

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>36,966</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>36,966</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>2,336</u>	<u>1,776</u>	<u>6,352</u>	<u>10,464</u>	8
9	SNF/PED					9
10	ICF	<u>12,579</u>	<u>12,275</u>	<u>593</u>	<u>25,447</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,915</u>	<u>14,051</u>	<u>6,945</u>	<u>35,911</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.15%

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

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

YES NO

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

YES NO

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

Date started 04/01/1994

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

YES Date 04/01/1994 NO

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

YES NO If YES, enter number of beds certified 101 and days of care provided 6,296Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	218,350	27,460	7,373	253,183		253,183		253,183		1
2	Food Purchase		214,648		214,648		214,648	(1,096)	213,552		2
3	Housekeeping	108,495	18,523		127,018		127,018		127,018		3
4	Laundry	99,128	20,357		119,485		119,485		119,485		4
5	Heat and Other Utilities			127,286	127,286		127,286		127,286		5
6	Maintenance	53,996	17,523	39,028	110,547		110,547	549	111,096		6
7	Other (specify):* Waste Removal			7,737	7,737		7,737		7,737		7
8	TOTAL General Services	479,969	298,511	181,424	959,904		959,904	(547)	959,357		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,503,393	137,274	51,718	1,692,385	(7,173)	1,685,212	(824)	1,684,388		10
10a	Therapy	24,628	7,691	658,057	690,376		690,376	(44,487)	645,889		10a
11	Activities	54,636	4,339	5,374	64,349	896	65,245		65,245		11
12	Social Services	61,928	197	1,645	63,770		63,770		63,770		12
13	CNA Training			2,034	2,034	6,006	8,040	(475)	7,565		13
14	Program Transportation		8,050		8,050		8,050		8,050		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,644,585	157,551	728,428	2,530,564	(271)	2,530,293	(45,786)	2,484,507		16
	C. General Administration										
17	Administrative	90,117	8,709	543,031	641,857	(1,876)	639,981	(342,628)	297,353		17
18	Directors Fees			60,000	60,000		60,000	(60,000)			18
19	Professional Services			74,770	74,770	194	74,964	(58,849)	16,115		19
20	Dues, Fees, Subscriptions & Promotions			36,199	36,199		36,199	(18,326)	17,873		20
21	Clerical & General Office Expenses	51,627	25,119	69,559	146,305	1,297	147,602	30,440	178,042		21
22	Employee Benefits & Payroll Taxes			309,114	309,114		309,114	12,085	321,199		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,171	12,171	656	12,827	(495)	12,332		24
25	Other Admin. Staff Transportation							3,684	3,684		25
26	Insurance-Prop.Liab.Malpractice			51,575	51,575		51,575	222	51,797		26
27	Other (specify):*										27
28	TOTAL General Administration	141,744	33,828	1,156,419	1,331,991	271	1,332,262	(433,867)	898,395		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,266,298	489,890	2,066,271	4,822,459		4,822,459	(480,200)	4,342,259		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center #0039339 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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			206,126	206,126	206,126	4,386	210,512			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			215,797	215,797	215,797	(19,254)	196,543			32
33	Real Estate Taxes			51,522	51,522	51,522		51,522			33
34	Rent-Facility & Grounds						14,521	14,521			34
35	Rent-Equipment & Vehicles			2,884	2,884	2,884		2,884			35
36	Other (specify):* Mortgage Ins.			18,327	18,327	18,327		18,327			36
37	TOTAL Ownership			494,656	494,656	494,656	(347)	494,309			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			1,156	1,156	1,156		1,156			38
39	Ancillary Service Centers		224,516	28,427	252,943	252,943		252,943			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			55,450	55,450	55,450		55,450			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		224,516	85,033	309,549	309,549		309,549			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,266,298	714,406	2,645,960	5,626,664	5,626,664	(480,547)	5,146,117			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	(1,096)	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	(19,359)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,478)	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	(4,638)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,764)	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	(8,312)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,647)		\$	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)	(429,900)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (429,900)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (480,547)		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.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Reimbursements	\$ (269)	21	1
2	Offset C.N.A. Book Reimbursement	(475)	13	2
3	Offset LTC Insurance Reimbursement	(1,531)	26	3
4	Offset Employee Health Insurance Reimbursement	(250)	22	4
5	Eliminate PAC Dues, including lobbying portion	(2,485)	20	5
6	Eliminate Additional Promotional Advertising	(289)	24	6
7	Eliminate Additional Meals & Entertainment	(824)	10	7
8	Eliminate 2009 IDPH License paid in 2008	(995)	20	8
9	Eliminate Non-Allowable Dues	(1,250)	20	9
10	Offset duplicate legal fees	56	19	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	(8,312)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(1,096)	0	0	0	0	0	0	0	0	0	0	(1,096)	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	549	0	0	0	0	0	0	0	0	0	549	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,096)	549	0	0	0	0	0	0	0	0	0	(547)	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	(824)	0	0	0	0	0	0	0	0	0	0	(824)	10
10a	Therapy	0	0	(44,487)	0	0	0	0	0	0	0	0	(44,487)	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	(475)	0	0	0	0	0	0	0	0	0	0	(475)	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	(1,299)	0	(44,487)	0	(45,786)	16							
	C. General Administration													
17	Administrative	0	75,225	(417,853)	0	0	0	0	0	0	0	0	(342,628)	17
18	Directors Fees	0	0	(60,000)	0	0	0	0	0	0	0	0	(60,000)	18
19	Professional Services	56	2,691	(61,596)	0	0	0	0	0	0	0	0	(58,849)	19
20	Fees, Subscriptions & Promotions	(21,972)	3,646	0	0	0	0	0	0	0	0	0	(18,326)	20
21	Clerical & General Office Expenses	(269)	30,709	0	0	0	0	0	0	0	0	0	30,440	21
22	Employee Benefits & Payroll Taxes	(250)	12,335	0	0	0	0	0	0	0	0	0	12,085	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,927)	4,432	0	0	0	0	0	0	0	0	0	(495)	24
25	Other Admin. Staff Transportation	0	3,684	0	0	0	0	0	0	0	0	0	3,684	25
26	Insurance-Prop.Liab.Malpractice	(1,531)	1,753	0	0	0	0	0	0	0	0	0	222	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,893)	134,475	(539,449)	0	(433,867)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,288)	135,024	(583,936)	0	(480,200)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	4,386	0	0	0	0	0	0	0	0	0	4,386	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,359)	105	0	0	0	0	0	0	0	0	0	(19,254)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	14,521	0	0	0	0	0	0	0	0	0	14,521	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	(19,359)	19,012	0	0	0	0	0	0	0	0	0	(347)	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)	(50,647)	154,036	(583,936)	0	(480,547)	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 Fin.	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: 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	5 See Schedule VIII	\$	Wellington Management Co.	60.00%	\$	\$	1
2	V	6 See Schedule VIII		Wellington Management Co.	60.00%	549	549	2
3	V	17 See Schedule VIII		Wellington Management Co.	60.00%	75,225	75,225	3
4	V	19 See Schedule VIII		Wellington Management Co.	60.00%	2,691	2,691	4
5	V	20 See Schedule VIII		Wellington Management Co.	60.00%	3,646	3,646	5
6	V	21 See Schedule VIII		Wellington Management Co.	60.00%	30,709	30,709	6
7	V	22 See Schedule VIII		Wellington Management Co.	60.00%	12,335	12,335	7
8	V	24 See Schedule VIII		Wellington Management Co.	60.00%	4,432	4,432	8
9	V	25 See Schedule VIII		Wellington Management Co.	60.00%	3,684	3,684	9
10	V	26 See Schedule VIII		Wellington Management Co.	60.00%	1,753	1,753	10
11	V	30 See Schedule VIII		Wellington Management Co.	60.00%	4,386	4,386	11
12	V	32 See Schedule VIII		Wellington Management Co.	60.00%	105	105	12
13	V	34 See Schedule VIII		Wellington Management Co.	60.00%	14,521	14,521	13
14	Total		\$			\$ 154,036	\$ * 154,036	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	\$ 362,021	Wellington Management Co.	60.00%	\$	(362,021)	15
16	V	17 Management Fees	181,010	Health Care Financial, LLC	40.00%	125,178	(55,832)	16
17	V	19 Professional Services	61,596	C.J. Schlosser & Company, LLC	40.00%		(61,596)	17
18	V	10a Therapy Services	658,057	N.W. Rehab, LLC	100.00%	613,570	(44,487)	18
19	V	10 Nurse Consultant	44,945	Wellington Management Co.	60.00%	44,945		19
20	V	18 Director's Fees	36,000	John H. Rotherth	60.00%		(36,000)	20
21	V	18 Director's Fees	12,000	J. Terry Dooling	20.00%		(12,000)	21
22	V	18 Director's Fees	12,000	David L. Kamler	20.00%		(12,000)	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,367,629			\$ 783,693	\$ * (583,936)	39

* 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: 01/01/2008 Ending: 12/31/2008

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	275,598	8.58	21.44	Salary	\$ 75,225	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	\$ 75,225		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: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Wellington Management Corporation
 Street Address 707 Spirit 40 Park Drive
 City / State / Zip Code Chesterfield, MO 63005
 Phone Number (618) 537-8447
 Fax Number (618) 537-8446

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs 20,655,999	6	\$	\$	4,429,158	\$ 0	1
2	6	Maintenance	Accumulated Costs 20,655,999	6	2,559		4,429,158	549	2
3	17	Administrative	Accumulated Costs 20,655,999	6	350,823	350,823	4,429,158	75,225	3
4	19	Professional Services	Accumulated Costs 20,655,999	6	12,552		4,429,158	2,691	4
5	20	Dues, Fees, Subs, & Promos	Accumulated Costs 20,655,999	6	17,005		4,429,158	3,646	5
6	21	Clerical & General Office Exp.	Accumulated Costs 20,655,999	6	143,216	88,949	4,429,158	30,709	6
7	22	Employee Benefits & PR Taxes	Accumulated Costs 20,655,999	6	57,527		4,429,158	12,335	7
8	24	Travel & Seminar	Accumulated Costs 20,655,999	6	20,671		4,429,158	4,432	8
9	25	Other Admin Staff Transport	Accumulated Costs 20,655,999	6	17,182		4,429,158	3,684	9
10	26	Insuranc - Prop, Liab, Malprac.	Accumulated Costs 20,655,999	6	8,177		4,429,158	1,753	10
11	30	Depreciation	Accumulated Costs 20,655,999	6	20,454		4,429,158	4,386	11
12	32	Interest Expense	Accumulated Costs 20,655,999	6	488		4,429,158	105	12
13	34	Rent - Facility and Grounds	Accumulated Costs 20,655,999	6	67,721		4,429,158	14,521	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				\$ 718,375	\$ 439,772		\$ 154,036	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	\$ 3,645,963	10/31/41	5.8500	\$ 212,469	1				
2	First National Bank of St. Louis		X	Van Loan	\$1,221.44	2/21/07	39,507	14,976	11/21/09	7.0000	1,402	2				
3									Interest Income		(19,359)	3				
4									Loan Cost Amortization		1,926	4				
5									Home Office Allocation		105	5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related				\$22,063.02		\$ 3,760,207	\$ 3,660,939			\$ 196,543	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	\$ 3,660,939			\$ 196,543	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,327 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Jerseyville Nursing & Rehabilitation Center COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0039339

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>04-875-004-00</u>	<u>Outlots 59,62,63, & 64 S Pt. Outlot 6</u>	\$ <u>47,515.66</u>	\$ <u>47,515.66</u>
2. <u>04-208-017-00</u>	<u>S28 T8 R11 Unplatted Parcels</u>	\$ <u>3,506.22</u>	\$ <u>3,506.22</u>
3. _____	<u>S & W PT SE 1/4 NE 1/4 Less E PT</u>	\$ _____	\$ _____
4. _____	<u>Less .10 ACS for HWY</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>51,021.88</u>	\$ <u>51,021.88</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 Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		\$ 1,180,668	\$ 47,227	25	\$ 47,227		\$ 696,594	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Parking Lot		1994	26,304		5-10 yrs			26,304	9
10		Exterior Remodeling		1994	10,000	667	15	667		9,722	10
11		Flooring		1994	29,698		10			29,698	11
12		Electrical		1994	11,690	585	20	585		8,326	12
13		Air Conditioning		1994	25,830		10			25,830	13
14		Interior Remodeling		1994	40,265	1,359	5-20 yrs	1,359		39,050	14
15		Shed		1994	3,267		10			3,267	15
16		Nurses' Station		1994	6,055	303	20	303		4,415	16
17		Home Office Wallpapering/Flooring		1994	3,390		5			3,390	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		1,382	20
21		Storage Building		1996	3,500		10			3,500	21
22		2 Boilers		1996	7,400	370	20	370		4,779	22
23		Roof Repair & Drains Installed		1996	3,619		10			3,619	23
24		Ceiling Tile & End Caps		1996	3,506	244	12	244		3,506	24
25		Storage Building		1997	3,356		10			3,356	25
26		Alarm System		1997	1,750		10			1,750	26
27		Wallcovering		1997	6,355		5-10 yrs			6,355	27
28		Ceiling Tile & End Caps		1997	1,485	124	12	124		1,423	28
29		3 Windows & Sills & 1 Door Replaced		1997	4,108	274	15	274		3,104	29
30		Baseboards Remodeled		1997	1,167		10			1,167	30
31		Air Conditioner Unit		1997	2,185		10			2,185	31
32		Concrete Patio & Sidewalk		1997	1,842	123	15	123		1,392	32
33		Rock		1997	502		5			502	33
34		Landscaping		1997	1,075		10			1,075	34
35		Roofing		1998	2,592	22	10	22		2,592	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:

01/01/2008 Ending: 12/31/2008

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	\$ 12	10	\$ 12	\$	\$ 1,437	37
38	Baseboard Remodeling	1998	1,919	73	10	73		1,919	38
39	Air Conditioning Units & Ducts	1998	13,420	691	10-20 yrs	691		12,830	39
40	Wallcoverings	1998	1,495	137	10	137		1,495	40
41	4 Air Conditioning Units	1999	2,841	284	10	284		2,675	41
42	Roofing	1999	35,386	3,539	10	3,539		34,501	42
43	Home Office Wallpapering	1999	570		5			570	43
44	3 Air Conditioning Units	2000	2,118	212	10	212		1,783	44
45	Wallcoverings	2000	2,231		5			2,231	45
46	Chair Railings	2000	6,267	418	15	418		3,374	46
47	Cove Base	2000	1,797	180	10	180		1,437	47
48	Constr. Of 400 Wing - Design, Architecture & Engineering	2001	67,723	2,709	25	2,709		20,317	48
49	Constr. Of 400 Wing - Contractor Costs	2001	943,708	37,748	25	37,748		283,112	49
50	Constr. Of 400 Wing - Drawing, Surety Bond, & Misc.	2001	11,223	449	25	449		3,367	50
51	Constr. Of 400 Wing - Interest & Mortgage Ins. Premium	2001	89,316	3,573	25	3,573		26,795	51
52	400 Wing Nurse Call Station	2001	10,104	674	15	674		5,052	52
53	400 Wing Cable TV System Cabling	2001	1,962	196	10	196		1,472	53
54	400 Wing Fire Alarm System	2001	14,696	980	15	980		7,348	54
55	400 Wing Telecommunication System	2001	4,025	403	10	403		3,019	55
56	400 Wing Door Monitor System	2001	2,640	264	10	264		1,980	56
57	400 Wing TV Wall Mounts	2001	6,030	603	10	603		4,523	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		1,159	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 yrs	358		10,707	62
63	Landscaping, Shrubs, & Trees	2001	11,744	1,174	10	1,174		9,102	63
64	Fencing	2001	4,200	525	8	525		4,025	64
65	Wallpaper & Border - Existing Facility	2001	55,671		5			55,671	65
66	Storage Building	2001	3,268	327	10	327		2,560	66
67	Carpet - Administrative Offices	2001	2,687		5			2,687	67
68	Nurse Call System - Existing Facility	2001	3,700	247	15	247		1,871	68
69	Alarm System Services - Existing Facility	2001	3,903	260	15	260		2,082	69
70	TOTAL (lines 4 thru 69)		\$ 2,723,511	\$ 107,593		\$ 107,593	\$	\$ 1,416,134	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:

01/01/2008 Ending: 12/31/2008

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		\$ 2,723,511	\$ 107,593		\$ 107,593	\$	\$ 1,416,134	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		8,711	4
5	25 Overbed Lights	2001	1,625	163	10	163		1,205	5
6	Painting Door Frames	2001	8,932		5			8,932	6
7	2P 50 Amp Disconnect	2001	955	48	20	48		354	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		10,881	9
10	A/C Units	2001	3,424	342	10	342		2,584	10
11	Overbed Lights	2002	3,055	306	10	306		2,091	11
12	Cubicle Curtains	2002	6,155		5			6,155	12
13	A/C Units - 2	2002	1,398	140	10	140		932	13
14	Security Camera System	2002	1,010		5			1,010	14
15	Fire Doors	2002	1,543	103	15	103		668	15
16	Roofing - North Entrance	2002	1,680	168	10	168		1,036	16
17	Wall Guard & End Caps	2002	1,497	100	15	100		615	17
18	Door Canopy	2002	3,800	253	15	253		1,520	18
19	Landscaping	2002	1,729	173	10	173		1,081	19
20	Home Office Light Fixtures	2002	207		10	21	21	143	20
21	Landscaping, Plants, Trees	2003	18,903	1,891	10	1,891		10,230	21
22	A/C Units	2003	5,551	555	10	555		3,072	22
23	Home Office Cabinets	2003	895		10	89	89	492	23
24	Landscaping, Plants, Trees	2004	4,371	437	10	437		2,004	24
25	100 Amp Transfer Switch to Generator	2004	11,865	791	15	791		3,757	25
26	Smoke Detectors	2004	1,600	160	10	160		747	26
27	Extend Activities Wall/Replace Door	2004	2,002	133	15	133		623	27
28	Air Conditioners	2004	1,814	181	10	181		816	28
29	Cove Base	2004	2,188	218	10	218		985	29
30	Hollow Metal Double Doors	2004	8,520	426	20	426		1,740	30
31	Wall/Flooring Kitchen	2004	2,983	298	10	298		1,193	31
32	Landscaping	2005	1,142	114	10	114		419	32
33	Cubicle Curtains	2005	289	58	5	58		217	33
34	TOTAL (lines 1 thru 33)		\$ 2,868,831	\$ 117,232		\$ 117,342	\$ 110	\$ 1,510,726	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:

01/01/2008 Ending: 12/31/2008

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		\$ 2,868,831	\$ 117,232		\$ 117,342	\$ 110	\$ 1,510,726	1
2	Generator Control Panel	2005	3,689	307	12	307		999	2
3	Resident Room Doors	2005	19,393	1,293	15	1,293		4,277	3
4	Fire Doors	2005	4,955	492	5-15 yrs	492		1,949	4
5	Water Heater	2005	4,000	400	10	400		1,433	5
6	Generator	2005	5,690	474	12	474		1,462	6
7	3 A/C's	2005	1,753	175	10	175		526	7
8	Electrical Wiring	2005	4,862	243	20	243		770	8
9	Dishwasher Booster Heater	2005	1,766	176	10	176		530	9
10	Kitchen & Laundry Flooring	2005	2,556	255	10	255		788	10
11	4-Door Monitoring System	2006	2,696	269	10	269		652	11
12	2 Door Awnings	2006	1,671	111	15	111		260	12
13	Built-In Waterfall	2006	3,499	350	10	350		904	13
14	Drywall & Supplies - Lobby	2006	1,234	82	15	82		199	14
15	Wallpaper	2006	5,219	1,044	5	1,044		2,302	15
16	Labor for Lobby Remodel	2006	17,774	1,185	15	1,185		2,567	16
17	4 Ton Heat Pump	2006	5,580	558	10	558		1,163	17
18	Doors	2006	47,653	3,285	10-15 yrs	3,285		8,196	18
19	A/C Units	2006	9,474	824	15	824		1,970	19
20	Flooring	2006	6,924	692	10	692		1,807	20
21	Ceiling Tiles	2006	4,411	467	8-10 yrs	467		995	21
22	Sprinkler System	2006	5,025	201	25	201		543	22
23	Carpet	2006	3,419	684	5	684		1,535	23
24	Electrical Wiring	2006	15,869	793	20	793		1,711	24
25	Smoke Damper	2006	1,793	90	20	90		254	25
26	Vinyl Fencing	2006	12,359	1,236	10	1,236		2,678	26
27	Concrete Patios & Sidewalks	2006	10,744	716	15	716		1,552	27
28	Landscaping	2006	4,325	433	10	433		1,226	28
29	Wallpapering	2007	12,135	2,427	5	2,427		2,756	29
30	A/C Units	2007	16,341	1,618	5-15 yrs	1,618		2,267	30
31	Flooring	2007	31,280	3,128	10	3,128		4,044	31
32	Alarm System	2007	4,732	516	7-10 yrs	516		875	32
33	Handrails	2007	11,039	1,259	5-15 yrs	1,259		1,315	33
34	TOTAL (lines 1 thru 33)		\$ 3,152,691	\$ 143,015		\$ 143,125	\$ 110	\$ 1,565,231	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:

01/01/2008 Ending: 12/31/2008

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 12C, Carried Forward		\$ 3,152,691	\$ 143,015		\$ 143,125	\$ 110	\$ 1,565,231	1
2	Fabricate/Install Exhaust Duct	2007	2,000	100	20	100		167	2
3	Roof	2007	5,700	273	20-25 yrs	273		348	3
4	Satellite System Cabling	2007	16,581	829	20	829		1,105	4
5	Electrical for HVAC Unit	2007	3,964	198	20	198		281	5
6	Home Office New Carpet	2007	1,345		10	135	135	202	6
7	Courtyard Landscaping	2007	3,800	380	10	380		602	7
8	Courtyard Pavilion Built	2007	9,870	658	15	658		932	8
9	Asphalt, Seal, Stripe Parking Lot	2007	13,500	1,688	8	1,688		1,969	9
10	Water Recirculation Line-Labor & Materials	2007	2,475	123	20	123		175	10
11	Stainless Steel Backsplash-Kitchen	2007	2,523	126	20	126		158	11
12	Drywall Replaced-So DR, Install Cabinets	2007	3,790	252	15	252		379	12
13	Flooring	2008	23,598	635	10-20 yrs	635		635	13
14	Wallpapering	2008	31,055	3,221	5	3,221		3,221	14
15	2 Hot Water Heaters	2008	14,000	467	10	467		467	15
16	Phone & Network Cabling to New Trailer & Maint Bldg	2008	3,709	128	20	128		128	16
17	New Front Porch Entrance-Construction Costs	2008	63,826	1,862	20	1,862		1,862	17
18	Sprinkler System-Front Porch Area	2008	16,900	450	25	450		450	18
19	New Door	2008	887	39	15	39		39	19
20	Electric Installation-New Trailer	2008	3,236	148	20	148		148	20
21	Outside Handrail-SouthSide, Righth Front	2008	1,294	72	15	72		72	21
22	2 A/C/Heat Units	2008	1,422	166	5	166		166	22
23	Nurse Call System-Setup to rm 101	2008	871	87	10	87		87	23
24	Facility Signage	2008	3,212	267	5	267		267	24
25	Corner Guards & Handrails	2008	2,042	34	15	34		34	25
26	Landscaping	2008	5,700	95	10	95		95	26
27	Outdoor Lighting & Trees	2008	1,057	12	15	12		12	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,391,048	\$ 155,325		\$ 155,570	\$ 245	\$ 1,579,232	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	\$ 303,315	\$ 26,236	\$ 27,112	\$ 876	3-20 yrs	\$ 160,620	71
72	Current Year Purchases	101,841	2,776	2,805	29	3-20 yrs	2,805	72
73	Fully Depreciated Assets	357,976	1,395	1,536	141	5-10 yrs	357,975	73
74								74
75	TOTALS	\$ 763,132	\$ 30,407	\$ 31,453	\$ 1,046		\$ 521,400	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	2006 Ford Wheelchair Van	2007	\$ 52,471	\$ 13,118	\$ 13,118	\$	4	\$ 24,049	76
77	Facility Use	2007 Hyundai Vera Cruz	2007	29,106	7,276	7,276		4	10,308	77
78	See Attached Schedule			19,163		3,095	3,095	4	8,490	78
79										79
80	TOTALS			\$ 100,740	\$ 20,394	\$ 23,489	\$ 3,095		\$ 42,847	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)		\$ 4,326,584	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 206,126	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 210,512	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 4,386	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,143,479	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	Construction In Progress	\$ 149,796	92
93			93
94			94
95		\$ 149,796	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

N/A YES NO

16. Rental Amount for movable equipment: \$ 2,859 Description: Postage Machine \$555 ; Copier \$2,304

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>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		977		977
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		5,856		5,856
6	Transportation				
7	Contractual Payments		225		225
8	CNA Competency Tests		507		507
9	TOTALS	\$	\$ 7,565	\$	\$ 7,565
10	SUM OF line 9, col. 1 and 2 (e)	\$	7,565		

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	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	18

- (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	9100 hrs	\$ 294,366		\$	\$ 815	9,100	\$ 295,181	1
2	Licensed Speech and Language Development Therapist	10a,8	2490 hrs	123,078			1,825	2,490	124,903	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	6688 hrs	196,126			5,051	6,688	201,177	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				207,911		207,911	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Laboratory Fees	39,3				22,743				
	Other (specify): <u>X-Ray & Spec. Mattres</u>	39,3; 39,2				5,684	16,605		22,289	13
14	TOTAL			\$ 613,570		\$ 28,427	\$ 232,207	18,278	\$ 851,461	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339Report Period Beginning: 01/01/2008

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2008

(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	\$ 2,714	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 40,423)	1,412,377		3
4	Supply Inventory (priced at cost)	13,272		4
5	Short-Term Investments			5
6	Prepaid Insurance	44,383		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	368,690		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,841,436	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	219,023		13
14	Buildings, at Historical Cost	3,387,074		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	826,833		16
17	Accumulated Depreciation (book methods)	(2,118,007)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	150,845		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	64,029		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,549,997	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,391,433	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 196,707	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,312		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,748		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	726		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 384,493	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,976		39
40	Mortgage Payable	3,710,317		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)	\$ 3,725,293	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,109,786	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 281,647	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,391,433	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 547,683	1
2	Restatements (describe):		2
3	Income effect of prior year adjustment not included on	(30,643)	3
4	prior year cost report		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 517,040	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	414,607	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	(650,000)	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)	\$ (235,393)	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)	\$ 281,647	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339Report Period Beginning: 01/01/2008Ending: 12/31/2008**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	\$ 6,058,430	1
2	Discounts and Allowances for all Levels	(1,123,522)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,934,908	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	10,577	5
6	Therapy	1,044,210	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,054,787	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	39	13
14	Non-Patient Meals	1,096	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	17,430	19
20	Radiology and X-Ray	2,796	20
21	Other Medical Services	650	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,011	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	19,359	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,359	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	7,920	28
28a	<u>Vending Machine</u>	2,286	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,206	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,041,271	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	959,904	31
32	Health Care	2,530,564	32
33	General Administration	1,331,991	33
B. Capital Expense			
34	Ownership	494,656	34
C. Ancillary Expense			
35	Special Cost Centers	254,099	35
36	Provider Participation Fee	55,450	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,626,664	40
41	Income before Income Taxes (line 30 minus line 40)**	414,607	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 414,607	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. 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:

01/01/2008

Ending:

12/31/2008

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	2,075	2,217	\$ 61,490	\$ 27.74	1
2	Assistant Director of Nursing	1,774	2,074	50,067	24.14	2
3	Registered Nurses	7,646	8,154	175,242	21.49	3
4	Licensed Practical Nurses	21,084	22,638	408,459	18.04	4
5	CNAs & Orderlies	78,567	83,616	781,999	9.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,084	2,487	24,628	9.90	8
9	Activity Director					9
10	Activity Assistants	5,232	5,581	54,636	9.79	10
11	Social Service Workers	4,555	4,677	61,928	13.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,981	26,164	218,350	8.35	15
16	Dishwashers					16
17	Maintenance Workers	4,181	4,437	53,996	12.17	17
18	Housekeepers	12,266	12,873	108,495	8.43	18
19	Laundry	10,522	11,479	99,128	8.64	19
20	Administrator	2,031	2,219	90,117	40.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,509	4,625	51,627	11.16	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	1,854	2,111	26,136	12.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	183,361	195,352	\$ 2,266,298 *	\$ 11.60	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	\$ 7,373	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	27	1,350	10,3	37
38	Nurse Consultant	N/A	44,945	10,3	38
39	Pharmacist Consultant	Contract	625	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	1,710	11,3	44
45	Social Service Consultant	25	1,645	12,3	45
46	Other(specify)				46
47	Billing Consultant	N/A	158	10,3	47
48	Quality Assurance Doctor	N/A	2,400	10,3	48
49	TOTAL (lines 35 - 48)	269	\$ 69,806		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-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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Association
- (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. \$ 14,170 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,450
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,096
- (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? 41.36%
- 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? Yes 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.

SEE ACCOUNTANTS' COMPILATION REPORT

JERSEYVILLE NURSING AND REHABILITATION CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2008

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
ADMINISTRATIVE	17	(2,355)
ACTIVITIES	11	896
NURSING & MEDICAL RECORDS	10	258
TRAVEL & SEMINAR	24	280
PROFESSIONAL SERVICES	19	194
CLERICAL & GENERAL OFFICE EXPENSE	21	727
To reclass various expenses to proper lines		
NURSE AIDE TRAINING	13	5,856
NURSING & MEDICAL RECORDS	10	(5,856)
To reclass CNA trainer wages		
TRAVEL & SEMINAR	24	(479)
ADMINISTRATIVE	17	479
To reclass meeting expenses to the proper line		
NURSE AIDE TRAINING	13	150
NURSING & MEDICAL RECORDS	10	(150)
To reclass CNA Evaluator		
CLERICAL & GENERAL OFFICE EXPENSES	21	570
NURSING & MEDICAL RECORDS	10	(570)
TRAVEL & SEMINAR	24	855
NURSING & MEDICAL RECORDS	10	(855)

Jerseyville Nursing & Rehabilitation Center
 Attachment to Sch. XI, Part D
 December 31, 2008

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 Taurus	2000	5,107	-	-	-	4	5,107
2004 Jaguar	2007	6,657	-	1,664	1,664	4	2,774
2001 Infiniti-sold in 2008	2004	-	-	59	59	4	-
2004 Infiniti-sold in 2008	2006	-	-	763	763	4	-
2008 Hyundai Sonata	2008	3,644	-	531	531	4	531
2003 Infiniti I-35	2008	3,755	-	78	78	4	78
		<u>19,163</u>	-	<u>3,095</u>	<u>3,095</u>		<u>8,490</u>

JERSEYVILLE NURSING AND REHABILITATION CENTER
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/2008

Miscellaneous Income	\$	5,395
C.N.A. Book Reimbursement		475
LTC Insurance Reimbursement		1,531
Employee Health Insurance Reimbursement		250
Employee Cell Phone Reimbursement		90
Miscellaneous Office Supplies Reimbursements		179
	\$	<u>7,920</u>

Jerseyville Nursing and Rehabilitation Center
Attachment to Sch. XVII
December 31, 2008

BOOK TO TAX NET INCOME RECONCILIATION:

BOOK NET INCOME (LOSS)	\$ 414,607
CONVERSION TO CASH BASIS ADJUSTMENTS	<u>(19,430)</u>
SUBTOTAL	395,177
DEPRECIATION ADJUSTMENT	(148,910)
MISC. NON-DEDUCTIBLE EXPENSES	4,616
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u>\$ 250,883</u>

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
 TRAVEL AND SEMINAR SCHEDULE
 ATTACHMENT TO SCHEDULE XIX PART G
 12/31/2008

<u>SEMINAR PARTICIPANT</u>	<u>JOB TITLE</u>	<u>DATE(S)</u>	<u>CITY</u>	<u>TITLE OF SEMINAR</u>	<u>SPONSOR</u>	<u>COST</u>	<u>SEMINAR LODGING/ TRAVEL/MEALS</u>
Various	Various	1/28/2008	Mt. Vernon, IL	Be Prepared for MDS Medicaid Audits	Illinois Health Care Association	600	79
Rhonda Carter	Medicare Billing	3/25/2008	St. Louis, MO	Skilled Nursing Facility Billing/Compliance Seminar	Wisconsin Physicians Service-Medicare	30	
Terrie Weilble	Administrator	2/21/2008		Audio Conference	Life Services Network	149	
Terrie Weilble & Robin White	Administrator & Quality Assurance Nurse	8/13/08-8/14/08	Springfield, IL	INHAA Annual Convention	Illinois Nursing Home Administrator's Association	143	206
Various	Various	8/5/2008	Springfield, IL	Illinois Health Care Association Annual Convention & Trade Show	Illinois Health Care Association	745	
Lori Bates	Business Office Manager	7/15/2008	Springfield, IL	Still Confused about Medicare Notices in your SNF?	Illinois Health Care Association	75	
Marcy Ballard	Director of Nursing	5/6/08-5/7/08	Springfield, IL	Resources for Success	Illinois Health Care Association	200	
Kathy McElroy	Registered Nurse	4/18/08	Springfield, IL	CNA Instructor Conference 2008	Lincoln Land Community College Capital City Center	80	191
Charlotte Powell	Food Service Sanitation Manager	7/26/2008	Carrollton, IL	Food Service Sanitation Manager Refresher Course on Food safety	Greene County Health Department	30	
Jenny Stewart	Social Service Director	11/14/2008	Springfield, IL	13th Annual Conference on Alzheimer Disease for Professionals	SIU School of Medicine	60	
Various	Various	5/20-5/23/08	Springfield, IL	Annual NCAL Convention	American Health Care Association	855	
Total Seminars						<u>2,967</u>	<u>476</u>
Total Seminar Lodging/Travel/Meals						476	
Other Travel Expense <\$250 each						4,457	
Home Office Travel & Seminar						4,432	
Total Travel and Seminar, Line 24						<u>12,332</u>	