Section Not Applicable</u>				<u>Out-of-State Travel</u>		<u>\$</u>
<u>Health Care Financial, L.L.C. - Management Fees</u>			<u>72,775</u>					<u>In-State Travel</u>		<u>8,278</u>
								<u>Seminar Expense</u>		<u>1,180</u>
								<u>Home Office Travel & Seminar</u>		<u>9,556</u>
								<u>Entertainment Expense</u>		()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 259,911	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 19,014
C. Professional Services										
Vendor/Payee	Type		Amount							
<u>C.J. Schlosser & Co., L.L.C.</u>	<u>Accounting Services</u>		<u>\$ 52,883</u>							
<u>Hughes & Associates, CPA</u>	<u>Audit Fees</u>		<u>7,090</u>							
<u>Ted Frapolli</u>	<u>Legal Fees</u>		<u>244</u>							
<u>Duane Morris</u>	<u>Legal Fees</u>		<u>6,266</u>							
<u>McMahon, Berger</u>	<u>Legal Fees</u>		<u>156</u>							
<u>MPRO</u>	<u>Legal Fees</u>		<u>575</u>							
<u>Strang & Parish</u>	<u>Legal Fees</u>		<u>1,585</u>							
<u>Kutak Rock</u>	<u>Legal Fees</u>		<u>1,183</u>							
<u>John W. Guntren</u>	<u>Legal Fees</u>		<u>900</u>							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 70,882							
(If total legal fees exceed \$5,000, attach copy of invoices.)										

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

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. Illinois Healthcare Association \$4,310
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes 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 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,595 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. \$ 55,298
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? None
- (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. \$ 352
- (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? 14.91%
- 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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Hughes & Associates, CPA, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2006

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
ADMINISTRATIVE	17	(2,501)
ACTIVITIES	11	1,192
NURSING & MEDICAL RECORDS	10	349
PROFESSIONAL SERVICES	19	392
DUES, FEES, SUBSCRIPTIONS, & PROMOTIONS	20	187
TRAVEL & SEMINAR	24	381
To reclass various expenses to proper lines		

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/06

Miscellaneous Income	202
Gain on Insurance Stock Buyout	2,525
Loss on Sale of Progym	(51)
Telephone Reimbursements	67
Health Insurance Reimbursments	476
Dietary Rebates	200
Insurance Dividend	<u>10,247</u>
	<u><u>13,666</u></u>

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2006

<u>SEMINAR PARTICIPANT</u>	<u>JOB TITLE</u>	<u>DATE(S)</u>	<u>CITY</u>	<u>TITLE OF SEMINAR</u>	<u>SPONSOR</u>	<u>COST</u>	<u>SEMINAR LODGING/ TRAVEL/MEALS</u>
Terrie Weibel, Mark Weibel, & Marcy Ballard	Administrator, Director of Therapy, and DON	6/2/2006	St. Louis, MO	Recruiting and Retaining Talented Employees	The Missouri League of Nursing	345	
Cindy Tefteller	Corporate Accountant	5/31/2006	Alton, IL	Census & Billing/ Medicare B Caps	Computata Health Corporation	27	
Cindy Tefteller & Amy Elik	Corporate Accountants	1/12/2006	Alton, IL	RUGs 53: Navigating the new payment categories from the SNF PPS Final Rule	hcPro	95	
Various	Various	9/11-9/14/06	Springfield, IL	IHCA Annual Convention & Trade Show	Illinois Healthcare Association	373	
Cindy Bloodworth	Acitivity Director	6/27/2006	Springfield, IL	The New Acitivity Survey Guidance and Psychosocial Outomes Expectations	Life Services Network,	150	
Terrie Weibel and Robin White	Administrator and Quality Assurance Nurse	3/29-3/30/2006	Springfield, IL	INHAA Annual Convention	Illinois Nursing Home Administrator's Association	190	
						1,180	-
					Total Seminar Lodging/Travel/Meals	-	
					CPR Training	-	
					Other Travel Expense <\$250	8,278	
					Home Office Travel & Seminar	9,556	
					Total Travel & Seminar, Line 24	19,014	

Jerseyville Nursing & Rehabilitation Center
Attachment to Sch. XI, Part D
December 31, 2006

Detail of Line 79: Home Office Admin Vehicles

<u>Model, Make & Year</u>	<u>Year</u> <u>Acquired</u>	<u>Cost</u>	<u>Current Book</u> <u>Depreciation</u>	<u>Straight Line</u> <u>Depreciation</u>	<u>Adjustments</u>	<u>Life in</u> <u>Years</u>	<u>Accumulated</u> <u>Depreciation</u>
2001 Infiniti	2004	2,981	0	745	745	4	2,174
2000 Dodge Caravan	2005	1134	0	283	283	4	496
2004 Infiniti	2006	4400	0	147	147	4	147
		<u>8,515</u>	<u>0</u>	<u>1,175</u>	<u>1,175</u>		<u>2,817</u>

Jerseyville Nursing & Rehabilitation Center
Attachment to Sch. XVII
December 31, 2006

BOOK TO TAX NET INCOME RECONCILIATION:

BOOK NET INCOME (LOSS)	135,998
DEPRECIATION ADJUSTMENT	48,695
MISC. NON-DEDUCTIBLE EXPENSES	3,141
CONVERSION TO CASH BASIS ADJUSTMENTS	(287,549)
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>(99,715)</u></u>