

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0020131

Facility Name: JACKSONVILLE CONVALESCENT CENTER

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

County: MORGAN

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

HFS ID Number: 370983545001

Date of Initial License for Current Owners: AUGUST 1974

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

Phone # (217) 782-1630

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

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>61</u>	Skilled (SNF)	<u>61</u>	<u>22,265</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>27</u>	Intermediate (ICF)	<u>27</u>	<u>9,855</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>88</u>	TOTALS	<u>88</u>	<u>32,120</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>157</u>	<u>255</u>	<u>4,109</u>	<u>4,521</u>	8
9	SNF/PED					9
10	ICF	<u>13,832</u>	<u>6,279</u>		<u>20,111</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,989</u>	<u>6,534</u>	<u>4,109</u>	<u>24,632</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.69%

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? 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 AUGUST 1974

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 27 and days of care provided 4,109Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/07 Fiscal Year: 6/30/07

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

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

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	120,380	13,247	9,835	143,462		143,462		143,462		1
2	Food Purchase		120,345		120,345		120,345	(1,206)	119,139		2
3	Housekeeping	53,987	18,650		72,637		72,637		72,637		3
4	Laundry	29,918	9,011		38,929		38,929		38,929		4
5	Heat and Other Utilities			75,592	75,592		75,592		75,592		5
6	Maintenance	35,435	32,416	39,213	107,064		107,064	1,953	109,017		6
7	Other (specify):*										7
8	TOTAL General Services	239,720	193,669	124,640	558,029		558,029	747	558,776		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	2,504	14,504		9
10	Nursing and Medical Records	1,151,520	324,140	36,268	1,511,928	(218,813)	1,293,115	6,085	1,299,200		10
10a	Therapy	35,537	6,201	291,861	333,599	(291,861)	41,738		41,738		10a
11	Activities	47,051	6,658		53,709		53,709		53,709		11
12	Social Services	41,270		6,111	47,381		47,381		47,381		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,275,378	336,999	346,240	1,958,617	(510,674)	1,447,943	8,589	1,456,532		16
	C. General Administration										
17	Administrative	41,366		9,060	50,426	2,090	52,516	38,651	91,167		17
18	Directors Fees										18
19	Professional Services			212,261	212,261		212,261	(200,225)	12,036		19
20	Dues, Fees, Subscriptions & Promotions			38,148	38,148		38,148	(26,632)	11,516		20
21	Clerical & General Office Expenses	44,866	16,207	4,958	66,031		66,031	32,073	98,104		21
22	Employee Benefits & Payroll Taxes			298,908	298,908		298,908	20,066	318,974		22
23	Inservice Training & Education			3,961	3,961		3,961	1,987	5,948		23
24	Travel and Seminar			5,446	5,446	(4,060)	1,386	596	1,982		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			80,326	80,326		80,326	36	80,362		26
27	Other (specify):*			58,380	58,380		58,380	(58,380)			27
28	TOTAL General Administration	86,232	16,207	711,448	813,887	(1,970)	811,917	(191,828)	620,089		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,601,330	546,875	1,182,328	3,330,533	(512,644)	2,817,889	(182,492)	2,635,397		29

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

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			26,250	26,250		26,250	14,382	40,632		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			31,735	31,735		31,735	(17,535)	14,200		32
33	Real Estate Taxes			28,944	28,944		28,944		28,944		33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(127,082)	4,918		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			218,929	218,929		218,929	(130,235)	88,694		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					512,644	512,644		512,644		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			48,180	48,180		48,180		48,180		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			48,180	48,180	512,644	560,824		560,824		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,601,330	546,875	1,449,437	3,597,642		3,597,642	(312,727)	3,284,915		45

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

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

0020131

Report Period Beginning: **07/01/06**

Ending: **06/30/07**

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(377)	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	10,371	30		9
10	Interest and Other Investment Income	(1,532)	32		10
11	Discounts, Allowances, Rebates & Refunds	(48)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,800)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(490)	20		17
18	Fines and Penalties	(988)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,583)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,592)	27		24
25	Fund Raising, Advertising and Promotional	(25,731)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(776)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(829)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (79,375)		\$	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)	(233,352)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (233,352)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (312,727)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39	Therapy	X		291,861	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		32,918	10	42
43	Prescription Drugs	X		154,074	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule <u>O2, Supply</u>	X		29,314	10	45
46	Other-Attach Schedule <u>Amb,Other</u>	X		4,477	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 512,644		47

BHF USE ONLY						
48		49		50		52

STATE OF ILLINOIS
 JACKSONVILLE CONVALESCENT CENTER

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	(377)	0	0	0	0	0	0	0	0	0	0	(377)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(377)	0	0	0	0	0	0	0	0	0	0	(377)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	268	0	0	0	0	0	0	0	0	0	268	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,583)	(199,513)	0	0	0	0	0	0	0	0	0	(201,096)	19
20	Fees, Subscriptions & Promotions	(26,997)	175	0	0	0	0	0	0	0	0	0	(26,822)	20
21	Clerical & General Office Expenses	(48)	0	0	0	0	0	0	0	0	0	0	(48)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(268)	0	0	0	0	0	0	0	0	0	(268)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(58,380)	0	0	0	0	0	0	0	0	0	0	(58,380)	27
28	TOTAL General Administration	(87,008)	(199,338)	0	(286,346)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,385)	(199,338)	0	(286,723)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/06 Ending:

06/30/07

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	10,371	2,066	0	0	0	0	0	0	0	0	0	12,437	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,532)	(16,003)	0	0	0	0	0	0	0	0	0	(17,535)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,839	(145,937)	0	(137,098)	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)	(78,546)	(345,275)	0	(423,821)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	0	HILLTOP NURSING HOME, INC.	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
SAM KLEIN	50%	MEADOW MANOR, INC.	TAYLORVILLE	J'ville Land Trust	SPRINGFIELD	LAND TRUST
DORYS BERG, TRUSTEE	50%	MENARD CONVALESCENT CENTER, INC.	PETERSBURG			
		SUNRISE MANOR OF VIRDEN, INC.	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 132,000	JACKSONVILLE LAND TRUST	100.00%	\$	\$ (132,000)	1
2	V	30 DEPRECIATION		JACKSONVILLE LAND TRUST	100.00%	2,066	2,066	2
3	V	20 TRUST FEES		JACKSONVILLE LAND TRUST	100.00%	175	175	3
4	V	32 INTEREST		JACKSONVILLE LAND TRUST	100.00%	(51)	(51)	4
5	V	32 INTEREST		JACKSONVILLE LAND TRUST	100.00%	(15,952)	(15,952)	5
6	V							6
7	V	19 MANAGEMENT FEES	208,859	NURSING HOME MANAGERS, INC	50.00%		(208,859)	7
8	V	VAR SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC	50.00%	111,923	111,923	8
9	V	19 ACCOUNTING		NURSING HOME MANAGERS - DIRECT ALLOCATION	50.00%	9,346	9,346	9
10	V	24 TRAVEL	268	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(268)	10
11	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW		268	268	11
12	V							12
13	V							13
14	Total		\$ 341,127			\$ 107,775	\$ * (233,352)	14

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	H. RAYMOND KLEIN		MANAGEMENT						\$ 594	17 - 7	1
2											2
3	H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC.										3
4	A RELATED ORGANIZATION. TOTAL COMPENSATION OF \$2,750 WAS										4
5	ALLOCATED AMONG THE FIVE RELATED NURSING HOMES BASED										5
6	UPON 10 HOURS PER WEEK FOR H. RAYMOND KLEIN.										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 594		13

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1							\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	J'ville Land Trust	X		WORKING CAPITAL		8/27/04	70,000	531,000	DEMAND	4.0000	15,952						
7	Bank of Springfield		X	WORKING CAPITAL	INTEREST	5/25/06	112,000		5/25/07	8.2500	15,478						
8	Stockholders	X		WORKING CAPITAL		3/28/06	8,000	273,000	DEMAND	VAR	305						
9	TOTAL Facility Related						\$ 190,000	\$ 804,000			\$ 31,735						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 190,000	\$ 804,000			\$ 31,735						

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

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

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

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

0020131 Report Period Beginning: **07/01/06**

Ending: **06/30/07**

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.	\$	40,399	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	26,932	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(13,467)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	42,411	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	28,944	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	26,086	8
	2003	24,773	9
	2004	25,952	10
	2005	26,932	11
	2006	28,274	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

LINE 4: 2006 REAL ESTATE TAX BILL	\$28,274
6/12 OF \$28,274	\$14,137
TOTAL LINE 4	\$42,411

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JACKSONVILLE CONVALESCENT CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0020131

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-18-301-002</u>	<u>JACKSONVILLE CONV. CENTER</u>	<u>\$ 28,273.76</u>	<u>\$ 28,273.76</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 28,273.76	\$ 28,273.76

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131 Report Period Beginning:

07/01/06 Ending:

06/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,061 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/06

Ending:

06/30/07

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1974	1974	\$ 541,766	\$	30	\$	\$	\$ 541,766	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		LANDSCAPING		1975	3,850		5			3,850	9
10		AIR CONDITIONING / HEATING		1974	14,470		8			14,470	10
11		MOTORS		1980	533		5			533	11
12		BIDS		1981	739	19	30	25	6	657	12
13		FURNACE		1981	678		8			678	13
14		FAN		1981	972		15			972	14
15		USED AIR CONDITIONER		1982	2,000		8			2,000	15
16		VACUUM REPAIR - PER 1982 AUDIT		1982	1,031		10			1,031	16
17		FLOORING		1983	1,229		10			1,229	17
18		WATER HEATER		1983	1,498		8			1,498	18
19		WATER HEATER		1983	1,575		8			1,575	19
20		CEILING AND DOORS		1984	2,041		15			2,041	20
21		ASPHALT		1984	13,350		15			13,350	21
22		AIR CONDITIONING		1987	1,155		8			1,155	22
23		SIDEWALKS		1987	6,700	213	20	335	122	6,533	23
24		ROOF		1988	21,783	691	20	1,089	398	20,147	24
25		LIGHT DIFFUSER		1990	1,054	34	10		(34)	1,054	25
26		FLOORING		1990	1,030	33	15		(33)	1,030	26
27		WATER HEATER		1992	1,450	46	15	45	(1)	1,450	27
28		AIR CONDITIONING		1992	1,025		10			1,025	28
29		REWIRE FIXTURES		1992	1,110	35	10		(35)	1,110	29
30		COMPRESSOR		1993	1,479	38	10		(38)	1,479	30
31		DOOR STOPS		1993	2,168	56	15	146	90	1,951	31
32		ROOF		1993	34,178	876	20	1,709	833	23,070	32
33		FIRE DOORS		1996	1,011	26	15	70	44	774	33
34		WATER HEATER		1997	3,915	100	15	260	160	2,664	34
35		AIR CONDITIONING		1997	5,982	153	10	600	447	5,982	35
36		SWAMP COOLER		1998	1,125	29	8		(29)	1,125	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/06

Ending:

06/30/07

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1998	\$ 1,950	\$ 50	15	\$ 130	\$ 80	\$ 1,137	37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	1,380	38
39	SHUTTERS	1999	912	23	15	61	38	467	39
40	DOOR ENTRANCE	2000	4,507	116	15	300	184	2,152	40
41	DUCT SMOKE DETECTORS	2000	2,295	59	20	115	56	794	41
42	DOOR	2000	2,280	59	15	152	93	1,026	42
43	ROOFTOP AIR CONDITIONER	2001	7,619	195	10	762	567	4,445	43
44	COMBUSTION AIR DUCT	2002	710	18	15	47	29	260	44
45	SMOKE DETECTORS	2002	2,511	64	15	168	104	879	45
46	GARAGE	2002	11,636	298	15	776	478	4,009	46
47	SMOKE DETECTORS	2002	809	21	15	54	33	279	47
48	FIRE DAMPERS	2002	1,166	30	15	78	48	403	48
49	ROOFTOP AIR CONDITIONER & HEATING (2)	2002	9,766	250	8	1,221	971	5,519	49
50	GARAGE INSULATION	2003	1,652	42	15	110	68	477	50
51	ROOFTOP AIR CONDITIONER & HEATING	2003	5,300	136	8	662	526	2,760	51
52	PARKING LOT	2003	13,306	341	15	887	546	3,400	52
53	VENTILATION	2004	4,380	112	15	292	180	900	53
54	SIDEWALK & CONCRETE PAD	2003	5,900	454	20	295	(159)	1,127	54
55	FENCE	2004	1,453	112	8	181	69	606	55
56	FIRE ALARM SYSTEM	2004	5,540	142	15	369	227	1,059	56
57	WATER HEATER	2005	2,673	69	15	178	109	430	57
58	ALARM SYSTEM	2005	4,171	107	15	278	171	672	58
59	EXIT FIXTURES	2005	1,541	40	10	154	114	244	59
60	EXHAUST SYSTEM	2006	3,545	91	15	236	145	236	60
61	SIDEWALK & CONCRETE PATIO	2005	3,600	342	20	180	(162)	345	61
62	ROOF	2006	83,800	1,701	20	3,142	1,441	3,142	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 856,591	\$ 7,290		\$ 15,285	\$ 7,995	\$ 694,347	70

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

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

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	\$ 190,962	\$ 16,272	\$ 15,612	\$ (660)	Various	\$ 106,624	71
72	Current Year Purchases	12,834	1,904	739	(1,165)	Various	739	72
73	Fully Depreciated Assets	173,067					173,067	73
74	Assets no longer in service	(77,603)					(77,603)	74
75	TOTALS	\$ 299,260	\$ 18,176	\$ 16,351	\$ (1,825)		\$ 202,827	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	2003 FORD F350	2004	\$ 28,203	\$ 2,850	\$ 7,051	\$ 4,201	4	\$ 20,565	76
77										77
78										78
79										79
80	TOTALS			\$ 28,203	\$ 2,850	\$ 7,051	\$ 4,201		\$ 20,565	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,219,483	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 38,687	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,371	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 917,739	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JACKSONVILLE LAND TRUST

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1974</u>	<u>88</u>	<u>08/01/74</u>	\$ <u>132,000</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		88		\$ 132,000			7

10. Effective dates of current rental agreement:

Beginning 07/01/06

Ending 06/30/07

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

Fiscal Year Ending Annual Rent

12.	<u>06/30/08</u>	\$ <u>132,000</u>
13.	<u>06/30/09</u>	\$ <u>132,000</u>
14.	<u>06/30/10</u>	\$ <u>132,000</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: INCLUDED IN THE ABOVE AMOUNT

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	39 - 8	hrs	\$	2,871	\$ 133,355	\$	2,871	\$ 133,355	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		232	18,965		232	18,965	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		2,116	139,541		2,116	139,541	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 8	# of prescripts				154,074		154,074	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab,O2,Amb,Sup,Othe	39 - 8					66,709		66,709	13
14	TOTAL			\$	5,219	\$ 291,861	\$ 220,783	5,219	\$ 512,644	14

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

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

Ending:

06/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/07

(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	\$ 16,408	\$ 36,253	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	579,503	579,503	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,151	18,151	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 614,062	\$ 633,907	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		35,429	13
14	Buildings, at Historical Cost		658,844	14
15	Leasehold Improvements, at Historical Cost	196,716	196,716	15
16	Equipment, at Historical Cost	310,961	403,125	16
17	Accumulated Depreciation (book methods)	(272,877)	(986,413)	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)	\$ 234,800	\$ 307,701	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 848,862	\$ 941,608	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 397,040	\$ 397,040	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	804,000	273,000	29
30	Accrued Salaries Payable	50,267	50,267	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,035	34,035	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,411	42,411	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)	\$ 1,327,753	\$ 796,753	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,327,753	\$ 796,753	46
47	TOTAL EQUITY(page 18, line 24)	\$ (478,891)	\$ 144,855	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 848,862	\$ 941,608	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 192,714	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 192,714	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(193,621)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) JACKSONVILLE LAND TRUST INCOME	145,762	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (47,859)	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)	\$ 144,855	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/06Ending: 06/30/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,387,802	1
2	Discounts and Allowances for all Levels	(125,739)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,262,063	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	128,552	6
7	Oxygen	6,472	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 135,024	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	377	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	648	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,025	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,532	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,532	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING \$829 W/A \$48	877	28
28a	BAD DEBT RECOVERY \$3500	3,500	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,377	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,404,021	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	558,029	31
32	Health Care	1,958,617	32
33	General Administration	813,887	33
B. Capital Expense			
34	Ownership	218,929	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	48,180	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,597,642	40
41	Income before Income Taxes (line 30 minus line 40)**	(193,621)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (193,621)	43

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

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

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

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

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

0020131

Report Period Beginning: **07/01/06**

Ending:

06/30/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 48,851	\$ 23.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,836	6,049	130,177	21.52	3
4	Licensed Practical Nurses	23,079	24,427	441,868	18.09	4
5	CNAs & Orderlies	51,802	52,977	530,624	10.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,447	3,581	35,537	9.92	8
9	Activity Director	1,836	2,007	20,005	9.97	9
10	Activity Assistants	3,240	3,337	27,046	8.10	10
11	Social Service Workers	3,445	3,612	41,270	11.43	11
12	Dietician					12
13	Food Service Supervisor	2,001	2,205	28,895	13.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,310	10,648	91,485	8.59	15
16	Dishwashers					16
17	Maintenance Workers	3,333	3,492	35,435	10.15	17
18	Housekeepers	6,265	6,593	53,987	8.19	18
19	Laundry	3,939	3,939	29,918	7.60	19
20	Administrator	1,520	1,640	41,366	25.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,069	4,277	44,866	10.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,122	130,864	\$ 1,601,330 *	\$ 12.24	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	291	\$ 9,835	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	17	515	10 - 3	37
38	Nurse Consultant	504	25,056	10 - 3	38
39	Pharmacist Consultant	88	1,650	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	99	6,111	12 - 3	45
46	Other(specify) <u>Medicare Consultant</u>	20	3,047	10 - 3	46
47	<u>Psychiatric Consultant</u>	24	6,000	10 - 3	47
48	<u>Administrative Consultant</u>	328	9,060	17 - 3	48
49	TOTAL (lines 35 - 48)	1,491	\$ 73,274		49

C. CONTRACT NURSES

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning: 07/01/06

Ending: 06/30/07

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,697 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,180
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 377
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 3 & 4 - SCHEDULE V

LINE 27 - GENERAL ADMINISTRATION - OTHER	
SALES TAX	\$ 6,800
BAD DEBTS	50,592
FINES	988
TOTAL LINE 27 - COLUMN 3	<u>\$ 58,380</u>

PAGE 3 & 4 - SCHEDULE V

DETAIL COLUMN 5 - RECLASSIFICATIONS		
		LINE #
RECLASS TO:		
NURSE CONSULTANT TRAVEL:	\$ 1,970	10
ADMINISTRATIVE CONSULTANT TRAVEL	<u>2,090</u>	17
RECLASS FROM: TRAVEL	<u>\$ (4,060)</u>	24
RECLASS FROM:		
MEDICARE SUPPLIES	\$ (9,290)	10
MEDICARE X-RAYS	(10,255)	10
MEDICARE DRUGS	(140,134)	10
MEDICARE LABORATORY FEES	(22,663)	10
MEDICARE I.V. THERAPY	(13,940)	10
MEDICARE AMBULANCE	(1,863)	10
OXYGEN	(20,024)	10
MEDICARE OTHER ANCILLARY SERVICES	(2,614)	10
PHYSICAL THERAPY	(139,541)	10A
SPEECH THERAPY	(18,965)	10A
OCCUPATIONAL THERAPY	<u>(133,355)</u>	10A
RECLASS TO: ANCILLARY SERVICES	<u>\$ 512,644</u>	39

PAGE 3 - SCHEDULE V - LINE 23

DETAIL - INSERVICE TRAINING & EDUCATION	
MDS TRAINING	\$ 1,449
DIETARY MANAGEMENT COURSE	512
INFECTION CONTROL SEMINAR	90
ACTIVITY DIRECTOR COURSE	400
CNA SEMINAR	20
VASCULAR DISEASE SEMINAR	90
ALZHEIMER DISEASE SEMINAR	30
LEGAL ASPECTS / END OF LIFE SEMINAR	100
PRESSURE ULCER MANAGEMENT SEMINAR	22
HOME OFFICE INSERVICES	1,248
NHM ALLOCATION	1,987
SCHEDULE V - LINE 23 - COLUMN 8	<u>\$ 5,948</u>

PAGE 9 - SCHEDULE IX - LINE 6

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

ONS

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION	
LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 38,687
NURSING HOME MANAGERS ALLOCATION	1,945
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 40,632</u>

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME	
NET INCOME - LINE 43	\$ (193,621)
* MANAGEMENT FEE 6/30/06	(36,682)
* MANAGEMENT FEE 6/30/07	50,188
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(1,532)
TAXABLE INCOME	<u>\$ (181,647)</u>

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

PAGE 21 - SCHEDULE XIX - SECTION F

DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	
PUBLIC RELATIONS	\$ 25731
CHAMBER OF COMMERCE DUES	315
FRANCHISE FEES	185
LTCNA DUES	105
INHAA DUES	195
AUTOMOBILE LICENSE	158
YELLOW PAGES	776
MORGAN COUNTY HEALTH DEPT ADMINISTRATOR LICENSE	100
	<u>320</u>
	<u>\$ 27885</u>

PAGE 23 - SCHEDULE XX

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

CENTRAL OFFICE COST ALLOCATION
 JACKSONVILLE
 2006

	JULY 06	AUG	SEPT	OCT	NOV	DEC	JAN 07	FEB	MARCH	APRIL	MAY	JUNE	2006 TOTAL	LINE #
SALARIES-ADMIN	2,857	3,186	3,031	3,085	3,049	3,121	\$1,838	\$1,906	\$1,905	\$1,817	\$1,828	\$1,885	\$29,507	17
SALARIES-CLERIC	2,254	2,587	2,462	2,505	2,476	2,534	2,461	2,552	2,550	2,432	2,447	2,524	29,782	21
SALARIES-CONTR	0	0	0	0	0	0	1,362	1,412	1,411	1,346	1,354	1,397	8,282	17
SALARIES-NURSE	421	419	399	406	401	411	596	619	618	589	593	612	6,085	10
ACCOUNTING	10	51	48	49	49	50	101	105	105	100	100	104	871	19
WORK COMP INS	21	43	41	42	41	42	62	65	65	62	62	64	609	22
SUPPLIES	96	62	59	60	59	60	80	83	83	79	79	82	880	21
TELEPHONE	137	119	113	115	113	116	123	127	127	121	122	126	1,459	21
EMPL BENEFITS	1,095	1,305	1,242	1,264	1,249	1,278	1,142	1,185	1,184	1,129	1,136	1,172	14,381	22
PAYROLL TAXES	440	415	395	402	398	407	430	446	446	425	428	442	5,076	22
TRAVEL	67	93	88	90	89	91	57	59	59	57	57	59	864	24
IN SERVICE	181	265	252	256	253	259	86	89	89	85	85	88	1,987	23
MEDICAL CONSULT	100	215	205	208	206	211	223	232	232	221	222	229	2,504	9
MACHINE RENTAL	21	24	23	24	23	24	20	20	20	19	19	20	258	6
OWNERS COMP	183	85	80	82	81	83	0	0	0	0	0	0	594	17
INS-PROP,LIAB,WC	30	107	102	104	103	105	(85)	(88)	(88)	(84)	(84)	(87)	36	26
DEPRECIATION	166	164	156	159	157	161	162	168	167	160	161	166	1,945	30
RENT	423	418	398	405	400	410	405	420	420	400	403	416	4,918	34
MAINTENANCE	95	181	172	175	173	177	119	123	123	117	118	122	1,695	6
FEES & PUBLICAT	12	21	20	20	20	21	12	13	13	12	12	13	190	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	8,606	9,759	9,287	9,451	9,340	9,560	\$9,194	\$9,535	\$9,529	\$9,086	\$9,143	\$9,430	\$111,923	
FIXED ASSETS	0	0	0	0	0	0							111,923	
EQUIP - PRIOR	14,321	14,151	13,466	13,704	13,544	13,862	13,432	13,930	13,922	13,275	13,357	13,777	13,728	
EQUIP - CURR	224	221	210	214	211	497	0	0	238	227	229	236	209	
EQUIP - FULLY DEP	4,242	4,192	3,989	4,059	4,012	4,106	4,834	5,013	5,010	4,777	4,807	4,958	4,500	
BLDG - PRIOR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	1,494	1,477	1,405	1,430	1,413	1,446	1,431	1,484	1,483	1,414	1,423	1,468	1,447	

OCCUPIED DAYS 2006	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,331	2,170	2,010		1,459	1,952	9,922
FEBRUARY	2,071	1,914	1,868		1,302	1,756	8,911
MARCH	2,411	2,193	2,142		1,383	1,917	10,046
APRIL	2,269	2,014	2,034		1,346	1,718	9,381
MAY	2,177	1,972	2,041		1,447	1,746	9,383
JUNE	2,081	1,987	2,014		1,386	1,745	9,213
JULY	2,181	2,119	2,133		1,338	1,765	9,536
AUGUST	2,154	2,036	2,111		1,269	1,703	9,273
SEPTEMBER	2,072	1,880	2,074		1,249	1,723	8,998
OCTOBER	1,974	2,055	2,267		1,418	1,951	9,665
NOVEMBER	1,830	1,947	2,126		1,414	1,948	9,265
DECEMBER	2,029	2,088	2,182		1,441	1,968	9,708
TOTAL	25,580	24,375	25,002	0	16,452	21,892	113,301 113,301

OCCUPIED DAYS 2007	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,105	2,057	2,233		1,442	1,831	9,668
FEBRUARY	1,883	1,964	1,995		1,398	1,661	8,901
MARCH	2,115	2,213	2,327		1,564	1,816	10,035
APRIL	2,110	2,059	2,367		1,470	1,786	9,792
MAY	2,143	2,106	2,417		1,514	1,774	9,954
JUNE	2,064	2,099	2,224		1,533	1,698	9,618
JULY	2,163	2,215	2,305		1,590	1,731	10,004
AUGUST	2,265	2,186	2,329		1,594	1,714	10,088
SEPTEMBER							0
OCTOBER							0
NOVEMBER							0
DECEMBER							0
TOTAL	16,848	16,899	18,197	0	12,105	14,011	78,060 78,060

ALLOCATION PERCENTAGE 2006	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	23.49%	21.87%	20.26%	14.70%	19.67%	100.00%
FEBRUARY	23.24%	21.48%	20.96%	14.61%	19.71%	100.00%
MARCH	24.00%	21.83%	21.32%	13.77%	19.08%	100.00%
APRIL	24.19%	21.47%	21.68%	14.35%	18.31%	100.00%
MAY	23.20%	21.02%	21.75%	15.42%	18.61%	100.00%
JUNE	22.59%	21.57%	21.86%	15.04%	18.94%	100.00%
JULY	22.87%	22.22%	22.37%	14.03%	18.51%	100.00%
AUGUST	23.23%	21.96%	22.77%	13.68%	18.37%	100.00%
SEPTEMBER	23.03%	20.89%	23.05%	13.88%	19.15%	100.00%
OCTOBER	20.42%	21.26%	23.46%	14.67%	20.19%	100.00%
NOVEMBER	19.75%	21.01%	22.95%	15.26%	21.03%	100.00%
DECEMBER	20.90%	21.51%	22.48%	14.84%	20.27%	100.00%

ALLOCATION PERCENTAGE 2007	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	21.77%	21.28%	23.10%	14.92%	18.94%	100.00%
FEBRUARY	21.15%	22.06%	22.41%	15.71%	18.66%	100.00%
MARCH	21.08%	22.05%	23.19%	15.59%	18.10%	100.00%
APRIL	21.55%	21.03%	24.17%	15.01%	18.24%	100.00%
MAY	21.53%	21.16%	24.28%	15.21%	17.82%	100.00%
JUNE	21.46%	21.82%	23.12%	15.94%	17.65%	100.00%
JULY	21.62%	22.14%	23.04%	15.89%	17.30%	100.00%