

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	61	Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	160	68	4,422	4,650	8
9	SNF/PED					9
10	ICF	13,326	7,463		20,789	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,486	7,531	4,422	25,439	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.20%

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)

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 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 4,422

Medicare Intermediary NATIONAL GOVERNMENT SERVICES - KENTUCKY

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number **JACKSONVILLE CONVALESCENT CENT** # **0020131** Report Period Beginning: **07/01/09** Ending: **06/30/10**

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	145,497	14,993	11,317	171,807		171,807		171,807		1
2	Food Purchase		154,910		154,910		154,910	(1,470)	153,440		2
3	Housekeeping	63,939	22,067		86,006		86,006		86,006		3
4	Laundry	39,937	15,267		55,204		55,204		55,204		4
5	Heat and Other Utilities			91,902	91,902		91,902		91,902		5
6	Maintenance	51,218	44,499	49,383	145,100		145,100	14,615	159,715		6
7	Other (specify):* UTILITY WORKERS	390			390		390		390		7
8	TOTAL General Services	300,981	251,736	152,602	705,319		705,319	13,145	718,464		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	2,808	14,808		9
10	Nursing and Medical Records	1,249,734	393,435	16,442	1,659,611	(225,021)	1,434,590	8,096	1,442,686		10
10a	Therapy	36,544	9,902	639,364	685,810	(639,364)	46,446		46,446		10a
11	Activities	47,661	3,510		51,171		51,171		51,171		11
12	Social Services	39,167		4,847	44,014		44,014		44,014		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,373,106	406,847	672,653	2,452,606	(864,385)	1,588,221	10,904	1,599,125		16
	C. General Administration										
17	Administrative	72,283		21,855	94,138	5,370	99,508	35,705	135,213		17
18	Directors Fees										18
19	Professional Services			209,192	209,192		209,192	(196,618)	12,574		19
20	Dues, Fees, Subscriptions & Promotions			36,169	36,169		36,169	(26,858)	9,311		20
21	Clerical & General Office Expenses	110,693	14,505	4,828	130,026		130,026	56,223	186,249		21
22	Employee Benefits & Payroll Taxes			344,115	344,115		344,115	1,311	345,426		22
23	Inservice Training & Education			5,568	5,568		5,568	1,708	7,276		23
24	Travel and Seminar			8,860	8,860	(6,130)	2,730	856	3,586		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			41,772	41,772		41,772	1,105	42,877		26
27	Other (specify):*			56,428	56,428		56,428	(28,979)	27,449		27
28	TOTAL General Administration	182,976	14,505	728,787	926,268	(760)	925,508	(155,547)	769,961		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,857,063	673,088	1,554,042	4,084,193	(865,145)	3,219,048	(131,498)	3,087,550		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: 07/01/09 Ending: 06/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			23,115	23,115		23,115	16,273	39,388			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,781	27,781		27,781	(25,268)	2,513			32
33	Real Estate Taxes			31,432	31,432		31,432		31,432			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(121,739)	10,261			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			214,328	214,328		214,328	(130,734)	83,594			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					865,145	865,145		865,145			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			48,180	48,180	865,145	913,325		913,325			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,857,063	673,088	1,816,550	4,346,701		4,346,701	(262,232)	4,084,469			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	(322)	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	12,058	30		9
10	Interest and Other Investment Income	(3,312)	32		10
11	Discounts, Allowances, Rebates & Refunds	(968)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,775)	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	(365)	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	(1,709)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,653)	27		24
25	Fund Raising, Advertising and Promotional	(25,413)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,532)	20		28
29	Other-Attach Schedule	(6,990)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (84,981)		\$	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)	(177,251)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (177,251)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (262,232)		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		639,364	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		49,078	10	42
43	Prescription Drugs	X		161,661	10	43
44	Ambulance	X		1,494	10	44
45	Other-Attach Schedule Oxygen	X		5,333	10	45
46	Other-Attach Schedule Supplies	X		8,215	10	46
47	TOTAL (C): (sum of lines 38-46)			\$ 865,145		47

BHF USE ONLY							
48		49		50		51	52

JACKSONVILLE CONVALESCENT CENTER

ID# 0020131

Report Period Beginning: 07/01/09

Ending: 06/30/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	VENDING	\$	(1,148)	2 1
2	EXPENSE REIMBURSEMENT - DON SALARY		(5,842)	10 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		(6,990)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,470)	0	0	0	0	0	0	0	0	0	0	(1,470)	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	(1,470)	0	0	0	0	0	0	0	0	0	0	(1,470)	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	(5,842)	0	0	0	0	0	0	0	0	0	0	(5,842)	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	(5,842)	0	0	0	0	0	0	0	0	0	0	(5,842)	16
	C. General Administration													
17	Administrative	0	384	0	0	0	0	0	0	0	0	0	384	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,709)	(194,842)	0	0	0	0	0	0	0	0	0	(196,551)	19
20	Fees, Subscriptions & Promotions	(27,310)	175	0	0	0	0	0	0	0	0	0	(27,135)	20
21	Clerical & General Office Expenses	(968)	0	0	0	0	0	0	0	0	0	0	(968)	21
22	Employee Benefits & Payroll Taxes	0	(27,449)	0	0	0	0	0	0	0	0	0	(27,449)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(384)	0	0	0	0	0	0	0	0	0	(384)	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):*	(56,428)	27,449	0	0	0	0	0	0	0	0	0	(28,979)	27
28	TOTAL General Administration	(86,415)	(194,667)	0	(281,082)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(93,727)	(194,667)	0	(288,394)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER# 0020131

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	12,058	2,066	0	0	0	0	0	0	0	0	0	14,124	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,312)	(21,956)	0	0	0	0	0	0	0	0	0	(25,268)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,746	(151,890)	0	(143,144)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(84,981)	(346,557)	0	0	0	0	0	0	0	0	0	(431,538)	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
<u>SAM KLEIN</u>	<u>50%</u>	<u>HILLTOP NURSING HOME, INC.</u>	<u>CHARLESTON</u>	<u>Nursing Home Mngrs</u>	<u>SPRINGFIELD</u>	<u>MANAGEMENT</u>
<u>DORYS BERG, TRUSTEE</u>	<u>50%</u>	<u>MEADOW MANOR, INC.</u>	<u>TAYLORVILLE</u>	<u>J'ville Land Trust</u>	<u>SPRINGFIELD</u>	<u>LAND TRUST</u>
		<u>MENARD CONVALESCENT CENTER, INC.</u>	<u>PETERSBURG</u>			
		<u>SUNRISE MANOR OF VIRDEN, INC.</u>	<u>VIRDEN</u>			

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	<u>34 RENT</u>	<u>\$ 132,000</u>	<u>JACKSONVILLE LAND TRUST</u>	<u>100.00%</u>	<u>\$</u>	<u>\$</u>	<u>(132,000)</u> 1
2	V	<u>30 DEPRECIATION</u>		<u>JACKSONVILLE LAND TRUST</u>	<u>100.00%</u>	<u>2,066</u>		<u>2,066</u> 2
3	V	<u>20 TRUST FEES</u>		<u>JACKSONVILLE LAND TRUST</u>	<u>100.00%</u>	<u>175</u>		<u>175</u> 3
4	V	<u>32 INTEREST INCOME</u>		<u>JACKSONVILLE LAND TRUST</u>	<u>100.00%</u>	<u>(18)</u>		<u>(18)</u> 4
5	V	<u>32 INTEREST INCOME</u>		<u>JACKSONVILLE LAND TRUST</u>	<u>100.00%</u>	<u>(21,938)</u>		<u>(21,938)</u> 5
6	V							
7	V	<u>19 MANAGEMENT FEES</u>	<u>202,737</u>	<u>NURSING HOME MANAGERS, INC.</u>	<u>50.00%</u>			<u>(202,737)</u> 7
8	V	<u>VAR SEE ATTACHED SCHEDULES</u>		<u>NURSING HOME MANAGERS, INC.</u>	<u>50.00%</u>	<u>169,306</u>		<u>169,306</u> 8
9	V	<u>19 ACCOUNTING</u>		<u>NURSING HOME MANAGERS - DIRECT ALLOCATION</u>	<u>50.00%</u>	<u>7,895</u>		<u>7,895</u> 9
10	V	<u>24 TRAVEL</u>	<u>384</u>	<u>TO TRANSFER 31% OF HOME OFFICE TRAVEL</u>				<u>(384)</u> 10
11	V	<u>17 ADMINISTRATIVE TRAVEL</u>		<u>TO ADMINISTRATIVE - PER DESK REVIEW</u>		<u>384</u>		<u>384</u> 11
12	V	<u>22 EMPL.BENEFITS & PR TAXES</u>	<u>27,449</u>	<u>TO TRANSFER HOME OFFICE EMPLOYEE BENEFITS</u>				<u>(27,449)</u> 12
13	V	<u>27 OTHER - GENERAL ADMINISTRATION</u>		<u>AND PAYROLL TAXES TO OTHER - PER DESK REVIEW</u>		<u>27,449</u>		<u>27,449</u> 13
14	Total		<u>\$ 362,570</u>			<u>\$ 185,319</u>	<u>\$ *</u>	<u>(177,251)</u> 14

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

Facility Name & ID Number **JACKSONVILLE CONVALESCENT CEN** # **0020131** Report Period Beginning: **07/01/09** Ending: **06/30/10**

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	NOT APPLICABLE								\$	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: 07/01/09 Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT. # 0020131 Report Period Beginning: 07/01/09 Ending: 06/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	J'VILLE LAND TRUST	X		WORKING CAPITAL		8/27/04	70,000	485,474	DEMAND	4.0000	21,938	6							
7	STOCKHOLDERS	X		WORKING CAPITAL	INTEREST	6/22/07	150,000		DEMAND	5.0000	5,843	7							
8												8							
9	TOTAL Facility Related						\$ 220,000	\$ 485,474			\$ 27,781	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 220,000	\$ 485,474			\$ 27,781	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.)

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 2009 report.		\$	42,820	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.)		\$	43,782	2
3. Under or (over) accrual (line 2 minus line 1).		\$	962	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,470	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.		\$	31,432	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	<u>26,932</u>	<u>8</u>	
	2006	<u>28,274</u>	<u>9</u>	
	2007	<u>27,018</u>	<u>10</u>	
	2008	<u>28,547</u>	<u>11</u>	
	2009	<u>30,470</u>	<u>12</u>	
LINE 2: 2008 BOTH INSTALLMENTS	\$28,547	LINE 4: 2009 SECOND INSTALLMENT	\$15,235	
2009 FIRST INSTALLMENT	\$15,235	6/12 OF \$30,470	\$15,235	
LINE 2	\$43,782	LINE 4	\$30,470	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/09

Ending:

06/30/10

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.

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

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

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include NURSING HOME, TITLE WORK, and TOTALS.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER

0020131

Report Period Beginning:

07/01/09

Ending:

06/30/10

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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	23	5	727	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		(213)	6,700	23
24	ROOF		1988	21,783	692	20	183	(509)	21,783	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		(56)	2,168	31
32	ROOF		1993	34,178	876	20	1,709	833	28,197	32
33	FIRE DOORS		1996	1,011	26	15	67	41	977	33
34	WATER HEATER		1997	3,915	100	15	261	161	3,447	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:

07/01/09

Ending:

06/30/10

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	\$ 1,527	37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	1,914	38
39	SHUTTERS	1999	912	23	15	61	38	649	39
40	DOOR ENTRANCE	2000	4,507	116	15	301	185	3,055	40
41	DUCT SMOKE DETECTORS	2000	2,295	59	20	114	55	1,138	41
42	DOOR	2000	2,280	58	15	152	94	1,482	42
43	ROOFTOP AIR CONDITIONER	2001	7,619	195	10	762	567	6,730	43
44	COMBUSTION AIR DUCT	2002	710	18	15	48	30	402	44
45	SMOKE DETECTORS	2002	2,511	64	15	167	103	1,382	45
46	GARAGE	2002	11,636	298	15	776	478	6,335	46
47	SMOKE DETECTORS	2002	809	21	15	54	33	441	47
48	FIRE DAMPERS	2002	1,166	30	15	78	48	635	48
49	ROOFTOP AIR CONDITIONER & HEATING (2)	2002	9,766	251	8	1,220	969	9,181	49
50	GARAGE INSULATION	2003	1,652	42	15	110	68	807	50
51	ROOFTOP AIR CONDITIONER & HEATING	2003	5,300	136	8	662	526	4,748	51
52	PARKING LOT	2003	13,306	341	15	887	546	6,061	52
53	VENTILATION	2004	4,380	112	15	293	181	1,777	53
54	SIDEWALK & CONCRETE PAD	2003	5,900	348	20	295	(53)	2,012	54
55	FENCE	2004	1,453	86	8	182	96	1,151	55
56	FIRE ALARM SYSTEM	2004	5,540	142	15	369	227	2,168	56
57	WATER HEATER	2005	2,673	69	15	178	109	964	57
58	ALARM SYSTEM	2005	4,171	107	15	278	171	1,506	58
59	EXIT FIXTURES	2005	1,541	40	10	154	114	706	59
60	EXHAUST SYSTEM	2006	3,545	91	15	236	145	944	60
61	SIDEWALK & CONCRETE PATIO	2005	3,600	249	20	180	(69)	885	61
62	ROOF	2006	83,800	2,149	20	4,190	2,041	15,714	62
63	ROOFTOP A/C & HTG AND ELECTRICAL WORK	2008	34,274	879	10	3,428	2,549	5,758	63
64	3.5 TON COMPRESSOR	2009	1,650	42	8	206	164	206	64
65	WATER HEATER	2009	3,350	54	15	149	95	149	65
66	ROOF DRAINS & PLUMBING	2010	3,625	43	15	101	58	101	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 899,490	\$ 8,530		\$ 18,182	\$ 9,652	\$ 744,930	70

**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	\$ 206,419	\$ 11,753	\$ 18,715	\$ 6,962	VARIOUS	\$ 116,042	71
72	Current Year Purchases	5,682	3,274	342	(2,932)	VARIOUS	342	72
73	Fully Depreciated Assets	217,778					217,778	73
74	Assets no longer in use	(77,603)					(77,603)	74
75	TOTALS	\$ 352,276	\$ 15,027	\$ 19,057	\$ 4,030		\$ 256,559	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	\$ 1,624	\$	\$ (1,624)	4	\$ 28,203	76
77										77
78										78
79										79
80	TOTALS			\$ 28,203	\$ 1,624	\$	\$ (1,624)		\$ 28,203	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)	\$ 1,315,398	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,181	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,239	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,058	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,029,692	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? YES NO

If NO, see instructions.

		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		<u>88</u>		\$ <u>132,000</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ 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

10. Effective dates of current rental agreement:

Beginning 07/01/09

Ending 06/30/10

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

Fiscal Year Ending Annual Rent

12. 06/30/2011 \$ 132,000

13. 06/30/2012 \$ 132,000

14. 06/30/2013 \$ 132,000

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
							Units	Cost									
1	Licensed Occupational Therapist	39 - 8	hrs	\$	6,094	\$	274,220	\$	6,094	\$	274,220		6,094	\$	274,220	1	
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		1,173		84,111		1,173		84,111		1,173		84,111	2	
3	Licensed Recreational Therapist		hrs													3	
4	Licensed Physical Therapist	39 - 8	hrs		4,448		281,033		4,448		281,033		4,448		281,033	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 prescrpts							161,661					161,661	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10	
11	Academic Education		hrs													11	
12	Other (specify): <u>Labs, X-ray, Oxygen</u>	39 - 8								54,411					54,411	12	
13	Other (specify): <u>Supplies, Ambulance</u>	39 - 8								9,709					9,709	13	
14	TOTAL			\$	11,715	\$	639,364	\$	225,781	\$	865,145		11,715	\$	865,145	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**

0020131

Report Period Beginning: **07/01/09**

Ending: **06/30/10**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/10** (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	\$ 26,596	\$ 30,955	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	466,266	466,266	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,570	19,570	6
7	Other Prepaid Expenses	218,431	218,431	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 730,863	\$ 735,222	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	239,615	239,615	15
16	Equipment, at Historical Cost	363,977	456,141	16
17	Accumulated Depreciation (book methods)	(367,618)	(1,087,351)	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)	\$ 235,974	\$ 302,678	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 966,837	\$ 1,037,900	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 123,789	\$ 123,789	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	485,474		29
30	Accrued Salaries Payable	3,537	3,537	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,029	5,029	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,470	30,470	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)	\$ 648,299	\$ 162,825	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)	\$ 648,299	\$ 162,825	46
47	TOTAL EQUITY(page 18, line 24)	\$ 318,538	\$ 875,075	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 966,837	\$ 1,037,900	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 975,273	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 975,273	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	12,086	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) J'VILLE LAND TRUST INCOME	151,716	15
16	Other (describe) J'VILLE LAND TRUST DISTRIBUTIONS	(264,000)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (100,198)	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)	\$ 875,075	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/09

Ending: 06/30/10

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	\$ 4,452,858	1
2	Discounts and Allowances for all Levels	(398,128)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,054,730	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	287,501	6
7	Oxygen	3,533	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 291,034	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	322	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	1,431	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,753	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,312	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,312	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING \$1148 W/A \$36 OLD CHECKS \$932	2,116	28
28a	EXPENSE REIMBURSEMENT \$5842	5,842	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,958	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,358,787	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	705,319	31
32	Health Care	2,452,606	32
33	General Administration	926,268	33
B. Capital Expense			
34	Ownership	214,328	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	48,180	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,346,701	40
41	Income before Income Taxes (line 30 minus line 40)**	12,086	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 12,086	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: 07/01/09

Ending:

06/30/10

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	2,093	2,213	\$ 61,465	\$ 27.77	1
2	Assistant Director of Nursing	298	314	5,768	18.37	2
3	Registered Nurses	3,546	3,724	88,527	23.77	3
4	Licensed Practical Nurses	24,288	25,348	498,695	19.67	4
5	CNAs & Orderlies	54,036	55,812	595,279	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,437	3,524	36,544	10.37	8
9	Activity Director	2,001	2,089	24,658	11.80	9
10	Activity Assistants	2,662	2,670	23,003	8.62	10
11	Social Service Workers	3,630	3,829	39,167	10.23	11
12	Dietician					12
13	Food Service Supervisor	1,604	2,095	29,646	14.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,868	11,629	115,851	9.96	15
16	Dishwashers					16
17	Maintenance Workers	4,179	4,258	51,218	12.03	17
18	Housekeepers	6,381	6,662	63,939	9.60	18
19	Laundry	4,381	4,591	39,937	8.70	19
20	Administrator	1,743	1,847	64,041	34.67	20
21	Assistant Administrator	343	343	8,242	24.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,158	7,684	110,693	14.41	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) <u>UTILITY WORK</u>	39	48	390	8.13	33
34	TOTAL (lines 1 - 33)	132,687	138,680	\$ 1,857,063 *	\$ 13.39	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	289	\$ 11,317	1-3	35
36	Medical Director	120	12,000	9-3	36
37	Medical Records Consultant	16	502	10-3	37
38	Nurse Consultant	176	6,013	10-3	38
39	Pharmacist Consultant	144	3,927	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	73	4,847	12-3	45
46	Other(specify)				46
47	<u>Psychiatric Consultant</u>	24	6,000	10-3	47
48	<u>Administrative Consultant</u>	808	21,855	17-3	48
49	TOTAL (lines 35 - 48)	1,650	\$ 66,461		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 0		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
RAPHAEL C. UTTERBACK	ADMINISTRATOR	0	\$ 64,041	Workers' Compensation Insurance	\$ 33,165	IDPH License Fee	\$	
PEGGY CAWTHON	ASST. ADMINISTRATOR	0	8,242	Unemployment Compensation Insurance	34,970	Advertising: Employee Recruitment	6,493	
				FICA Taxes	138,721	Health Care Worker Background Check	662	
				Employee Health Insurance		(Indicate # of checks performed 41)		
				Employee Meals		Patient Background Checks	71	
				Illinois Municipal Retirement Fund (IMRF)*		SEE ATTACHED SCHEDULE	27,878	
				CAFETERIA - 125 PLAN	128,634	J'VILLE LAND TRUST - TRUST FEES	175	
				EMPLOYEE LIFE INSURANCE	4,038	NHM ALLOCATION	277	
				VACCINES & LABS	2,143			
				GIFT CERTIFICATES & PARTY	1,800	Less: Non-allowable Fees	(365)	
				EMPLOYEE APPRECIATION	644	Less: Public Relations Expense	(25,413)	
				NHM ALLOCATION	28,760	Non-allowable advertising ()	
				NHM TSF TO LINE 27 - PER DESK REVIEW	(27,449)	Yellow page advertising	(1,532)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 72,283	TOTAL (agree to Schedule V, line 22, col.8)	\$ 345,426	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,311	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
ADMINISTRATIVE CONSULTANT			\$ 21,855	VACCINES & LABS	22	\$ 2,143	Out-of-State Travel	\$
				GIFT CERTIFICATES & PARTY	22	1,800		
				EMPLOYEE APPRECIATION	22	644		
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 21,855	TOTAL		\$ 4,587	SEE ATTACHED SCHEDULE	2,730
(Attach a copy of any management service agreement)							NHM ALLOCATION	1,240
							TSF 31% OF NHM TO ADMINISTRATIVE	(384)
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount					
NURSING HOME MANAGERS	MANAGEMENT FEE		\$ 202,737				Entertainment Expense ()
C S C	CORP. REPRESENTATION		356				(agree to Sch. V, line 24, col. 8)	
FELDMAN, WASSER, ETAL	LEGAL		1,709				TOTAL	\$ 3,586
ACCUMED	ACCOUNTING		4,390					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 209,192					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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? 9 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,515 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,180
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 322
- (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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 3 & 4 - SCHEDULE V - LINE 27

LINE 27 - GENERAL ADMINISTRATION - OTHER	
SALES TAX	\$ 7,775
BAD DEBTS	48,653
TOTAL LINE 27 - COLUMN 3	<u>\$ 56,428</u>

PAGE 3 - SCHEDULE V - LINE 23

DETAIL - INSERVICE TRAINING & EDUCATION	
SOCIAL SERVICE & ACTIVITY TRAINING	\$ 150
VICURA TRAINING	809
ACTIVITY DIRECTOR COURSE	640
HEALTH CARE PROVIDER RENEWAL COURSE	140
TRAVEL & MEALS FOR TRAINING	165
ONLINE TRAINING	2,415
LTC SURVEYOR WORKSHOP	145
PSYCHOSOCIAL SURVEYOR SEMINAR	295
RESTORATIVE & REHABILITATION COURSE	600
DIETARY SANITATION COURSE	129
WOUND CONFERENCE	80
NHM ALLOCATION	1,708
SCHEDULE V - LINE 23 - COLUMN 8	<u>\$ 7,276</u>

PAGE 3 & 4 - SCHEDULE V

DETAIL COLUMN 5 - RECLASSIFICATIONS		
		LINE #
RECLASS TO:		
NURSE CONSULTANT TRAVEL:	\$ 760	10
ADMINISTRATIVE CONSULTANT TRAVEL	<u>5,370</u>	17
RECLASS FROM: TRAVEL	<u>\$ (6,130)</u>	24

RECLASS FROM:		
MEDICARE SUPPLIES	\$ (8,215)	10
MEDICARE X-RAYS	(14,755)	10
MEDICARE DRUGS	(153,340)	10
MEDICARE LABORATORY FEES	(34,323)	10
MEDICARE I.V. THERAPY	(8,321)	10
MEDICARE AMBULANCE	(1,494)	10
MEDICARE OXYGEN	(1,800)	10
OXYGEN - PRIVATE & DPA	(3,533)	10
PHYSICAL THERAPY	(281,033)	10A
SPEECH THERAPY	(84,111)	10A
OCCUPATIONAL THERAPY	<u>(274,220)</u>	10A

RECLASS TO: ANCILLARY SERVICES	<u>\$ 865,145</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.

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION	
LINE 83 - STRAIGHT LINE DEPRECIATION	\$ 37,239
NURSING HOME MANAGERS ALLOCATION	2,149
SCHEDULE V - LINE 30 - COLUMN 8	<u>\$ 39,388</u>

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME	
NET INCOME - LINE 43	\$ 12,086
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(3,312)
TAXABLE INCOME	<u>\$ 8,774</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	\$ 25,413
CHAMBER OF COMMERCE DUES	190
FRANCHISE FEES	100
INHAA DUES	100
AUTOMOBILE LICENSE	158
YELLOW PAGES	1,532
MORGAN COUNTY HEALTH DEPT	100
ADMINISTRATOR LICENSE	100
FOOD SERVICE SANITATION CERTIFICATE	35
CLIA LAB WAIVER	150
	<u>\$ 27,878</u>

PAGE 21 - SCHEDULE XIX - SECTION G

TRAVEL AND SEMINAR	
ACTIVITY & COMMUNITY RELATIONS MILEAGE	\$ 250
OFFICE & SCREENING MILEAGE	379
D.O.N. MILEAGE REIMBURSEMENT	322
ADMINISTRATOR MILEAGE REIMB.	658
MAINTENANCE MILEAGE REIMB.	196
HOME OFFICE MEETING MILEAGE & MEALS	925
	<u>\$ 2,730</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
 2009

	JULY 09	AUG	SEPT	OCT	NOV	DEC	JAN 10	FEB	MARCH	APRIL	MAY	JUNE	TOTAL	2009	LINE #
SALARIES-ADMIN	2,766	2,698	2,800	2,774	2,848	2,840	1,907	1,869	1,901	1,853	1,873	1,950	28,079		17
SALARIES-CLERIC	3,795	4,252	4,411	4,371	4,487	4,475	4,218	4,133	4,203	4,098	4,142	4,311	50,896		21
SALARIES-CONTR	1,330	(499)	(518)	(513)	(527)	(526)	1,427	1,398	1,422	1,387	1,402	1,459	7,242		17
SALARIES-NURSE	287	1,722	1,786	1,770	1,817	1,812	797	781	794	774	783	815	13,938		10
ACCOUNTING	96	(83)	(86)	(86)	(88)	(88)	45	44	45	44	44	46	(67)		19
WORK COMP INS	(37)	123	128	127	130	130	120	117	119	116	117	122	1,311		22
SUPPLIES	95	141	147	145	149	149	220	216	220	214	216	225	2,138		21
TELEPHONE	265	302	313	310	319	318	391	384	390	380	384	400	4,157		21
EMPL BENEFITS	998	2,345	2,432	2,411	2,474	2,468	1,073	1,052	1,070	1,043	1,054	1,097	19,516		22
PAYROLL TAXES	545	754	783	776	796	794	586	574	584	569	575	599	7,933		22
TRAVEL	131	63	65	64	66	66	132	129	131	128	129	135	1,240		24
IN SERVICE	43	51	53	52	54	54	235	231	235	229	231	241	1,708		23
MEDICAL CONSULT	227	230	238	236	242	242	234	229	233	227	230	239	2,808		9
MACHINE RENTAL	936	885	918	910	934	931	909	891	906	884	893	930	10,927		6
OWNERS COMP	-	-	-	-	-	-	-	-	-	-	-	-	-		17
INS-PROP,LIAB,WC	-	169	175	174	178	178	39	38	39	38	38	40	1,105		26
DEPRECIATION	228	59	61	61	62	62	271	266	270	264	266	277	2,149		30
RENT	609	918	952	944	969	966	824	807	821	800	809	842	10,261		34
MAINTENANCE	405	337	350	347	356	355	258	253	258	251	254	264	3,688		6
FEES & PUBLICAT	3	36	37	37	38	38	15	14	15	14	14	15	277		20
ADVERTISING	-	-	-	-	-	-	-	-	-	-	-	-	-		20
MEDICAL CONSULT	-	-	-	-	-	-	-	-	-	-	-	-	-		9
TOTAL	12,724	14,502	15,045	14,911	15,304	15,264	13,702	13,426	13,655	13,312	13,457	14,005	169,306		
FIXED ASSETS	-														
EQUIP - PRIOR	14,771	14,922	15,481	15,342	15,747	15,706	15,220	14,914	15,168	14,787	14,948	15,557	15,214		
EQUIP - CURR	4,696	4,745	5,056	5,010	5,143	5,129	4,970	4,870	4,953	4,829	4,882	5,080	4,947		
EQUIP - FULLY DEP	5,702	5,761	5,976	5,923	6,079	6,063	5,876	5,757	5,856	5,708	5,771	6,006	5,873		
BLDG - PRIOR	-	-	-	-	-	-	-	-	-	-	-	-	-		
BLDG - CURR	-	-	-	-	-	-	-	-	-	-	-	-	-		
BLDG - FULLY DEP	1,455	1,470	1,525	1,512	1,552	1,547	1,500	1,469	1,494	1,457	1,473	1,533	1,499		

NURSING HOME MANAGERS COST ALLOCATION JULY 2009

ALLOCPERCENT	DADR	HLP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
0	0.1838919	0.2164082	0.265933	0.1510755	0.1826913		1
SALARIES-ADMIN	-	2,360	2,766	3,369	1,531	2,335	12,761
SALARIES-CLERIC	-	3,225	3,795	4,663	2,649	3,204	17,536
SALARIES-CONTR	-	1,125	1,338	1,636	816	1,122	6,147
SALARIES-NURSE	-	244	287	363	201	243	1,328
ACCOUNTING	-	82	96	118	67	81	443
WORK COMP INS	-	620	727	890	420	620	3,287
SUPPLIES	-	81	95	117	67	81	441
TELEPHONE	-	391	456	563	281	391	2,079
EMPL BENEFITS	-	848	998	1,227	697	843	4,613
PAYROLL TAXES	-	463	545	670	381	460	2,519
TRAVEL	-	131	151	161	82	111	607
IN SERVICE	-	36	43	53	30	36	188
MEDICAL CONSULT	-	153	180	226	159	182	1,050
MACHINE RENTAL	-	795	926	1,150	653	790	4,325
OWNERS COMP	-	-	-	-	-	-	-
INS-PROPLIAB.WC	-	-	-	-	-	-	-
DEPRECIATION	-	194	228	280	159	192	1,053
RENT	-	519	606	751	416	514	2,815
MAINTENANCE	-	344	405	498	283	342	1,872
FEES & PUBLIC	-	3	3	4	2	3	14
ADVERTISING	-	-	-	-	-	-	-
TOTAL	-	10,812	12,724	15,636	8,883	10,742	58,796

FIXED ASSETS

EQUIP - PRIOR	-	12,562	14,771	18,152	10,312	12,470	68,256
EQUIP - CURR	-	3,981	4,698	5,771	3,279	3,890	21,702
EQUIP - FULLY DEP	-	4,846	5,702	7,007	3,981	4,814	26,350
BLDG - PRIOR	-	-	-	-	-	-	-
BLDG - CURR	-	-	-	-	-	-	-
BLDG - FULLY DEP	-	1,237	1,455	1,788	1,016	1,229	6,725

NURSING HOME MANAGERS COST ALLOCATION AUGUST 2009

ALLOCPERCENT	DADR	HLP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
0	0.1810013	0.2186236	0.2613805	0.1462427	0.192752		1
SALARIES-ADMIN	-	2,234	2,698	3,226	1,805	2,379	12,343
SALARIES-CLERIC	-	3,520	4,252	5,083	2,844	3,749	19,448
SALARIES-CONTR	-	1,413	1,699	2,097	1,049	1,448	7,249
SALARIES-NURSE	-	1,425	1,722	2,098	1,152	1,516	7,875
ACCOUNTING	-	699	833	1,000	566	733	3,811
WORK COMP INS	-	122	147	181	95	125	647
SUPPLIES	-	117	141	169	95	125	647
TELEPHONE	-	291	342	420	212	291	1,581
EMPL BENEFITS	-	1,941	2,345	2,803	1,568	2,067	10,724
PAYROLL TAXES	-	624	754	902	505	665	3,450
TRAVEL	-	152	181	221	113	149	773
IN SERVICE	-	42	51	61	34	45	233
MEDICAL CONSULT	-	179	216	274	154	199	1,050
MACHINE RENTAL	-	733	865	1,058	592	790	4,047
OWNERS COMP	-	-	-	-	-	-	-
INS-PROPLIAB.WC	-	140	169	202	113	149	773
DEPRECIATION	-	49	59	71	40	52	271
RENT	-	749	891	1,088	614	808	4,199
MAINTENANCE	-	279	337	403	226	297	1,543
FEES & PUBLIC	-	30	36	43	24	32	165
ADVERTISING	-	-	-	-	-	-	-
TOTAL	-	12,007	14,502	17,338	9,701	12,786	65,334

FIXED ASSETS

EQUIP - PRIOR	-	12,354	14,922	17,841	9,982	13,156	68,256
EQUIP - CURR	-	3,528	4,745	5,672	3,174	4,183	21,702
EQUIP - FULLY DEP	-	4,769	5,761	6,987	3,653	4,579	26,350
BLDG - PRIOR	-	-	-	-	-	-	-
BLDG - CURR	-	-	-	-	-	-	-
BLDG - FULLY DEP	-	1,217	1,470	1,758	983	1,296	6,725

NURSING HOME MANAGERS COST ALLOCATION SEPTEMBER 2009

ALLOCPERCENT	DADR	HLP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
0	0.1713011	0.2268106	0.2594937	0.1480598	0.1943349		1
SALARIES-ADMIN	-	2,114	2,800	3,203	1,828	2,399	12,343
SALARIES-CLERIC	-	3,331	4,411	5,047	2,879	3,779	19,448
SALARIES-CONTR	-	1,391	1,619	1,997	1,049	1,448	7,249
SALARIES-NURSE	-	1,349	1,785	2,044	1,156	1,530	7,875
ACCOUNTING	-	695	830	1,000	566	733	3,811
WORK COMP INS	-	122	146	178	95	125	647
SUPPLIES	-	111	147	168	96	128	647
TELEPHONE	-	287	342	420	212	291	1,581
EMPL BENEFITS	-	1,837	2,432	2,783	1,588	2,084	10,724
PAYROLL TAXES	-	591	783	895	511	670	3,450
TRAVEL	-	142	175	211	113	150	773
IN SERVICE	-	40	53	61	35	45	233
MEDICAL CONSULT	-	155	188	232	122	160	848
MACHINE RENTAL	-	693	818	1,059	599	797	4,047
OWNERS COMP	-	-	-	-	-	-	-
INS-PROPLIAB.WC	-	132	175	201	114	150	773
DEPRECIATION	-	46	61	70	40	53	271
RENT	-	719	844	1,038	618	814	4,199
MAINTENANCE	-	264	320	390	228	300	1,543
FEES & PUBLIC	-	28	37	43	24	32	165
ADVERTISING	-	-	-	-	-	-	-
TOTAL	-	11,383	15,045	17,213	9,821	12,891	65,334

FIXED ASSETS

EQUIP - PRIOR	-	11,892	15,481	17,712	10,108	13,265	68,256
EQUIP - CURR	-	3,818	5,056	5,794	3,300	4,332	22,290
EQUIP - FULLY DEP	-	4,514	5,976	6,838	3,501	4,121	26,350
BLDG - PRIOR	-	-	-	-	-	-	-
BLDG - CURR	-	-	-	-	-	-	-
BLDG - FULLY DEP	-	1,152	1,525	1,745	996	1,307	6,725

NURSING HOME MANAGERS COST ALLOCATION OCTOBER 2009

ALLOCPERCENT	DADR	HLP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
0	0.1737758	0.2247786	0.2616291	0.1466965	0.19322		1
SALARIES-ADMIN	-	2,145	2,774	3,229	1,811	2,385	12,343
SALARIES-CLERIC	-	3,380	4,371	5,086	2,853	3,758	19,448
SALARIES-CONTR	-	1,397	1,619	1,997	1,049	1,448	7,249
SALARIES-NURSE	-	1,389	1,770	2,060	1,155	1,552	7,875
ACCOUNTING	-	698	830	1,000	566	733	3,811
WORK COMP INS	-	122	147	181	95	125	647
SUPPLIES	-	112	145	169	95	125	647
TELEPHONE	-	281	342	420	212	291	1,581
EMPL BENEFITS	-	1,884	2,411	2,805	1,573	2,024	10,724
PAYROLL TAXES	-	600	776	902	506	667	3,450
TRAVEL	-	142	175	211	113	150	773
IN SERVICE	-	41	52	61	34	45	233
MEDICAL CONSULT	-	155	188	232	122	160	848
MACHINE RENTAL	-	703	810	1,059	594	792	4,047
OWNERS COMP	-	-	-	-	-	-	-
INS-PROPLIAB.WC	-	134	174	201	113	149	773
DEPRECIATION	-	47	61	71	40	52	271
RENT	-	728	844	1,038	618	814	4,199
MAINTENANCE	-	288	347	404	226	298	1,543
FEES & PUBLIC	-	29	37	43	24	32	165
ADVERTISING	-	-	-	-	-	-	-
TOTAL	-	11,527	14,911	17,348	9,731	12,817	65,334

FIXED ASSETS

EQUIP - PRIOR	-	11,881	15,342	17,851	10,013	13,188	68,256
EQUIP - CURR	-	3,873	5,010	5,829	3,270	4,307	22,290
EQUIP - FULLY DEP	-	4,573	5,923	6,891	3,665	4,301	26,350
BLDG - PRIOR	-	-	-	-	-	-	-
BLDG - CURR	-	-	-	-	-	-	-
BLDG - FULLY DEP	-	1,169	1,512	1,759	987	1,299	6,725

NURSING HOME MANAGERS COST ALLOCATION NOVEMBER 2009

ALLOCPERCENT	DADR	HLP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
0	0.1701833	0.2307118	0.2565004	0.1506882	0.1919224		1
SALARIES-ADMIN	-	2,101	2,848	3,166	1,860	2,369	12,343
SALARIES-CLERIC	-	3,310	4,487	4,988	2,830	3,738	19,448
SALARIES-CONTR	-	1,389	1,619	1,997	1,049	1,448	7,249
SALARIES-NURSE	-	1,380	1,817	2,020	1,187	1,511	7,875
ACCOUNTING	-	695	830	1,000	566	733	3,811
WORK COMP INS	-	122	146	178	95	125	647
SUPPLIES	-	116	148	169	95	128	647
TELEPHONE	-	235	319	364	208	265	1,381
EMPL BENEFITS	-	1,825	2,474	2,751	1,616	2,058	10,724
PAYROLL TAXES	-	587	795	895	520	662	3,450
TRAVEL	-	142	175	211	113	150	773
IN SERVICE	-	49	66	73	43	55	286
MEDICAL CONSULT	-	179	242	289	158	202	1,050
MACHINE RENTAL	-	689	834	1,038	610	777	4,047
OWNERS COMP	-	-	-	-	-	-	-
INS-PROPLIAB.WC	-	132	178	198	116	148	773
DEPRECIATION	-	48	62	69	41	52	271
RENT	-	715	869	1,077	633	806	4,199
MAINTENANCE	-	283	356	396	233	296	1,543
FEES & PUBLIC	-	28	38	43	25	32	165
ADVERTISING	-	-	-	-	-	-	-
TOTAL	-	11,289	15,304	17,015	9,995	12,731	65,334

FIXED ASSETS

EQUIP - PRIOR	-	11,816	15,747	17,508	10,285	13,100	68,256
EQUIP - CURR	-	3,793	5,143	5,717	3,359	4,278	22,290
EQUIP - FULLY DEP	-	4,484	6,079	6,759	3,970	5,057	26,350
BLDG - PRIOR	-	-	-	-	-	-	-
BLDG - CURR	-	-	-	-	-	-	-
BLDG - FULLY DEP	-	1,144	1,552	1,725	1,013	1,291	6,725

NURSING HOME MANAGERS COST ALLOCATION DECEMBER 2009

ALLOCPERCENT	DADR	HLP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
0	0.1646418	0.2301005	0.2584835	0.1574152	0.189359		1
SALARIES-ADMIN	-	2,032	2,840	3,190	1,843	2,337	12,343
SALARIES-CLERIC	-	3,232	4,475	5,027	3,061	3,680	19,448
SALARIES-CONTR	-	1,376	1,619	1,997	1,049	1,448	7,249
SALARIES-NURSE	-	1,287	1,812	2,036	1,240	1,491	7,875
ACCOUNTING	-	693	830	1,000	566	733	3,811
WORK COMP INS	-	122	148	178	95	125	647
SUPPLIES	-	117	148	169	95	128	647
TELEPHONE	-	227	318	367	217	262	1,381
EMPL BENEFITS	-	1,766	2,468	2,772	1,688	2,031	10,724
PAYROLL TAXES	-	568	795	892	543	693	3,450
TRAVEL	-	142	175	211	113	150	773
IN SERVICE	-	47					

OCCUPIED DAYS 2009	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1861	2413	2389		1630	1859	10152
FEBRUARY	1752	2160	2088		1341	1588	8929
MARCH	1882	2368	2469		1567	1841	10127
APRIL	1701	2113	2469		1466	1768	9517
MAY	1816	2090	2434		1499	1857	9696
JUNE	1718	2003	2476		1350	1754	9301
JULY	1838	2163	2658		1510	1826	9995
AUGUST	1833	2214	2647		1481	1952	10127
SEPTEMBER	1651	2186	2501		1427	1873	9638
OCTOBER	1707	2208	2569		1441	1898	9823
NOVEMBER	1597	2165	2407		1414	1801	9384
DECEMBER	1572	2197	2468		1503	1808	9548
TOTAL	20928	26280	29575	0	17629	21825	116237 116237

OCCUPIED DAYS 2010	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1593	2173	2620		1497	1862	9745
FEBRUARY	1481	1909	2317		1369	1661	8737
MARCH	1720	2126	2479		1442	1800	9567
APRIL	1700	1979	2386		1321	1749	9135
MAY	1689	2084	2388		1463	1892	9516
JUNE	1598	2026	2292		1268	1705	8889
JULY	1633	2138	2475		1446	1711	9403
AUGUST	1597	2178	2451		1441	1724	9391
SEPTEMBER							0
OCTOBER							0
NOVEMBER							0
DECEMBER							0
TOTAL	13011	16613	19408	0	11247	14104	74383 74383

ALLOCATION PERCENTAGE 2009	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.183314	0.237687	0.235323	0.160559	0.183117	1
FEBRUARY	0.196215	0.241908	0.233845	0.150185	0.177847	1
MARCH	0.18584	0.23383	0.243804	0.154735	0.181791	1
APRIL	0.178733	0.222024	0.25943	0.15404	0.185773	1
MAY	0.187294	0.215553	0.251031	0.1546	0.191522	1
JUNE	0.184711	0.215353	0.266208	0.145146	0.188582	1
JULY	0.183892	0.216408	0.265933	0.151076	0.182691	1
AUGUST	0.181001	0.218623	0.26138	0.146243	0.192752	1
SEPTEMBER	0.171301	0.226811	0.259494	0.14806	0.194335	1
OCTOBER	0.173776	0.224779	0.261529	0.146697	0.19322	1
NOVEMBER	0.170183	0.230712	0.2565	0.150682	0.191922	1
DECEMBER	0.164642	0.230101	0.258483	0.157415	0.189359	1

ALLOCATION PERCENTAGE 2010	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.163468	0.222986	0.268856	0.153617	0.191072	1
FEBRUARY	0.169509	0.218496	0.265194	0.15669	0.190111	1
MARCH	0.179785	0.222222	0.25912	0.150726	0.188147	1
APRIL	0.186097	0.216639	0.261193	0.144609	0.191461	1
MAY	0.177491	0.219	0.250946	0.153741	0.198823	1
JUNE	0.179773	0.227922	0.257847	0.142648	0.19181	1
JULY	0.173668	0.227374	0.263214	0.153781	0.181963	1
AUGUST	0.170056	0.231924	0.260995	0.153445	0.18358	1