

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER# 0020131 Report Period Beginning: 07/01/07 Ending: 06/30/08

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>22,326</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>27</u>	Intermediate (ICF)	<u>27</u>	<u>9,882</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>32,208</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>21</u>		<u>4,535</u>	<u>4,556</u>	8
9	SNF/PED					9
10	ICF	<u>14,183</u>	<u>8,650</u>		<u>22,833</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,204</u>	<u>8,650</u>	<u>4,535</u>	<u>27,389</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.04%

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 61 and days of care provided 4,535Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/07 Ending: 06/30/08

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	134,396	15,829	10,376	160,601		160,601		160,601		1
2	Food Purchase		142,961		142,961		142,961	(1,385)	141,576		2
3	Housekeeping	57,779	15,449		73,228		73,228		73,228		3
4	Laundry	32,657	7,053		39,710		39,710		39,710		4
5	Heat and Other Utilities			82,375	82,375		82,375		82,375		5
6	Maintenance	32,793	42,226	47,914	122,933		122,933	13,988	136,921		6
7	Other (specify):*										7
8	TOTAL General Services	257,625	223,518	140,665	621,808		621,808	12,603	634,411		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	1,383	13,383		9
10	Nursing and Medical Records	1,220,194	323,033	35,075	1,578,302	(212,822)	1,365,480	7,693	1,373,173		10
10a	Therapy	43,502	6,036	530,811	580,349	(530,811)	49,538		49,538		10a
11	Activities	42,760	4,188		46,948		46,948		46,948		11
12	Social Services	39,309		6,198	45,507		45,507		45,507		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,345,765	333,257	584,084	2,263,106	(743,633)	1,519,473	9,076	1,528,549		16
	C. General Administration										
17	Administrative	52,510		8,727	61,237	1,763	63,000	40,229	103,229		17
18	Directors Fees										18
19	Professional Services			207,825	207,825		207,825	(192,765)	15,060		19
20	Dues, Fees, Subscriptions & Promotions			51,693	51,693		51,693	(45,363)	6,330		20
21	Clerical & General Office Expenses	73,896	14,340	4,918	93,154		93,154	37,973	131,127		21
22	Employee Benefits & Payroll Taxes			318,016	318,016		318,016	617	318,633		22
23	Inservice Training & Education			3,871	3,871		3,871	1,872	5,743		23
24	Travel and Seminar			5,904	5,904	(3,550)	2,354	872	3,226		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			55,223	55,223		55,223	605	55,828		26
27	Other (specify):* PER DESK REVIEW			33,211	33,211		33,211	(12,366)	20,845		27
28	TOTAL General Administration	126,406	14,340	689,388	830,134	(1,787)	828,347	(168,326)	660,021		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,729,796	571,115	1,414,137	3,715,048	(745,420)	2,969,628	(146,647)	2,822,981		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: 07/01/07 Ending: 06/30/08

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			34,704	34,704		34,704	6,754	41,458			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,308	32,308		32,308	(22,983)	9,325			32
33	Real Estate Taxes			26,390	26,390		26,390		26,390			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(126,787)	5,213			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			225,402	225,402		225,402	(143,016)	82,386			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					745,420	745,420		745,420			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,312	48,312		48,312		48,312			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			48,312	48,312	745,420	793,732		793,732			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,729,796	571,115	1,687,851	3,988,762		3,988,762	(289,663)	3,699,099			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(107)	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	2,509	30		9
10	Interest and Other Investment Income	(1,062)	32		10
11	Discounts, Allowances, Rebates & Refunds	(36)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,871)	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	(375)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,340)	27		24
25	Fund Raising, Advertising and Promotional	(44,580)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(926)	20		28
29	Other-Attach Schedule <u>VENDING</u>	(1,278)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (79,066)		\$	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)	(210,597)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (210,597)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (289,663)		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		530,811	10a	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		38,011	10	42
43	Prescription Drugs	X		140,809	10	43
44	Oxygen, Supplies	X		25,730	10	44
45	Other-Attach Schedule <u>Ambulance</u>	X		7,433	10	45
46	Other-Attach Schedule <u>OtherAncilla</u>	X		2,626	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 745,420		47

BHF USE ONLY						
48		49		50		52

STATE OF ILLINOIS
 JACKSONVILLE CONVALESCENT CENTER

Report Period Beginning: 07/01/07
 Ending: 06/30/08

ID# 0020131

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:

07/01/07

Ending:

06/30/08

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	(107)	0	0	0	0	0	0	0	0	0	0	(107)	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	(107)	0	0	0	0	0	0	0	0	0	0	(107)	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	392	0	0	0	0	0	0	0	0	0	392	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(194,054)	0	0	0	0	0	0	0	0	0	(194,054)	19
20	Fees, Subscriptions & Promotions	(45,881)	175	0	0	0	0	0	0	0	0	0	(45,706)	20
21	Clerical & General Office Expenses	(36)	0	0	0	0	0	0	0	0	0	0	(36)	21
22	Employee Benefits & Payroll Taxes	0	(20,845)	0	0	0	0	0	0	0	0	0	(20,845)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(392)	0	0	0	0	0	0	0	0	0	(392)	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):*	(33,211)	20,845	0	0	0	0	0	0	0	0	0	(12,366)	27
28	TOTAL General Administration	(79,128)	(193,879)	0	(273,007)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(79,235)	(193,879)	0	(273,114)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/07 Ending:

06/30/08

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	2,509	2,066	0	0	0	0	0	0	0	0	0	4,575	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,062)	(21,921)	0	0	0	0	0	0	0	0	0	(22,983)	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	1,447	(151,855)	0	(150,408)	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)	(77,788)	(345,734)	0	(423,522)	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
SAM KLEIN	50%	HILLTOP NURSING HOME, INC.	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
DORYS BERG, TRUSTEE	50%	MEADOW MANOR, INC.	TAYLORVILLE	J'ville Land Trust	SPRINGFIELD	LAND TRUST
		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: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	34 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 INCOME		JACKSONVILLE LAND TRUST	100.00%	(52)	(52) 4
5	V	32 INTEREST INCOME		JACKSONVILLE LAND TRUST	100.00%	(21,869)	(21,869) 5
6	V						
7	V	19 MANAGEMENT FEES	205,894	NURSING HOME MANAGERS, INC.	50.00%		(205,894) 7
8	V	VAR SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	50.00%	135,137	135,137 8
9	V	19 ACCOUNTING		NURSING HOME MANAGERS - DIRECT ALLOCATION	50.00%	11,840	11,840 9
10	V	24 TRAVEL	392	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(392) 10
11	V	17 ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW		392	392 11
12	V	22 EMPL. BENEFITS & PR TAXES	20,845	TO TRANSFER HOME OFFICE EMPLOYEE BENEFITS			(20,845) 12
13	V	27 OTHER - GENERAL ADMIN.		AND PAYROLL TAXES TO OTHER - PER DESK REVIEW		20,845	20,845 13
14	Total		\$ 359,131			\$ 148,534	\$ * (210,597) 14

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

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									\$		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	\$ 0		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: 07/01/07 Ending: 06/30/08

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/07 Ending: 06/30/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	J'VILLE LAND TRUST	X		WORKING CAPITAL		8/27/04	70,000	699,869	DEMAND	4.0000	21,869	6								
7	STOCKHOLDERS	X		WORKING CAPITAL	INTEREST	6/22/07	150,000	150,000	DEMAND	6.0000	10,439	7								
8	STOCKHOLDERS	X		WORKING CAPITAL		3/28/06	8,000	128,000	DEMAND			8								
9	TOTAL Facility Related						\$ 228,000	\$ 977,869			\$ 32,308	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 228,000	\$ 977,869			\$ 32,308	15								

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

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

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

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

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

Ending: **06/30/08**

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 2007 report.		\$	42,411	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.)		\$	28,274	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(14,137)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	40,527	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.		\$	26,390	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	24,773	8	
	2004	25,952	9	
	2005	26,932	10	
	2006	28,274	11	
	2007	27,018	12	
LINE 4: 2007 REAL ESTATE TAX BILL		\$ 27,018		
6/12 OF \$27,018 =		13,509		
TOTAL		\$ 40,527		
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-18-301-002</u>	<u>JACKSONVILLE CONV. CTR.</u>	\$ <u>27,017.90</u>	\$ <u>27,017.90</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>27,017.90</u>	\$ <u>27,017.90</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

07/01/07 Ending:

06/30/08

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:

07/01/07

Ending:

06/30/08

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	\$ 541,766	\$	30	\$	\$	\$ 541,766	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		LANDSCAPING		1975	3,850		5			3,850	9
10		AIR CONDITIONING / HEATING		1974	14,470		8			14,470	10
11		MOTORS		1980	533		5			533	11
12		BIDS		1981	739	18	30	25	7	682	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	167	(46)	6,700	23
24		ROOF		1988	21,783	692	20	1,090	398	21,237	24
25		LIGHT DIFFUSER		1990	1,054	33	10		(33)	1,054	25
26		FLOORING		1990	1,030	33	15		(33)	1,030	26
27		WATER HEATER		1992	1,450	46	15		(46)	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	143	87	2,094	31
32		ROOF		1993	34,178	876	20	1,709	833	24,779	32
33		FIRE DOORS		1996	1,011	26	15	68	42	842	33
34		WATER HEATER		1997	3,915	100	15	261	161	2,925	34
35		AIR CONDITIONING		1997	5,982	153	10		(153)	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WATER HEATER	1998	\$ 1,950	\$ 50	15	\$ 130	\$ 80	\$ 1,267	37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	1,558	38
39	SHUTTERS	1999	912	23	15	60	37	527	39
40	DOOR ENTRANCE	2000	4,507	116	15	302	186	2,454	40
41	DUCT SMOKE DETECTORS	2000	2,295	59	20	115	56	909	41
42	DOOR	2000	2,280	58	15	152	94	1,178	42
43	ROOFTOP AIR CONDITIONER	2001	7,619	195	10	761	566	5,206	43
44	COMBUSTION AIR DUCT	2002	710	18	15	47	29	307	44
45	SMOKE DETECTORS	2002	2,511	64	15	168	104	1,047	45
46	GARAGE	2002	11,636	298	15	775	477	4,784	46
47	SMOKE DETECTORS	2002	809	21	15	54	33	333	47
48	FIRE DAMPERS	2002	1,166	30	15	77	47	480	48
49	ROOFTOP AIR CONDITIONER & HEATING (2)	2002	9,766	251	8	1,221	970	6,740	49
50	GARAGE INSULATION	2003	1,652	42	15	110	68	587	50
51	ROOFTOP AIR CONDITIONER & HEATING	2003	5,300	136	8	663	527	3,423	51
52	PARKING LOT	2003	13,306	341	15	887	546	4,287	52
53	VENTILATION	2004	4,380	112	15	292	180	1,192	53
54	SIDEWALK & CONCRETE PAD	2003	5,900	408	20	295	(113)	1,422	54
55	FENCE	2004	1,453	101	8	181	80	787	55
56	FIRE ALARM SYSTEM	2004	5,540	142	15	370	228	1,429	56
57	WATER HEATER	2005	2,673	69	15	178	109	608	57
58	ALARM SYSTEM	2005	4,171	107	15	278	171	950	58
59	EXIT FIXTURES	2005	1,541	40	10	154	114	398	59
60	EXHAUST SYSTEM	2006	3,545	91	15	236	145	472	60
61	SIDEWALK & CONCRETE PATIO	2005	3,600	308	20	180	(128)	525	61
62	ROOF	2006	83,800	2,149	20	4,191	2,042	7,333	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 856,591	\$ 7,646		\$ 15,518	\$ 7,872	\$ 709,865	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: 07/01/07 Ending: 06/30/08

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	\$ 180,721	\$ 14,755	\$ 16,134	\$ 1,379	VARIOUS	\$ 100,422	71
72	Current Year Purchases	22,061	11,120	577	(10,543)	VARIOUS	577	72
73	Fully Depreciated Assets	196,142					196,142	73
74		(77,603)					(77,603)	74
75	TOTALS	\$ 321,321	\$ 25,875	\$ 16,711	\$ (9,164)		\$ 219,538	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	\$ 3,249	\$ 7,050	\$ 3,801	4	\$ 27,615	76
77										77
78										78
79										79
80	TOTALS			\$ 28,203	\$ 3,249	\$ 7,050	\$ 3,801		\$ 27,615	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)		\$ 1,241,544	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 36,770	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 39,279	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 2,509	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 957,018	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 07/01/07

Ending 06/30/08

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

Fiscal Year Ending Annual Rent

12.	<u>06/30/09</u>	\$ <u>132,000</u>
13.	<u>06/30/10</u>	\$ <u>132,000</u>
14.	<u>06/30/11</u>	\$ <u>132,000</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/07 Ending: 06/30/08

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	\$	4,637	\$ 246,357	\$	4,637	\$ 246,357	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		671	66,028		671	66,028	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		2,385	218,426		2,385	218,426	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				140,809		140,809	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxy, Supp, Ambul.</u>	39 - 8					33,163		33,163	12
13	Other (specify): <u>Lab, X-Ray, Other</u>	39 - 8					40,637		40,637	13
14	TOTAL			\$	7,693	\$ 530,811	\$ 214,609	7,693	\$ 745,420	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: 07/01/07Ending: 06/30/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/08

(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	\$ 81,880	\$ 86,602	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,078,243	1,078,243	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,741	30,741	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)	\$ 1,190,864	\$ 1,195,586	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	333,022	425,186	16
17	Accumulated Depreciation (book methods)	(307,581)	(1,023,182)	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)	\$ 222,157	\$ 292,993	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,413,021	\$ 1,488,579	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 420,269	\$ 420,269	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	977,869	278,000	29
30	Accrued Salaries Payable	98,815	98,815	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,334	4,334	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,527	40,527	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)	\$ 1,541,814	\$ 841,945	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)	\$ 1,541,814	\$ 841,945	46
47	TOTAL EQUITY(page 18, line 24)	\$ (128,793)	\$ 646,634	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,413,021	\$ 1,488,579	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 144,855	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 144,855	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	350,098	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	151,681	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 501,779	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)	\$ 646,634	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/07Ending: 06/30/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,473,897	1
2	Discounts and Allowances for all Levels	(356,015)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,117,882	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	213,477	6
7	Oxygen	5,018	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 218,495	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	107	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 107	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,062	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,062	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	1,278	28
28a	WAGE ASSIGNMENTS	36	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,314	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,338,860	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	621,808	31
32	Health Care	2,263,106	32
33	General Administration	830,134	33
B. Capital Expense			
34	Ownership	225,402	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	48,312	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,988,762	40
41	Income before Income Taxes (line 30 minus line 40)**	350,098	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 350,098	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: **07/01/07**

Ending:

06/30/08

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	\$ 53,204	\$ 25.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,565	3,987	101,404	25.43	3
4	Licensed Practical Nurses	24,750	25,978	486,466	18.73	4
5	CNAs & Orderlies	52,602	54,207	579,120	10.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,109	4,169	43,502	10.43	8
9	Activity Director	1,293	1,375	15,281	11.11	9
10	Activity Assistants	2,860	2,952	27,479	9.31	10
11	Social Service Workers	3,065	3,455	39,309	11.38	11
12	Dietician					12
13	Food Service Supervisor	1,958	2,174	30,184	13.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,250	10,763	104,212	9.68	15
16	Dishwashers					16
17	Maintenance Workers	3,040	3,222	32,793	10.18	17
18	Housekeepers	5,934	6,263	57,779	9.23	18
19	Laundry	3,754	3,895	32,657	8.38	19
20	Administrator	2,000	2,080	52,510	25.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,359	5,866	73,896	12.60	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)	126,539	132,466	\$ 1,729,796 *	\$ 13.06	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	287	\$ 10,376	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	17	515	10 - 3	37
38	Nurse Consultant	466	26,082	10 - 3	38
39	Pharmacist Consultant	104	1,950	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	6,198	12 - 3	45
46	Other(specify)				46
47	PSYCHIATRIC CONSULTANT	24	6,000	10 - 3	47
48	ADMINISTRATIVE CONSULTANT	320	8,727	17 - 3	48
49	TOTAL (lines 35 - 48)	1,437	\$ 71,848		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 528	10 - 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 528		53

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning: 07/01/07

Ending: 06/30/08

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 13 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,773 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. \$ 48,312
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. \$ 107
- (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 2 - SCHEDULE III - QUESTION K

NUMBER OF MEDICARE CERTIFIED BEDS
 07/1/07 - 12/31/07 27 BEDS
 01/01/08 - 06/30/08 61 BEDS

PAGE 3 & 4 - SCHEDULE V - LINE 27

LINE 27 - GENERAL ADMINISTRATION - OTHER
 SALES TAX \$ 6,871
 BAD DEBTS 26,340
 TOTAL LINE 27 - COLUMN 3 \$ 33,211

PAGE 3 - SCHEDULE V - LINE 23

DETAIL - INSERVICE TRAINING & EDUCATION

CPR COURSES \$ 140
 FOOD SERVICE SANITATION SEMINAR 50
 INFECTION CONTROL SEMINAR 190
 INHAA CONVENTION 125
 LIFE SAFETY SEMINAR 150
 MEDICAID AUDIT PREP WORKSHOP 100
 HOME OFFICE INSERVICES 3,116
 NHM ALLOCATION 1,872
 SCHEDULE V - LINE 23 - COLUMN 8 \$ 5,743

PAGE 3 & 4 - SCHEDULE V

DETAIL COLUMN 5 - RECLASSIFICATIONS

		LINE #
RECLASS TO:		
NURSE CONSULTANT TRAVEL:	\$ 1,787	10
ADMINISTRATIVE CONSULTANT TRAVEL	<u>1,763</u>	17
RECLASS FROM: TRAVEL	\$ <u>(3,550)</u>	24
RECLASS FROM:		
MEDICARE SUPPLIES	\$ (2,468)	10
MEDICARE X-RAYS	(13,354)	10
MEDICARE DRUGS	(131,902)	10
MEDICARE LABORATORY FEES	(24,657)	10
MEDICARE I.V. THERAPY	(8,907)	10
MEDICARE AMBULANCE	(7,433)	10
OXYGEN	(23,262)	10
MEDICARE OTHER ANCILLARY SERVICES	(2,626)	10
PHYSICAL THERAPY	(218,426)	10A
SPEECH THERAPY	(66,028)	10A
OCCUPATIONAL THERAPY	<u>(246,357)</u>	10A
RECLASS TO: ANCILLARY SERVICES	\$ <u>745,420</u>	39

PAGE 9 - SCHEDULE IX - LINE 6

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

IONS

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION	
LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 39,279
NURSING HOME MANAGERS ALLOCATION	2,179
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 41,458</u>

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME	
NET INCOME - LINE 43	\$ 350,098
* MANAGEMENT FEE 6/30/07	(50,188)
* MANAGEMENT FEE 6/30/08	81,082
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(1,062)
TAXABLE INCOME	<u>\$ 379,930</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	\$ 44,580
CHAMBER OF COMMERCE DUES	200
FRANCHISE FEES	100
CLIA LAB WAIVER	150
INHAA DUES	100
AUTOMOBILE LICENSE	158
YELLOW PAGES	926
MORGAN COUNTY HEALTH DEPT	100
FOOD SERVICE SUPERVISER CERTIFICATE	35
	<u>\$ 46,349</u>

PAGE 21 - SCHEDULE XIX - SECTION G

TRAVEL AND SEMINAR	
ACTIVITY MILEAGE REIMBURSEMENT	\$ 554
SEMINAR & WORKSHOP	774
D.O.N. MILEAGE REIMBURSEMENT	379
ADMINISTRATOR MILEAGE REIMB.	56
MISCELLANEOUS MILEAGE REIMB.	591
	<u>\$ 2,354</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
 2007

	JULY 07	AUG	SEPT	OCT	NOV	DEC	JAN 08	FEB	MARCH	APRIL	MAY	JUNE	2007 TOTAL	LINE #
SALARIES-ADMIN	1,913	1,694	1,698	1,756	1,824	1,797	\$1,993	\$2,024	\$1,948	\$1,815	\$1,685	\$1,756	\$21,902	17
SALARIES-CLERIC	2,561	2,622	2,627	2,717	2,822	2,780	3,218	3,268	3,147	2,932	2,722	2,836	34,252	21
SALARIES-CONTR	1,417	1,451	1,454	1,504	1,562	1,539	1,600	1,625	1,564	1,457	1,353	1,410	17,935	17
SALARIES-NURSE	621	365	366	379	393	387	920	935	900	838	778	811	7,693	10
ACCOUNTING	105	68	69	71	74	73	147	150	144	134	125	130	1,289	19
WORK COMP INS	65	32	32	33	35	34	69	70	67	63	58	60	617	22
SUPPLIES	83	107	107	111	115	113	165	167	161	150	139	145	1,563	21
TELEPHONE	128	123	123	127	132	130	254	258	248	231	215	224	2,194	21
EMPL BENEFITS	1,189	1,244	1,246	1,289	1,339	1,319	1,176	1,195	1,150	1,072	995	1,037	14,249	22
PAYROLL TAXES	448	557	558	577	599	590	580	589	567	529	491	511	6,596	22
TRAVEL	59	72	72	75	78	77	148	150	144	134	125	130	1,264	24
IN SERVICE	89	211	211	219	227	224	123	125	120	112	104	108	1,872	23
MEDICAL CONSULT	232	273	274	283	294	290	246	250	241	224	208	217	3,031	9
MACHINE RENTAL	20	580	582	602	625	615	815	828	797	743	690	719	7,616	6
OWNERS COMP	0	0	0	0	0	0	0	0	0	0	0	0	0	17
INS-PROP,LIAB,WC	(88)	128	128	133	138	136	6	6	5	5	5	5	605	26
DEPRECIATION	168	169	169	175	181	179	202	205	198	184	171	178	2,179	30
RENT	422	413	413	428	444	438	472	479	461	430	399	416	5,213	34
MAINTENANCE	123	369	370	382	397	391	771	783	753	702	652	679	6,372	6
FEES & PUBLICAT	13	51	51	53	55	54	12	12	11	10	10	10	343	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
MEDICAL CONSULT	0	(319)	(319)	(330)	(343)	(338)	0	0	0	0	0	0	(1,648)	9
TOTAL	9,568	10,211	10,230	10,581	10,990	10,827	\$12,915	\$13,116	\$12,628	\$11,766	\$10,924	\$11,381	\$135,137	
FIXED ASSETS	0	0	0	0	0	0							135,137	
EQUIP - PRIOR	13,978	13,680	13,706	14,176	14,724	14,506	14,793	15,023	14,464	13,477	12,513	13,036	14,006	
EQUIP - CURR	883	864	865	1,167	1,540	1,893	0	0	248	231	214	223	677	
EQUIP - FULLY DEP	5,030	4,923	4,932	5,102	5,299	5,220	5,324	5,406	5,205	4,850	4,503	4,691	5,041	
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	1,489	1,457	1,460	1,510	1,568	1,545	1,576	1,600	1,541	1,436	1,333	1,389	1,492	

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	2,297	2,135	2,316		1,480	1,606	9,834
OCTOBER	2,414	2,286	2,309		1,478	1,693	10,180
NOVEMBER	2,208	2,308	2,308		1,423	1,649	9,896
DECEMBER	2,162	2,394	2,490		1,505	1,868	10,419
TOTAL	25,929	26,022	27,620	0	17,991	20,827	118,389 118,389

OCCUPIED DAYS 2008	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,239	2,512	2,573		1,460	1,936	10,720
FEBRUARY	2,140	2,453	2,399		1,407	1,909	10,308
MARCH	2,260	2,436	2,476		1,475	1,985	10,632
APRIL	2,248	2,186	2,456		1,483	1,867	10,240
MAY	2,356	2,118	2,479		1,731	2,002	10,686
JUNE	2,283	2,143	2,410		1,661	1,881	10,378
JULY	2,369	2,288	2,429		1,632	1,992	10,710
AUGUST							0
SEPTEMBER							0
OCTOBER							0
NOVEMBER							0
DECEMBER							0
TOTAL	15,895	16,136	17,222	0	10,849	13,572	73,674 73,674

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%
AUGUST	22.45%	21.67%	23.09%	15.80%	16.99%	100.00%
SEPTEMBER	23.36%	21.71%	23.55%	15.05%	16.33%	100.00%
OCTOBER	23.71%	22.46%	22.68%	14.52%	16.63%	100.00%
NOVEMBER	22.31%	23.32%	23.32%	14.38%	16.66%	100.00%
DECEMBER	20.75%	22.98%	23.90%	14.44%	17.93%	100.00%

ALLOCATION PERCENTAGE 2008	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	20.89%	23.43%	24.00%	13.62%	18.06%	100.00%
FEBRUARY	20.76%	23.80%	23.27%	13.65%	18.52%	100.00%
MARCH	21.26%	22.91%	23.29%	13.87%	18.67%	100.00%
APRIL	21.95%	21.35%	23.98%	14.48%	18.23%	100.00%
MAY	22.05%	19.82%	23.20%	16.20%	18.73%	100.00%
JUNE	22.00%	20.65%	23.22%	16.01%	18.12%	100.00%
JULY	22.12%	21.36%	22.68%	15.24%	18.60%	100.00%