

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF		<u>12,096</u>	<u>7,944</u>	<u>20,040</u>	8
9	SNF/PED					9
10	ICF	<u>14,925</u>			<u>14,925</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,925</u>	<u>12,096</u>	<u>7,944</u>	<u>34,965</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.85%

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 7,944

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	204,122	25,985	7,121	237,228		237,228		237,228		1
2	Food Purchase		196,304		196,304		196,304	(230)	196,074		2
3	Housekeeping	102,694	17,944		120,638		120,638	(30)	120,608		3
4	Laundry	94,580	19,612		114,192		114,192		114,192		4
5	Heat and Other Utilities			117,587	117,587		117,587	61	117,648		5
6	Maintenance	52,813	16,458	33,793	103,064		103,064	502	103,566		6
7	Other (specify):* Waste Removal			7,749	7,749		7,749		7,749		7
8	TOTAL General Services	454,209	276,303	166,250	896,762		896,762	303	897,065		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,406,704	123,867	29,619	1,560,190	(1,751)	1,558,439	(138)	1,558,301		10
10a	Therapy	32,510	10,933	676,877	720,320		720,320	(37,294)	683,026		10a
11	Activities	52,768	6,850	4,814	64,432	199	64,631		64,631		11
12	Social Services	61,377		1,541	62,918		62,918		62,918		12
13	CNA Training			1,332	1,332	3,199	4,531		4,531		13
14	Program Transportation		5,762		5,762		5,762		5,762		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,553,359	147,412	723,783	2,424,554	1,647	2,426,201	(37,432)	2,388,769		16
	C. General Administration										
17	Administrative	86,123	6,262	546,309	638,694	(1,244)	637,450	(444,515)	192,935		17
18	Directors Fees			60,000	60,000		60,000	(60,000)			18
19	Professional Services			73,131	73,131	407	73,538	(61,447)	12,091		19
20	Dues, Fees, Subscriptions & Promotions			36,614	36,614	(120)	36,494	(11,661)	24,833		20
21	Clerical & General Office Expenses	54,579	19,684	74,971	149,234		149,234	25,900	175,134		21
22	Employee Benefits & Payroll Taxes			336,487	336,487		336,487	10,057	346,544		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,931	11,931	(690)	11,241	1,984	13,225		24
25	Other Admin. Staff Transportation							1,764	1,764		25
26	Insurance-Prop.Liab.Malpractice			55,261	55,261		55,261	2,188	57,449		26
27	Other (specify):*										27
28	TOTAL General Administration	140,702	25,946	1,194,704	1,361,352	(1,647)	1,359,705	(535,730)	823,975		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,148,270	449,661	2,084,737	4,682,668		4,682,668	(572,859)	4,109,809		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.

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			184,093	184,093		184,093	4,472	188,565			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214,079	214,079		214,079	(44,784)	169,295			32
33	Real Estate Taxes			50,620	50,620		50,620		50,620			33
34	Rent-Facility & Grounds							8,948	8,948			34
35	Rent-Equipment & Vehicles			2,964	2,964		2,964		2,964			35
36	Other (specify):* Mortgage Ins.			19,082	19,082		19,082		19,082			36
37	TOTAL Ownership			470,838	470,838		470,838	(31,364)	439,474			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		307,209	32,729	339,938		339,938		339,938			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		307,209	88,027	395,236		395,236		395,236			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,148,270	756,870	2,643,602	5,548,742		5,548,742	(604,223)	4,944,519			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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(230)	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	(44,955)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,282)	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	(3,014)	24		19
20	Contributions	(1,275)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,488)	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	(3,706)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,950)		\$	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)	(541,273)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (541,273)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (604,223)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Jerseyville Nursing & Rehabilitation Center

ID# 0039339

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Offset misc income against expense	\$ (100)	21	1
2	Offset misc income against expense	(138)	10	2
3	Offset misc income against expense	(30)	3	3
4	Eliminate PAC fees & lobbying dues	(2,472)	20	4
5	Eliminate Employee Advances in expense	(180)	17	5
6	Add expense for 2007 IDPH license paid in 2006	995	20	6
7	Eliminate country club membership dues	(1,725)	20	7
8	Eliminate duplicate legal fees payment	(56)	19	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	(3,706)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(230)	0	0	0	0	0	0	0	0	0	0	(230)	2
3	Housekeeping	(30)	0	0	0	0	0	0	0	0	0	0	(30)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	61	0	0	0	0	0	0	0	0	0	61	5
6	Maintenance	0	502	0	0	0	0	0	0	0	0	0	502	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(260)	563	0	0	0	0	0	0	0	0	0	303	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	(138)	0	0	0	0	0	0	0	0	0	0	(138)	10
10a	Therapy	0	0	(37,294)	0	0	0	0	0	0	0	0	(37,294)	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	(138)	0	(37,294)	0	(37,432)	16							
	C. General Administration													
17	Administrative	(180)	32,899	(477,234)	0	0	0	0	0	0	0	0	(444,515)	17
18	Directors Fees	0	0	(60,000)	0	0	0	0	0	0	0	0	(60,000)	18
19	Professional Services	(56)	367	(61,758)	0	0	0	0	0	0	0	0	(61,447)	19
20	Fees, Subscriptions & Promotions	(14,247)	2,586	0	0	0	0	0	0	0	0	0	(11,661)	20
21	Clerical & General Office Expenses	(100)	26,000	0	0	0	0	0	0	0	0	0	25,900	21
22	Employee Benefits & Payroll Taxes	0	10,057	0	0	0	0	0	0	0	0	0	10,057	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,014)	4,998	0	0	0	0	0	0	0	0	0	1,984	24
25	Other Admin. Staff Transportation	0	1,764	0	0	0	0	0	0	0	0	0	1,764	25
26	Insurance-Prop.Liab.Malpractice	0	2,188	0	0	0	0	0	0	0	0	0	2,188	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(17,597)	80,859	(598,992)	0	(535,730)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,995)	81,422	(636,286)	0	(572,859)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339

Report Period Beginning:

01/01/2007 Ending:12/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	4,472	0	0	0	0	0	0	0	0	0	4,472	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(44,955)	171	0	0	0	0	0	0	0	0	0	(44,784)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,948	0	0	0	0	0	0	0	0	0	8,948	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	(44,955)	13,591	0	(31,364)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(62,950)	95,013	(636,286)	0	0	0	0	0	0	0	0	(604,223)	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
John H. Rothert	60.00	Montgomery Nursing and Rehabilitation Ctr., Inc	Hillsboro, IL	Wellington Mgt. Co	Chesterfield, MO	Management Co.
David L. Kamler	20.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co.
J. Terry Dooling	20.00	Spanish Lake Nursing & Rehabilitation Ctr.	Florissant, MO	C.J. Schlosser & Co	Alton, IL	Public Accountants
				NW Rehab, 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%	\$ 61	\$	61	1
2	V	6 See Schedule VIII		Wellington Management Co.	60.00%	502		502	2
3	V	17 See Schedule VIII		Wellington Management Co.	60.00%	32,899		32,899	3
4	V	19 See Schedule VIII		Wellington Management Co.	60.00%	367		367	4
5	V	20 See Schedule VIII		Wellington Management Co.	60.00%	2,586		2,586	5
6	V	21 See Schedule VIII		Wellington Management Co.	60.00%	26,000		26,000	6
7	V	22 See Schedule VIII		Wellington Management Co.	60.00%	10,057		10,057	7
8	V	24 See Schedule VIII		Wellington Management Co.	60.00%	4,998		4,998	8
9	V	25 See Schedule VIII		Wellington Management Co.	60.00%	1,764		1,764	9
10	V	26 See Schedule VIII		Wellington Management Co.	60.00%	2,188		2,188	10
11	V	30 See Schedule VIII		Wellington Management Co.	60.00%	4,472		4,472	11
12	V	32 See Schedule VIII		Wellington Management Co.	60.00%	171		171	12
13	V	34 See Schedule VIII		Wellington Management Co.	60.00%	8,948		8,948	13
14	Total		\$			\$ 95,013	\$ *	95,013	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	17 Management Fees	\$ 364,206	Wellington Management Co.	60.00%	\$	\$ (364,206)
16	V	17 Management Fees	182,103	Health Care Financial, LLC	40.00%	69,075	(113,028)
17	V	19 Professional Services	61,758	C.J. Schlosser & Company, LLC	40.00%		(61,758)
18	V	10a Therapy Services	676,877	N.W. Rehab, LLC	100.00%	639,583	(37,294)
19	V	10 Nurse Consultant	24,603	Wellington Management Co.	60.00%	24,603	
20	V	18 Director's Fees	36,000	John H. Rothert	60.00%		(36,000)
21	V	18 Director's Fees	12,000	J. Terry Dooling	20.00%		(12,000)
22	V	18 Director's Fees	12,000	David L. Kamler	20.00%		(12,000)
23	V						
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		\$ 1,369,547			\$ 733,261	\$ * (636,286)

* 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: 01/01/2007 Ending: 12/31/2007

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	117,101	8.77	21.93	Salary	\$ 32,899	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	\$ 32,899		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: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Wellington Management Corporation
 Street Address 750 Spirit 40 Park Drive
 City / State / Zip Code Chesterfield, MO 63005
 Phone Number (618) 537-8447
 Fax Number (618) 537-8446

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	19,475,962	6	\$ 278	\$ 4,271,597	\$ 61	1
2	6	Maintenance	Accumulated Costs	19,475,962	6	2,291	4,271,597	502	2
3	17	Administrative	Accumulated Costs	19,475,962	6	150,000	4,271,597	32,899	3
4	19	Professional Services	Accumulated Costs	19,475,962	6	1,675	4,271,597	367	4
5	20	Dues, Fees, Subs, & Promos	Accumulated Costs	19,475,962	6	11,792	4,271,597	2,586	5
6	21	Clerical and General Office Exp.	Accumulated Costs	19,475,962	6	118,543	4,271,597	26,000	6
7	22	Employee Benefits and PR Taxes	Accumulated Costs	19,475,962	6	45,854	4,271,597	10,057	7
8	24	Travel & Seminar	Accumulated Costs	19,475,962	6	22,787	4,271,597	4,998	8
9	25	Other Admin Staff Transport	Accumulated Costs	19,475,962	6	8,044	4,271,597	1,764	9
10	26	Insurance - Prop, Liab, Malprac.	Accumulated Costs	19,475,962	6	9,978	4,271,597	2,188	10
11	30	Depreciation	Accumulated Costs	19,475,962	6	20,388	4,271,597	4,472	11
12	32	Interest Expense	Accumulated Costs	19,475,962	6	779	4,271,597	171	12
13	34	Rent - Facility and Grounds	Accumulated Costs	19,475,962	6	40,796	4,271,597	8,948	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				\$ 433,205	\$ 234,081		\$ 95,013	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										
										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	Capmark Finance, Inc	X	Refinance Mortgage	\$20,841.58	10/31/06	\$ 3,720,700	\$ 3,681,633	10/31/41	5.8500	\$ 209,991	1								
2	First National Bank of St. Louis	X	Van Loan	\$1,221.44	2/21/07	39,507	27,011	11/21/09	7.0000	2,161	2								
3								Interest Income		(44,955)	3								
4								Loan Cost Amortization		1,927	4								
5								Home Office Allocation		171	5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$22,063.02		\$ 3,760,207	\$ 3,708,644			\$ 169,295	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 3,760,207	\$ 3,708,644			\$ 169,295	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,082 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.)

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.		\$	51,500	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.)		\$	50,620	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	(880)	3															
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	51,500	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.		\$	50,620	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2002	42,692	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2006 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		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
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																	
	2003	47,246	9																
	2004	49,269	10																
	2005	50,047	11																
	2006	50,620	12																
Line 2: 2006 Taxes Paid																			
Line 4: Accrual is based on 2006 taxes paid plus approx. 2%.																			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>158,994</u>	<u>1994</u>	<u>\$ 71,664</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	158,994		\$ 71,664	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	101	1994		\$ 1,180,668	\$ 47,227	25	\$ 47,227	\$	\$ 649,367	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		9,056	10
11	Flooring		1994	29,698		10			29,698	11
12	Electrical		1994	11,690	585	20	585		7,743	12
13	Air Conditioning		1994	25,830		10			25,830	13
14	Interior Remodeling		1994	40,265	1,359	5-20	1,359		37,690	14
15	Shed		1994	3,267		10			3,267	15
16	Nurses' Station		1994	6,055	303	20	303		4,113	16
17	Home Office Wallpapering/Flooring		1994	3,467		5			3,467	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		1,329	20
21	Storage Building		1996	3,500		10			3,500	21
22	2 Boilers		1996	7,400	370	20	370		4,409	22
23	Roof Repair & Drains Installed		1996	3,619		10			3,619	23
24	Ceiling Tile & End Caps		1996	3,506	292	12	292		3,262	24
25	Storage Building		1997	3,356	28	10	28		3,356	25
26	Alarm System		1997	1,750	15	10	15		1,750	26
27	Wallcovering		1997	6,355	106	5-10	106		6,355	27
28	Ceiling Tile & End Caps		1997	1,485	124	12	124		1,300	28
29	3 Windows & Sills & 1 Door Replaced		1997	4,108	274	15	274		2,530	29
30	Baseboards Remodeled		1997	1,167	78	10	78		1,166	30
31	Air Conditioner Unit		1997	2,185	115	10	115		2,185	31
32	Concrete Patio & Sidewalk		1997	1,842	123	15	123		1,269	32
33	Rock		1997	502		5			502	33
34	Landscaping		1997	1,075	36	10	36		1,075	34
35	Roofing		1998	2,592	259	10	259		2,570	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:

01/01/2007 Ending: 12/31/2007

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 Remodeled	1998	\$ 1,437	\$ 144	10	\$ 144	\$	\$ 1,426	37
38	Baseboard Remodeling	1998	1,919	192	10	192		1,847	38
39	Air Conditioning Units & Ducts	1998	13,420	1,280	10-20	1,280		12,139	39
40	Wallcoverings	1998	1,495	149	10	149		1,357	40
41	4 Air Conditioning Units	1999	2,841	284	10	284		2,391	41
42	Roofing	1999	35,386	3,539	10	3,539		30,963	42
43	Home Office Wallpapering	1999	583		5			583	43
44	3 Air Conditioning Units	2000	2,118	212	10	212		1,572	44
45	Wallcoverings	2000	2,231		5			2,231	45
46	Chair Railings	2000	6,267	418	15	418		2,957	46
47	Cove Base	2000	1,797	180	10	180		1,258	47
48	Constr. Of 400 Wing - Design, Architecture & Engineering	2001	67,723	2,709	25	2,709		17,608	48
49	Constr. Of 400 Wing - Contractor Costs	2001	943,708	37,748	25	37,748		245,364	49
50	Constr. Of 400 Wing - Drawing, Surety Bond, & Misc.	2001	11,223	449	25	449		2,918	50
51	Constr. Of 400 Wing - Interest & Mortgage Ins. Premiums	2001	89,316	3,573	25	3,573		23,222	51
52	400 Wing Nurse Call Station	2001	10,104	674	15	674		4,379	52
53	400 Wing Cable TV System Cabling	2001	1,962	196	10	196		1,275	53
54	400 Wing Fire Alarm System	2001	14,696	980	15	980		6,369	54
55	400 Wing Telecommunication System	2001	4,025	402	10	402		2,615	55
56	400 Wing Door Monitor System	2001	2,640	264	10	264		1,716	56
57	400 Wing TV Wall Mounts	2001	6,030	603	10	603		3,920	57
58	400 Wing Signage	2001	1,161		5			1,161	58
59	400 Wing Hand Rails & Wall Guards	2001	2,319	155	15	155		1,006	59
60	400 Wing Chair Rails, Wallpaper, & Border	2001	4,208		5			4,208	60
61	400 Wing Door Guard	2001	607		5			607	61
62	400 Wing Cubicle Tracks, Curtains, & Window Treatments	2001	15,188	358	5-20	358		10,349	62
63	Landscaping, Shrubs, & Trees	2001	11,744	1,174	10	1,174		7,927	63
64	Fencing	2001	4,200	525	8	525		3,500	64
65	Wallpaper & Border - Existing Facility	2001	55,671		5			55,671	65
66	Storage Building	2001	3,268	327	10	327		2,234	66
67	Carpet - Administrative Offices	2001	2,687		5			2,687	67
68	Nurse Call System - Existing Facility	2001	3,700	247	15	247		1,625	68
69	Alarm System Services - Existing Facility	2001	3,903	260	15	260		1,821	69
70	TOTAL (lines 4 thru 69)		\$ 2,723,601	\$ 109,107		\$ 109,107	\$	\$ 1,308,392	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:

01/01/2007 Ending: 12/31/2007

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		\$ 2,723,601	\$ 109,107		\$ 109,107	\$	\$ 1,308,392	1
2	Replacement Signage - Existing Facility	2001	3,656		5			3,656	2
3	Door Guards - Existing Facility	2001	1,979		5			1,979	3
4	Vinyl Flooring & Cove Base 400 Wing	2001	11,615	1,162	10	1,162		7,551	4
5	25 Overbed Lights	2001	1,625	162	10	162		1,042	5
6	Painting Door Frames	2001	8,932		5			8,932	6
7	2P 50 Amp Disconnect	2001	955	48	20	48		307	7
8	Mini Blinds, Balances & Rods	2001	14,744		5			14,744	8
9	Asphalt Paving of Parking Lot	2001	14,193	1,419	10	1,419		9,462	9
10	A/C Units	2001	3,424	342	10	342		2,241	10
11	Overbed Lights	2002	3,055	306	10	306		1,786	11
12	Cubicle Curtains	2002	6,155	291	5	291		6,155	12
13	A/C Units - 2	2002	1,398	140	10	140		793	13
14	Security Camera System	2002	1,010	101	5	101		1,010	14
15	Fire Doors	2002	1,543	103	15	103		566	15
16	Roofing - North Entrance	2002	1,680	168	10	168		868	16
17	Wall Guard & End Caps	2002	1,497	100	15	100		516	17
18	Door Canopy	2002	3,800	253	15	253		1,266	18
19	Landscaping	2002	1,729	173	10	173		908	19
20	Home Office Light Fixtures	2002	211		10	21	21	125	20
21	Landscaping, Plants, Trees	2003	18,903	1,890	10	1,890		8,339	21
22	A/C Units	2003	5,551	555	10	555		2,519	22
23	Home Office Cabinets	2003	915		10	90	90	412	23
24	Landscaping, Plants, Trees	2004	4,371	437	10	437		1,566	24
25	100 Amp Transfer Switch to Generator	2004	11,865	791	15	791		2,966	25
26	Smoke Detectors	2004	1,600	160	10	160		587	26
27	Extend Activities Wall/Replace Door	2004	2,002	133	15	133		488	27
28	Air Conditioners	2004	1,814	181	10	181		634	28
29	Cove Base	2004	2,188	219	10	219		766	29
30	Hollow Metal Double Doors	2004	8,520	426	20	426		1,314	30
31	Wall/Flooring Kitchen	2004	2,983	298	10	298		894	31
32	Landscaping	2004	1,142	114	10	114		304	32
33	Cubicle Curtains	2004	289	58	5	58		159	33
34	TOTAL (lines 1 thru 33)		\$ 2,868,945	\$ 119,137		\$ 119,248	\$ 111	\$ 1,393,247	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:

01/01/2007 Ending: 12/31/2007

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		\$ 2,868,945	\$ 119,137		\$ 119,248	\$ 111	\$ 1,393,247	1
2	Generator Control Panel	2005	3,689	307	12	307		691	2
3	Resident Room Doors	2005	19,393	1,293	15	1,293		2,984	3
4	Fire Doors	2005	4,955	492	5-15	492		1,456	4
5	Water Heater	2005	4,000	400	10	400		1,033	5
6	Generator	2005	5,690	474	12	474		987	6
7	3 A/C's	2005	1,753	175	10	175		599	7
8	Electrical Wiring	2005	4,862	243	20	243		526	8
9	Dishwasher Booster Heater	2005	1,766	177	10	177		353	9
10	Kitchen & Laundry Flooring	2005	2,556	255	10	255		531	10
11	4-Door Monitoring System	2006	2,696	270	10	270		382	11
12	2 Door Awnings	2006	1,671	111	15	111		148	12
13	Built-In Waterfall	2006	3,499	350	10	350		554	13
14	Drywall & Supplies - Lobby	2006	1,234	82	15	82		116	14
15	Wallpaper	2006	5,219	1,044	5	1,044		1,259	15
16	Labor for Lobby Remodel	2006	17,774	1,185	15	1,185		1,382	16
17	4 Ton Heat Pump	2006	5,580	558	10	558		605	17
18	Doors	2006	47,653	3,285	10-15	3,285		4,911	18
19	A/C Units	2006	9,474	824	15	824		1,146	19
20	Flooring	2006	6,924	692	10	692		1,114	20
21	Ceiling Tiles	2006	4,411	468	8-10	468		528	21
22	Sprinkler System	2006	5,025	201	25	201		342	22
23	Carpet	2006	3,419	685	5	685		852	23
24	Electrical Wiring	2006	15,869	793	20	793		917	24
25	Smoke Damper	2006	1,793	90	20	90		165	25
26	Vinyl Fencing	2006	12,359	1,236	10	1,236		1,442	26
27	Concrete Patios & Sidewalks	2006	10,744	716	15	716		835	27
28	Landscaping	2006	4,325	433	10	433		793	28
29	Wallpapering	2007	12,135	329	5	329		329	29
30	A/C Units	2007	16,341	649	5-15	649		649	30
31	Flooring	2007	31,280	916	10	916		916	31
32	Alarm System	2007	4,732	359	7-10	359		359	32
33	Handrails	2007	11,039	56	5-15	56		56	33
34	TOTAL (lines 1 thru 33)		\$ 3,152,805	\$ 138,285		\$ 138,396	\$ 111	\$ 1,422,207	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,152,805	\$ 138,285		\$ 138,396	\$ 111	\$ 1,422,207	1
2	Interior Remodeling	2007	10,788	276	15-20	276		276	2
3	Roof	2007	5,700	75	20-25	75		75	3
4	Satellite System Cabling	2007	16,581	276	20	276		276	4
5	Electrical for HVAC Unit	2007	3,964	83	20	83		83	5
6	Home Office New Carpet	2007	1,375		10	70	70	69	6
7	Courtyard Landscaping	2007	3,800	222	10	222		222	7
8	Courtyard Pavilion Built	2007	9,870	274	15	274		274	8
9	Asphalt, Seal, Stripe Parking Lot	2007	13,500	281	8	281		281	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	TOTAL (lines 1 thru 33)		\$ 3,218,383	\$ 139,772		\$ 139,953	\$ 181	\$ 1,423,763	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 292,098	\$ 25,575	\$ 26,323	\$ 748	3-20	\$ 147,640	71
72	Current Year Purchases	26,808	1,667	1,765	98	3-20	1,765	72
73	Fully Depreciated Assets	343,246	2,241	2,522	281	5-10	343,246	73
74								74
75	TOTALS	\$ 662,152	\$ 29,483	\$ 30,610	\$ 1,127		\$ 492,651	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	00 Dodge Caravan-sold in '07	2005	\$	\$ 875	\$ 875	\$	4	\$	76
77	Facility Use	2006 Ford Wheelchair Van	2007	52,471	10,931	10,931		4	10,931	77
78	Facility Use	2007 Hyundai Vera Cruz	2007	29,106	3,032	3,032		4	3,032	78
79	See Attached Schedule			19,172		3,164	3,164		10,175	79
80	TOTALS			\$ 100,749	\$ 14,838	\$ 18,002	\$ 3,164		\$ 24,138	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)	\$ 4,052,948	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 188,565	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,472	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,940,552	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

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: \$ 2,964 Description: Time Clock \$263; Copier \$2,256; Postage Machine \$445

(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

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA <u>40</u></p>
--	--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		832		832
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		2,119		2,119
6	Transportation				
7	Contractual Payments		960		960
8	CNA Competency Tests		620		620
9	TOTALS	\$	\$ 4,531	\$	\$ 4,531
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,531		

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	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

- (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	8789 hrs	\$ 254,798		\$	1,632	8,789	\$ 256,430	1
2	Licensed Speech and Language Development Therapist	10a,8	2928 hrs	131,023			8,073	2,928	139,096	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	8238 hrs	253,762			1,228	8,238	254,990	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				283,892		283,892	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory Fees Other (specify): <u>X-Ray & Spec. Mattres</u>	39,3 39,3; 39,2				26,475 6,254	23,317		26,475 29,571	13
14	TOTAL			\$ 639,583		\$ 32,729	\$ 318,142	19,955	\$ 990,454	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 716,062	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>47,749</u>)	1,339,469		3
4	Supply Inventory (priced at <u>cost</u>)	11,925		4
5	Short-Term Investments			5
6	Prepaid Insurance	43,379		6
7	Other Prepaid Expenses	2,249		7
8	Accounts Receivable (owners or related parties)	211,865		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,324,949	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	212,266		13
14	Buildings, at Historical Cost	3,071,228		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	726,844		16
17	Accumulated Depreciation (book methods)	(1,911,882)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	132,257		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	59,593		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,310,506	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,635,455	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 115,772	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,853		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,688		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)	\$ 312,813	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	27,012		39
40	Mortgage Payable	3,747,947		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)	\$ 3,774,959	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,087,772	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 547,683	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,635,455	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,690)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,690)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	554,373	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)	\$ 554,373	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)	\$ 547,683	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	\$ 6,096,380	1
2	Discounts and Allowances for all Levels	(1,278,432)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,817,948	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	18,236	5
6	Therapy	1,156,227	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,174,463	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	73	13
14	Non-Patient Meals	230	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	26,268	19
20	Radiology and X-Ray	3,250	20
21	Other Medical Services	30,270	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 60,091	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	44,955	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44,955	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Machine Income</u>	2,009	28
28a	<u>Miscellaneous Income</u>	3,649	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,658	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,103,115	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	896,762	31
32	Health Care	2,424,554	32
33	General Administration	1,361,352	33
B. Capital Expense			
34	Ownership	470,838	34
C. Ancillary Expense			
35	Special Cost Centers	339,938	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)*	\$ 5,548,742	40
41	Income before Income Taxes (line 30 minus line 40)**	554,373	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 554,373	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: 01/01/2007

Ending:

12/31/2007

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	1,940	2,101	\$ 57,028	\$ 27.14	1
2	Assistant Director of Nursing	2,110	2,364	47,314	20.01	2
3	Registered Nurses	9,488	10,256	205,171	20.00	3
4	Licensed Practical Nurses	19,028	20,398	353,387	17.32	4
5	CNAs & Orderlies	73,441	78,169	717,833	9.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,099	3,398	32,510	9.57	8
9	Activity Director					9
10	Activity Assistants	5,460	5,703	52,768	9.25	10
11	Social Service Workers	4,823	4,894	61,377	12.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,847	26,058	204,122	7.83	15
16	Dishwashers					16
17	Maintenance Workers	4,055	4,597	52,813	11.49	17
18	Housekeepers	12,215	13,109	102,694	7.83	18
19	Laundry	10,958	11,577	94,580	8.17	19
20	Administrator	2,128	2,221	86,123	38.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,929	4,605	54,579	11.85	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	1,939	2,164	25,971	12.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,460	191,614	\$ 2,148,270 *	\$ 11.21	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	18	876	10,3	37
38	Nurse Consultant	N/A	24,603	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	25	1,612	11,3	44
45	Social Service Consultant	24	1,541	12,3	45
46	Other(specify) <u>Billing Consultant</u>	N/A	240	10,3	46
47	Quality Assurance Doctor	N/A	2,400	10,3	47
48					48
49	TOTAL (lines 35 - 48)	259	\$ 49,493		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

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				
Terrie Weible	Administrator	0.00	\$ 86,123	Workers' Compensation Insurance	\$ 93,823	IDPH License Fee	\$ 995				
				Unemployment Compensation Insurance	25,443	Advertising: Employee Recruitment	9,846				
				FICA Taxes	158,890	Health Care Worker Background Check	2,176				
				Employee Health Insurance	48,392	(Indicate # of checks performed 136)					
				Employee Meals		Patient Background Checks	29 464				
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fess	939				
				Employee Disability Insurance	809	Dues & Subscriptions	2,767				
				Staff Relations	8,611	IHCA Dues	4,032				
				Employee Dental Insurance	38	Bank Svc Charges	1,028				
				Home Office Employee Benefits	10,057	Home Office Dues & Subscriptions	2,586				
				Employee Physicals	481	Less: Public Relations Expense	()				
						Non-allowable advertising	()				
						Yellow page advertising	()				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 86,123	TOTAL (agree to Schedule V, line 22, col.8)			\$ 346,544	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,833	
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			
Wellington Management Co.-Management Fees			\$ 364,206	Section Not Applicable		\$	Out-of-State Travel	\$			
Health Care Financial, LLC - Management Fees			182,103								
							In-State Travel	5,573			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 546,309				Seminar Expense	2,654			
							Home Office Travel & Seminar	4,998			
C. Professional Services				TOTAL				Entertainment Expense			
Vendor/Payee	Type		Amount				()				
C.J. Schlosser & Co., LLC	Accounting Services		\$ 61,758				()				
Hughes & Associates, CPA	Audit Fees		7,695				()				
Ted Frapolli	Legal Fees		2,340				()				
McMahon, Berger, P.C.	Legal Fees		104				()				
Sandberg, Phoenix & von Gontard, P	Legal Fees		143				()				
Strang & Parish, LTD.	Legal Fees		978				()				
The Lowenbaum Partnership, LLC	Legal Fees		113				()				
							()				
							()				
							()				
							()				
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 73,131							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 13,225

* 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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

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 \$4,032
- (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. \$ 11,143 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 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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 230
- (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? 31.15%
 - 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: May, Cocagne & King The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Yet Available
- (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.

JERSEYVILLE NURSING AND REHABILITATION CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2007

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
DUES, FEES, SUBSCRIPTIONS, & PROMOTIONS	20	(120)
CNA TRAINING	13	120
To reclass CNA class expenses to proper lines		
ADMINISTRATIVE	17	(1,244)
ACTIVITIES	11	199
TRAVEL & SEMINAR	24	270
NURSING & MEDICAL RECORDS	10	368
PROFESSIONAL SERVICES	19	407
To reclass various expenses to proper lines		
TRAVEL & SEMINAR	24	(960)
CNA TRAINING	13	960
To reclass CNA class expenses to proper lines		
NURSE AIDE TRAINING	13	2,119
NURSING & MEDICAL RECORDS	10	(2,119)
To reclass CNA trainer wages		

Jerseyville Nursing & Rehabilitation Center
 Attachment to Sch. XI, Part D
 December 31, 2007

Detail of Line 79: Home Office Admin Vehicles

<u>Model, Make & Year</u>	<u>Year Acquired</u>	<u>Cost</u>	<u>Current Book Depreciation</u>	<u>Straight Line Depreciation</u>	<u>Adjustments</u>	<u>Life In Years</u>	<u>Accumulated Depreciation</u>
2000 Ford Taurus	2000	5,224	-	-	-	4	5,224
2004 Jaguar	2007	6,810	-	1,135	1,135	4	1,135
2001 Infiniti	2004	2,883	-	721	721	4	2,823
2004 Infiniti	2006	4,255	-	851	851	4	993
1998 Jaguar-sold in 2007	2004	-	-	411	411	4	-
2000 Dodge Caravan-sold in 20	2005	-	-	46	46	4	-
		<u>19,172</u>	<u>-</u>	<u>3,164</u>	<u>3,164</u>		<u>10,175</u>

Jerseyville Nursing and Rehabilitation Center
Attachment to Sch. XVII
December 31, 2007

BOOK TO TAX NET INCOME RECONCILIATION:

BOOK NET INCOME (LOSS)	554,373
DEPRECIATION ADJUSTMENT	(58,923)
MISC. NON-DEDUCTIBLE EXPENSES	5,610
CONVERSION TO CASH BASIS ADJUSTMENTS	(328,197)
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>172,863</u></u>

JERSEYVILLE NURSING AND REHABILITATION CENTER
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/2007

Miscellaneous Income	881
Gain on Sale of Auto	2,500
Record Copy Fee Received	20
2 Tens units purchased	72
Furniture & Cabinet purchased	60
Uniforms Reimbursed by Employee	66
Postage Reimbursement	20
Housekeeping Rebate	30
	<u>3,649</u>

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
 TRAVEL AND SEMINAR SCHEDULE
 ATTACHMENT TO SCHEDULE XIX PART G
 12/31/2007

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST	SEMINAR LODGING/ TRAVEL/MEALS
Terrie Weibel and Robin White	Administrator and Quality Assurance Nurse	3/28-3/29/07	East Peoria, IL	INHAA Annual Convention	Illinois Nursing Home Administrator's Association	190	
Cindy Draper	ADON	5/15/2007	St. Louis, MO	Neurological Emergencies	PESI, LLC	169	
Marcy Ballard & Robin White	Director of Nursing & Quality Assurance Nurse	5/16/2007	Fairview Heights, IL	Specialized Wound Management Conference	Specialized Wound Management	98	
Amy Elik	Corporate Accountant	9/11/2007	Kansas City, MO	HUD Multifamily Financial update, 2007	The Affordable Housing Association of Certified Public Accountants	275	350
Jenny Stewart & Cindy Bloodworth	Social Service & Activity Directors	5/21-5/22/07		12th Annual Conference on Alzheimer Disease & Related Disorders		120	
Terrie Weibel and Marcy Ballard	Administrator and Director of Nursing	11/13/2007	Springfield, IL	What is Immediate Jeopardy? - and What is Not?	Illinois Healthcare Association	170	
Various	Various	9/12-9/15/07	Springfield, IL	IHCA Annual Convention & Trade Show	Illinois Healthcare Association	540	50
Various	Various	10/26-12/14/07	7 week Web Seminar	The MDS Medicare and Illinois Medicaid Reimbursement	Illinois Healthcare Association	500	
Total Seminars						<u>2,062</u>	<u>400</u>
Total Seminar Lodging/Travel/Meals						400	
Other Travel Expense -\$250 each						5,573	
Home Office Travel & Seminar						4,998	
Training Manuals						192	
Total Travel and Seminar, Line 24						<u>13,225</u>	