

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 6/4/2010

	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	101	Skilled (SNF)	111	38,975	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	101	TOTALS	111	38,975	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	540	431	6,506	7,477	8
9	SNF/PED					9
10	ICF	14,407	13,682	148	28,237	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,947	14,113	6,654	35,714	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.63%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Outpatient Therapy

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

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

YES NO

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

YES NO

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

Date started 04/01/1994

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

YES Date 04/01/1994 NO

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

YES NO If YES, enter number of beds certified 111 and days of care provided 6,506

Medicare Intermediary Pinnacle Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

* 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:

01/01/2010

Ending:

12/31/2010

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	237,814	28,526	7,457	273,797		273,797		273,797		1
2	Food Purchase		227,937		227,937		227,937	(3,356)	224,581		2
3	Housekeeping	117,375	25,680		143,055	10	143,065		143,065		3
4	Laundry	115,154	21,062		136,216		136,216		136,216		4
5	Heat and Other Utilities			144,574	144,574		144,574		144,574		5
6	Maintenance	66,688	21,892	42,737	131,317		131,317	431	131,748		6
7	Other (specify):* Waste Removal			7,826	7,826		7,826		7,826		7
8	TOTAL General Services	537,031	325,097	202,594	1,064,722	10	1,064,732	(2,925)	1,061,807		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,812,271	159,628	48,676	2,020,575	(3,663)	2,016,912	(603)	2,016,309		10
10a	Therapy	21,337	5,565	824,326	851,228		851,228	(39,454)	811,774		10a
11	Activities	57,319	4,547	5,205	67,071	229	67,300	(604)	66,696		11
12	Social Services	68,790		1,464	70,254	126	70,380		70,380		12
13	CNA Training			1,101	1,101	3,031	4,132	(250)	3,882		13
14	Program Transportation		9,497		9,497		9,497		9,497		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,959,717	179,237	890,372	3,029,326	(277)	3,029,049	(40,911)	2,988,138		16
	C. General Administration										
17	Administrative	93,826	6,044	600,186	700,056	(1,360)	698,696	(407,925)	290,771		17
18	Directors Fees			60,000	60,000		60,000	(60,000)			18
19	Professional Services			95,131	95,131	597	95,728	(54,488)	41,240		19
20	Dues, Fees, Subscriptions & Promotions			52,697	52,697	300	52,997	(27,285)	25,712		20
21	Clerical & General Office Expenses	48,394	24,427	98,254	171,075	741	171,816	26,594	198,410		21
22	Employee Benefits & Payroll Taxes			355,639	355,639		355,639	12,656	368,295		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,583	10,583	(11)	10,572	968	11,540		24
25	Other Admin. Staff Transportation							3,437	3,437		25
26	Insurance-Prop.Liab.Malpractice			51,369	51,369		51,369	2,400	53,769		26
27	Other (specify):*										27
28	TOTAL General Administration	142,220	30,471	1,323,859	1,496,550	267	1,496,817	(503,643)	993,174		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,638,968	534,805	2,416,825	5,590,598		5,590,598	(547,479)	5,043,119		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:

01/01/2010

Ending:

12/31/2010

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			296,166	296,166		296,166	(1,039)	295,127			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			281,626	281,626		281,626	(8,189)	273,437			32
33	Real Estate Taxes			61,609	61,609		61,609		61,609			33
34	Rent-Facility & Grounds							14,451	14,451			34
35	Rent-Equipment & Vehicles			4,773	4,773		4,773	1,971	6,744			35
36	Other (specify):* Mortgage Ins.			23,472	23,472		23,472		23,472			36
37	TOTAL Ownership			667,646	667,646		667,646	7,194	674,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		282,503	43,173	325,676		325,676		325,676			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,463	58,463		58,463		58,463			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		282,503	101,636	384,139		384,139		384,139			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,638,968	817,308	3,186,107	6,642,383		6,642,383	(540,285)	6,102,098			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	(3,278)	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	(8,189)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,362)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,037)	24		19
20	Contributions	(600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,331)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,016)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,228)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,213)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,254)		\$	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)	(478,031)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (478,031)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (540,285)		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						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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	

ID# 0039339

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset C.N.A Book Reimbursement	\$ (250)	13	1
2	Offset Medical Supplies Reimbursement	(603)	10	2
3	Offset Maintenance Supplies Credit	(137)	6	3
4	Offset Activity Supply Reimbursement	(604)	11	4
5	Offset Therapy Supply Reimbursement	(37)	10A	5
6	Offset Dietary Supply Reimbursement	(78)	2	6
7	Eliminate PAC Dues, including lobbying portion	(2,336)	20	7
8	Eliminate 2011 IDPH license paid in 2010	(995)	20	8
9	Eliminate non-allowable dues	(1,250)	20	9
10	Add credit for 2009 duplicate legal fees	5,513	19	10
11	Eliminate depreciation exp for non-medicaid assets	(6,436)	30	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	(7,213)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	(3,356)	0	0	0	0	0	0	0	0	0	0	(3,356)	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	(137)	568	0	0	0	0	0	0	0	0	0	431	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,493)	568	0	0	0	0	0	0	0	0	0	(2,925)	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	(603)	0	0	0	0	0	0	0	0	0	0	(603)	10
10a	Therapy	(37)	0	(39,417)	0	0	0	0	0	0	0	0	(39,454)	10a
11	Activities	(604)	0	0	0	0	0	0	0	0	0	0	(604)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(250)	0	0	0	0	0	0	0	0	0	0	(250)	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	(1,494)	0	(39,417)	0	(40,911)	16							
	C. General Administration													
17	Administrative	0	73,776	(481,701)	0	0	0	0	0	0	0	0	(407,925)	17
18	Directors Fees	0	0	(60,000)	0	0	0	0	0	0	0	0	(60,000)	18
19	Professional Services	3,182	5,657	(63,327)	0	0	0	0	0	0	0	0	(54,488)	19
20	Fees, Subscriptions & Promotions	(28,559)	1,274	0	0	0	0	0	0	0	0	0	(27,285)	20
21	Clerical & General Office Expenses	(14,228)	40,822	0	0	0	0	0	0	0	0	0	26,594	21
22	Employee Benefits & Payroll Taxes	0	12,656	0	0	0	0	0	0	0	0	0	12,656	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,037)	4,005	0	0	0	0	0	0	0	0	0	968	24
25	Other Admin. Staff Transportation	0	3,437	0	0	0	0	0	0	0	0	0	3,437	25
26	Insurance-Prop.Liab.Malpractice	0	2,400	0	0	0	0	0	0	0	0	0	2,400	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(42,642)	144,027	(605,028)	0	(503,643)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(47,629)	144,595	(644,445)	0	(547,479)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center

0039339

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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	(6,436)	5,397	0	0	0	0	0	0	0	0	0	(1,039)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,189)	0	0	0	0	0	0	0	0	0	0	(8,189)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	14,451	0	0	0	0	0	0	0	0	0	14,451	34
35	Rent-Equipment & Vehicles	0	1,971	0	0	0	0	0	0	0	0	0	1,971	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,625)	21,819	0	0	0	0	0	0	0	0	0	7,194	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)	(62,254)	166,414	(644,445)	0	(540,285)	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 & Rehabilitation Center	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 Center	Florissant, MO	C.J. Schlosser & Co.	Alton, IL	Public Accountants
				NW Rehab, L.L.C.	Alton, IL	Therapy Co.
				Three Amigos, L.L.C.	Alton, IL	Real Estate Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	6 See Schedule VIII	\$	Wellington Management Co.	60.00%	\$ 568	\$	568	1
2	V	17 See Schedule VIII		Wellington Management Co.	60.00%	73,776		73,776	2
3	V	19 See Schedule VIII		Wellington Management Co.	60.00%	5,657		5,657	3
4	V	20 See Schedule VIII		Wellington Management Co.	60.00%	1,274		1,274	4
5	V	21 See Schedule VIII		Wellington Management Co.	60.00%	40,822		40,822	5
6	V	22 See Schedule VIII		Wellington Management Co.	60.00%	12,656		12,656	6
7	V	24 See Schedule VIII		Wellington Management Co.	60.00%	4,005		4,005	7
8	V	25 See Schedule VIII		Wellington Management Co.	60.00%	3,437		3,437	8
9	V	26 See Schedule VIII		Wellington Management Co.	60.00%	2,400		2,400	9
10	V	30 See Schedule VIII		Wellington Management Co.	60.00%	5,397		5,397	10
11	V	34 See Schedule VIII		Wellington Management Co.	60.00%	14,451		14,451	11
12	V	35 See Schedule VIII		Wellington Management Co.	60.00%	1,971		1,971	12
13	V								13
14	Total		\$			\$ 166,414	\$ *	166,414	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	\$ 396,277	Wellington Management Co.	60.00%	\$	\$ (396,277)
16	V	17 Management Fees	203,909	Health Care Financial, LLC	40.00%	118,485	(85,424)
17	V	19 Professional Services	63,327	C.J. Schlosser & Company, LLC	40.00%		(63,327)
18	V	10a Therapy Services	824,326	NW Rehab, LLC	100.00%	784,909	(39,417)
19	V	10 Nurse Consultant	23,517	Wellington Management Co.	60.00%	23,517	
20	V	18 Director's Fees	36,000	John H. Rothert	60.00%		(36,000)
21	V	18 Director's Fees	12,000	J. Terry Dooling	20.00%		(12,000)
22	V	18 Director's Fees	12,000	David L. Kamler	20.00%		(12,000)
23	V	21 Clerical	16,420	Wellington Management Co.	60.00%	16,420	
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,587,776			\$ 943,331	\$ * (644,445)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Jerseyville Nursing & Rehabilitation Center

#

0039339

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	241,431	9.34	23.36	Salary	\$ 73,569	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	\$ 73,569		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: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Heat and Other Utilities	Accumulated Costs	22,320,474	6	\$	\$	5,213,029	\$ 0	1
2	6	Maintenance	Accumulated Costs	22,320,474	6	2,431	5,213,029	568	2	
3	17	Administrative	Accumulated Costs	22,320,474	6	315,886	315,886	73,776	3	
4	19	Professional Services	Accumulated Costs	22,320,474	6	24,222	5,213,029	5,657	4	
5	20	Dues, Fees, Subs, & Promos	Accumulated Costs	22,320,474	6	5,455	5,213,029	1,274	5	
6	21	Clerical & General Office Exp.	Accumulated Costs	22,320,474	6	174,786	106,027	40,822	6	
7	22	Employee Benefits & PR Taxes	Accumulated Costs	22,320,474	6	54,187	5,213,029	12,656	7	
8	24	Travel & Seminar	Accumulated Costs	22,320,474	6	17,147	5,213,029	4,005	8	
9	25	Other Admin Staff Transport	Accumulated Costs	22,320,474	6	14,717	5,213,029	3,437	9	
10	26	Insurance - Prop, Liab, Malprac	Accumulated Costs	22,320,474	6	10,275	5,213,029	2,400	10	
11	30	Depreciation	Accumulated Costs	22,320,474	6	23,109	5,213,029	5,397	11	
12	32	Interest Expense	Accumulated Costs	22,320,474	6		5,213,029	0	12	
13	34	Rent - Facility and Grounds	Accumulated Costs	22,320,474	6	61,875	5,213,029	14,451	13	
14	35	Vehicle Lease	Accumulated Costs	22,320,474	6	8,439	5,213,029	1,971	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 712,529	\$ 421,913	\$ 166,414	25	

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Berkadia Finance, Inc.		X	Refinance Loan	\$20,841.58	10/31/06	\$ 3,720,700	\$ 3,568,064	10/31/41	5.8500	\$ 208,053	1							
2	First National Bank of St. Louis		X	Van Loan		2/21/07	39,507		2/21/10	7.0000	7	2							
3	Berkadia Finance, Inc.-Sec 241		X	Building Addition	\$12,356.95	7/31/10	2,032,500	2,025,261	1/31/44	6.4500	70,414	3							
4										Interest Income	(8,189)	4							
5										Loan Cost Amortization	3,152	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$33,198.53		\$ 5,792,707	\$ 5,593,325			\$ 273,437	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 5,792,707	\$ 5,593,325			\$ 273,437	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 23,472 Line # 36

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.		\$	54,000	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.)		\$	55,609	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,609	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,000	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.		\$	61,609	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	50,047	8
	2006	50,620	9
	2007	51,022	10
	2008	53,479	11
	2009	55,609	12

Line 2: 2009 Taxes Paid

Line 4: Accrual is based on 2009 taxes paid plus approx. 2%

	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 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 2009 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 2009.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-875-004-00</u>	<u>Outlots 59, 62, 63, & 64S PT Outlot 62</u>	\$ <u>51,787.50</u>	\$ <u>51,787.50</u>
2. <u>04-208-017-00</u>	<u>S28 T8 R11 Unplatted Parcels</u>	\$ <u>3,821.48</u>	\$ <u>3,821.48</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>55,608.98</u>	\$ <u>55,608.98</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 NO

If YES, attach an explanation and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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:

01/01/2010 Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,975 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).

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:

01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	101		1994		\$ 1,180,668	\$ 47,227	25	\$ 47,227		\$ 791,048	4
5	10			2010	2,044,012	47,694	25	47,694		47,694	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		15			10,000	10
11	Flooring		1994		29,698		10			29,698	11
12	Electrical		1994		11,690	585	20	585		9,495	12
13	Air Conditioners		1994		25,830		10			25,830	13
14	Interior Remodeling		1994		40,265	42	5-20 yrs	42		40,122	14
15	Hearla Shed		1994		3,267		10			3,267	15
16	Nurses Station		1994		6,055	303	20	303		5,020	16
17	Painting		1995		7,392		5			7,392	17
18	Electrical Work		1995		3,382		10			3,382	18
19	Call Lights		1995		1,564	78	15	78		1,564	19
20	Storage Building		1996		3,500		10			3,500	20
21	Boiler		1996		7,400	370	20	370		5,519	21
22	Roof Repairs		1996		3,619		10			3,619	22
23	Ceiling Tiles and End Caps		1996		3,506		12			3,506	23
24	Storage Building		1997		3,356		10			3,356	24
25	Alarm System		1997		1,750		10			1,750	25
26	Wallpaper		1997		6,355		5			6,355	26
27	Ceiling Tiles		1997		1,485		12			1,485	27
28	3 Windows & Sills & 1 Door Replaced		1997		4,108	274	15	274		3,652	28
29	Baseboards Remodeled		1997		1,167		10			1,167	29
30	Air Conditioners		1997		2,185		10			2,185	30
31	Concrete Patio & Sidewalk		1997		1,842	123	15	123		1,637	31
32	Rock		1997		502		5			502	32
33	Landscaping		1997		1,075		10			1,075	33
34	Roofing		1998		2,592		10			2,592	34
35	Shower Room Remodeling		1998		1,437		10			1,437	35
36	Baseboard Remodeling		1998		1,919		10			1,919	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:

01/01/2010 Ending: 12/31/2010

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

1	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 <u>Air Conditioners</u>	1998	\$ 13,420	\$ 71	10-20yrs	\$ 71	\$	\$ 12,972	37
38 <u>Wallcovering</u>	1998	1,495		10			1,495	38
39 <u>Air Conditioners</u>	1999	2,841		10			2,841	39
40 <u>New Roof</u>	1999	35,386		10			35,386	40
41 <u>Air Conditioners</u>	2000	2,118	123	10	123		2,118	41
42 <u>Wallcoverings</u>	2000	2,231		5			2,231	42
43 <u>Chair Rails</u>	2000	6,267	418	15	418		4,210	43
44 <u>Cove Base</u>	2000	1,797	180	10	180		1,797	44
45 <u>Constr. Of 400 Wing - Design, Architecture & Engineering</u>	2001	65,216	2,561	25	2,561		25,587	45
46 <u>Constr. Of 400 Wing - Contractor Costs</u>	2001	874,589	33,682	25	33,682		354,543	46
47 <u>Constr. Of 400 Wing - Drawing, Surety Bond, & Misc.</u>	2001	11,223	449	25	449		4,265	47
48 <u>Constr. Of 400 Wing - Interest & Mortgage Ins. Premium</u>	2001	83,401	3,225	25	3,225		33,592	48
49 <u>400 Wing - Nurse Call System</u>	2001	10,104	674	15	674		6,399	49
50 <u>400 Wing Cable TV System Cabling</u>	2001	1,962	196	10	196		1,864	50
51 <u>400 Wing - Fire Alarm System</u>	2001	13,326	784	15	784		9,112	51
52 <u>400 Wing - Telecommunication System</u>	2001	4,025	402	10	402		3,824	52
53 <u>400 Wing - Door Monitoring System</u>	2001	2,640	264	10	264		2,508	53
54 <u>400 Wing - TV Wall Mounts</u>	2001	5,851	514	10	514		5,639	54
55 <u>400 Wing - Signage</u>	2001	1,161		5			1,161	55
56 <u>400 Wing - Handrails and Wall Guards</u>	2001	2,319	155	15	155		1,469	56
57 <u>400 Wing - Chair Rail</u>	2001	4,208		5			4,208	57
58 <u>400 Wing - Door Guards</u>	2001	607		5			607	58
59 <u>400 Wing Cubicle Tracks, Curtains, Window Treatments</u>	2001	15,188	358	5-20 yrs	358		11,424	59
60 <u>Landscaping, Shrubs, Trees, Grass</u>	2001	11,744	1,174	10	1,174		11,450	60
61 <u>Fencing</u>	2001	4,200		8			4,200	61
62 <u>Wallpaper</u>	2001	22,669		5			22,669	62
63 <u>Storage Building</u>	2001	3,268	327	10	327		3,214	63
64 <u>Carpet</u>	2001	2,687		5			2,687	64
65 <u>Nurse Call System Upgrades</u>	2001	3,700	247	15	247		2,364	65
66 <u>Fire Alarm System Control Panel</u>	2001	3,903	260	15	260		2,602	66
67 <u>Replacement Signage</u>	2001	3,656		5			3,656	67
68 <u>Door Guards</u>	2001	1,979		5			1,979	68
69 <u>400 Wing - Vinyl Flooring</u>	2001	11,615	1,162	10	1,162		11,034	69
70 TOTAL (lines 4 thru 69)		\$ 4,668,721	\$ 143,922		\$ 143,922	\$	\$ 1,641,179	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:

01/01/2010 Ending: 12/31/2010

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,668,721	\$ 143,922		\$ 143,922	\$	\$ 1,641,179	1
2	Overbed Lights	2001	1,625	163	10	163		1,530	2
3	Painting	2001	8,932		5			8,932	3
4	2P 50 Amp Disconnect	2001	955	48	20	48		450	4
5	Mini Blinds	2001	14,744		5			14,744	5
6	Asphalt Paving of Parking Lot	2001	14,193	1,419	10	1,419		13,720	6
7	Air Conditioners	2001	3,424	342	10	342		3,269	7
8	Overbed Lights	2002	3,055	306	10	306		2,702	8
9	Cubicle Curtains	2002	6,155		5			6,155	9
10	Air Conditioners	2002	1,398	140	10	140		1,211	10
11	Security Camera System	2002	1,010		5			1,010	11
12	Fire Doors	2002	1,543	103	15	103		874	12
13	Roofing - North Entrance	2002	1,680	168	10	168		1,372	13
14	Wall Guard and End Caps	2002	1,497	100	15	100		815	14
15	Door Canopy	2002	3,800	253	15	253		2,027	15
16	Landscaping	2002	1,729	173	10	173		1,427	16
17	Landscaping	2003	18,903	1,890	10	1,890		14,010	17
18	Air Conditioners	2003	5,551	555	10	555		4,182	18
19	Home Office - Cabinets	2003	975		10	97	97	731	19
20	Landscaping, Plants, Trees	2004	4,371	437	10	437		2,878	20
21	100 Amp Transfer Switch to Generator	2004	11,865	791	15	791		5,339	21
22	Smoke Detectors	2004	1,600	160	10	160		1,067	22
23	Extend Activities Wall/Replace Doors	2004	2,002	133	15	133		890	23
24	Air Conditioners	2004	1,814	181	10	181		1,179	24
25	Cove Base	2004	2,188	219	10	219		1,423	25
26	Hollow Metal Double Door	2004	8,520	426	20	426		2,592	26
27	New Wall/Flooring - Kitchen	2004	2,983	298	10	298		1,790	27
28	Cubicle Curtains	2005	289	14	5	14		289	28
29	Generator Control Panel	2005	3,689	307	12	307		1,614	29
30	Resident Room Doors	2005	19,393	1,293	15	1,293		6,862	30
31	Fire Doors	2005	4,955	270	5-15 yrs	270		2,711	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,823,559	\$ 154,111		\$ 154,208	\$ 97	\$ 1,748,974	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,823,559	\$ 154,111		\$ 154,208	\$ 97	\$ 1,748,974	1
2	Water Heater	2005	4,000	400	10	400		2,233	2
3	Replace Generator	2005	5,690	474	12	474		2,410	3
4	Air Conditioners	2005	1,753	175	10	175		877	4
5	Electrical Wiring	2005	4,862	243	20	243		1,256	5
6	Dishwasher Booster Heater	2005	1,766	177	10	177		883	6
7	Kitchen & Laundry Flooring	2005	2,556	256	10	256		1,299	7
8	4-Door Monitor System	2006	2,696	270	10	270		1,191	8
9	2 Door Awnings - Side & Back Entrance	2006	1,671	111	15	111		483	9
10	Built-In Waterfall	2006	3,499	350	10	350		1,604	10
11	Drywall	2006	1,234	82	15	82		363	11
12	Wallpaper	2006	5,219	1,044	5	1,044		4,390	12
13	Lobby Remodeling	2006	17,774	1,185	15	1,185		4,937	13
14	4-Ton Heat Pump	2006	5,580	558	10	558		2,279	14
15	Glass Doors	2006	47,653	3,285	10-15 yrs	3,285		14,765	15
16	Air Conditioners	2006	9,474	824	10-15 yrs	824		3,617	16
17	Vinyl Flooring	2006	6,924	692	10	692		3,192	17
18	Kitchen Tile	2006	4,411	467	8-10 yrs	467		1,929	18
19	Sprinkler System Improvements	2006	5,025	201	25	201		945	19
20	Carpet	2006	3,419	684	5	684		2,903	20
21	Electrical Wiring	2006	15,869	793	20	793		3,298	21
22	Smoke Damper Motor	2006	1,793	90	20	90		433	22
23	Vinyl Fencing	2006	12,359	1,236	10	1,236		5,150	23
24	Concrete Patio & Sidewalk	2006	10,744	716	15	716		2,984	24
25	Lanscaping, Rock, Mulch	2006	4,325	433	10	433		2,091	25
26	Wallpaper	2007	12,135	2,427	5	2,427		7,610	26
27	Air Conditioners	2007	16,341	1,618	5-15 yrs	1,618		5,502	27
28	Flooring	2007	31,280	3,128	10	3,128		10,300	28
29	Alarm System	2007	4,732	516	7-10 yrs	516		1,906	29
30	Handrails	2007	11,039	1,259	5-15 yrs	1,259		3,834	30
31	Roof	2007	5,700	273	20-25 yrs	273		894	31
32	Satellite System	2007	16,581	829	20	829		2,764	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,101,663	\$ 178,907		\$ 179,004	\$ 97	\$ 1,847,296	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:

01/01/2010 Ending: 12/31/2010

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,101,663	\$ 178,907		\$ 179,004	\$ 97	\$ 1,847,296	1
2	Electrical for HVAC Unit	2007	3,964	198	20	198		677	2
3	Courtyard Landscaping	2007	3,800	380	10	380		1,362	3
4	Courtyard Pavilion Constructed	2007	9,870	658	15	658		2,248	4
5	Asphalt, Seal, Stripe Parking Lot	2007	13,500	1,688	8	1,688		5,344	5
6	Stainless Steel Backsplash	2007	2,523	126	20	126		410	6
7	Drywall	2007	3,790	253	15	253		884	7
8	Flooring	2008	23,598	2,241	10-20 yrs	2,241		5,117	8
9	Wallpaper	2008	31,055	6,211	5	6,211		15,642	9
10	Hot Water Heaters	2008	14,000	1,400	10	1,400		3,267	10
11	Network Cabling	2008	2,646	132	20	132		375	11
12	Front Porch Entrance	2008	63,826	3,191	20	3,191		8,244	12
13	Sprinkler System	2008	16,900	676	25	676		1,803	13
14	Electric Installation on Trailer	2008	3,236	162	20	162		472	14
15	Facility Signage	2008	3,212	642	5	642		1,552	15
16	Landscaping	2008	5,700	570	10	570		1,235	16
17	Flooring	2009	71,018	6,934	10-20 yrs	6,934		9,856	17
18	300 KW Cummins Generator - Whole Bldg	2009	104,540	5,227	20	5,227		7,840	18
19	Needler Remodeling - Wallpaper & Paint	2009	12,345	2,469	5	2,469		3,909	19
20	Replace 2" Drain Line	2009	4,111	164	25	164		315	20
21	Roofing	2009	3,000	300	10	300		525	21
22	Wi-Fi Access Installed	2009	725	36	20	36		45	22
23	Vinyl Fencing Labor/Materials	2009	1,400	140	10	140		175	23
24	Home Office - Shelving	2009	111		15	7	7	13	24
25	Home Office - New Carpet	2009	876		5	175	175	321	25
26	Home Office - Suite 140 Labor & Tenant Finish	2009	4,647		20	233	233	406	26
27	Flooring-Existing Facility	2010	21,980	1,972	10	1,972		1,972	27
28	Pt Room Remodeling-Patching/Painting	2010	2,925	439	5	439		439	28
29	Roofing-Mansard Wall	2010	2,222	185	10	185		185	29
30	Replace 55 sprinkler heads	2010	2,100	35	25	35		35	30
31	2 AC/Heat Units	2010	1,396	116	5	116		116	31
32	Dr's Room Sink	2010	1,356	22	20	22		22	32
33	400S Hall Facility Signage	2010	1,041	35	5	35		35	33
34	TOTAL (lines 1 thru 33)		\$ 5,539,076	\$ 215,509		\$ 216,021	\$ 512	\$ 1,922,137	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 5,539,076	\$ 215,509		\$ 216,021	\$ 512	\$ 1,922,137	1
2	2010	4,749	26	15	26		26	2
3	2010	8,704	435	10	435		435	3
4	2010	21,337	1,200	10	1,200		1,200	4
5	2010	8,829	258	20	258		258	5
6	2010	44,132	3,218	8	3,218		3,218	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	TOTAL (lines 1 thru 33)	\$ 5,626,827	\$ 220,646		\$ 221,158	\$ 512	\$ 1,927,274	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:

01/01/2010

Ending:

12/31/2010

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	\$ 316,066	\$ 25,683	\$ 27,867	\$ 2,184	3-20 yrs	\$ 177,139	71
72	Current Year Purchases	146,037	8,295	8,296	1	3-20 yrs	8,295	72
73	Fully Depreciated Assets	392,401	1,627	1,627		5-20 yrs	392,401	73
74								74
75	TOTALS	\$ 854,504	\$ 35,605	\$ 37,790	\$ 2,185		\$ 577,835	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	\$ 50,284	76
77	Facility Use	2007 Hyundai Vera Cruz	2007	29,106	7,276	7,276		4	24,861	77
78	Facility Use	2010 Ford E450 Wheelchair Van	2009	52,340		13,085	13,085	4	17,446	78
79	See Attached Schedule			24,593		2,700	2,700	4	10,942	79
80	TOTALS			\$ 158,510	\$ 20,394	\$ 36,179	\$ 15,785		\$ 103,533	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)		\$ 6,711,505	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 276,645	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 295,127	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 18,482	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,608,642	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 N/A	\$	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 6,744 Description: Copier \$3,496; Postage Machine \$1,277; H.O. Vehicle Lease \$1,971
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2011</u>	\$ _____
13.	<u>/2012</u>	\$ _____
14.	<u>/2013</u>	\$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		213		213
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		2,982		2,982
6	Transportation				
7	Contractual Payments		88		88
8	CNA Competency Tests		600		600
9	TOTALS	\$	\$ 3,883	\$	\$ 3,883
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,883		

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

- (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.)

1	2	3	4	5	6	7	8	XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)							
								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	10001 hrs	\$ 353,791		\$	149	10,001	\$ 353,940	1					
2	Licensed Speech and Language Development Therapist	10a-8	4240 hrs	191,605				4,240	191,605	2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	10a-8	7166 hrs	239,513			5,416	7,166	244,929	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				260,084		260,084	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				34,784			34,784						
	Other (specify): <u>X-Ray & Spec. Mattres</u>	39-3; 39,2				8,390	22,419		30,809	13					
14	TOTAL			\$ 784,909		\$ 43,174	\$ 288,068	21,407	\$ 1,116,151	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: 01/01/2010

Ending:

12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 159,667	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	951,793		3
4	Supply Inventory (priced at)	16,298		4
5	Short-Term Investments			5
6	Prepaid Insurance	51,581		6
7	Other Prepaid Expenses	1,869		7
8	Accounts Receivable (owners or related parties)	128,690		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,309,898	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	303,425		13
14	Buildings, at Historical Cost	5,517,781		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	970,897		16
17	Accumulated Depreciation (book methods)	(2,630,956)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	257,827		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	151,111		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,590,285	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,900,183	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 231,405	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,053		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,895		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000		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>	(787)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 476,566	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,653,759		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>B. Powell Memorial Donation</u>	18,812		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,672,571	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,149,137	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (248,954)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,900,183	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 203,417	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 203,417	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	47,629	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	(500,000)	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)	\$ (452,371)	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)	\$ (248,954)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339Report Period Beginning: 01/01/2010Ending: 12/31/2010**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	\$ 6,706,956	1
2	Discounts and Allowances for all Levels	(1,173,256)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,533,700	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	4,091	5
6	Therapy	1,078,126	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,082,217	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	8,984	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7	13
14	Non-Patient Meals	3,278	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	28,762	19
20	Radiology and X-Ray	7,013	20
21	Other Medical Services	12,831	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 60,875	23
D. Non-Operating Revenue			
24	Contributions	507	24
25	Interest and Other Investment Income***	8,189	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,696	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	2,673	28
28a	<u>Vending Machine</u>	1,851	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,524	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,690,012	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,064,722	31
32	Health Care	3,029,326	32
33	General Administration	1,496,550	33
B. Capital Expense			
34	Ownership	667,646	34
C. Ancillary Expense			
35	Special Cost Centers	325,676	35
36	Provider Participation Fee	58,463	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,642,383	40
41	Income before Income Taxes (line 30 minus line 40)**	47,629	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 47,629	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:

01/01/2010

Ending:

12/31/2010

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	2,084	2,192	\$ 62,926	\$ 28.71	1
2	Assistant Director of Nursing	1,948	2,051	51,857	25.28	2
3	Registered Nurses	11,487	12,115	276,296	22.81	3
4	Licensed Practical Nurses	22,692	24,327	463,961	19.07	4
5	CNAs & Orderlies	89,730	94,627	926,505	9.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,937	2,058	21,337	10.37	8
9	Activity Director					9
10	Activity Assistants	5,501	5,742	57,319	9.98	10
11	Social Service Workers	3,961	4,252	68,790	16.18	11
12	Dietician	25,772	26,856	237,814	8.86	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,344	4,782	66,688	13.95	17
18	Housekeepers	12,248	13,106	117,375	8.96	18
19	Laundry	11,814	12,590	115,154	9.15	19
20	Administrator	2,152	2,221	93,826	42.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,905	4,143	48,394	11.68	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	1,929	2,161	30,726	14.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	201,504	213,223	\$ 2,638,968 *	\$ 12.38	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	\$ 7,457	1, 3	35
36	Medical Director	Contract	9,600	9, 3	36
37	Medical Records Consultant	11	574	10, 3	37
38	Nurse Consultant	N/A	23,517	10, 3	38
39	Pharmacist Consultant	Contract	3,271	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	1,589	11, 3	44
45	Social Service Consultant	25	1,589	12, 3	45
46	Other(specify) <u>Compliance Consultant</u>	33	2,494	10, 3	46
47	<u>Clerical</u>	N/A	16,420	21, 3	47
48	<u>Quality Assurance Doctor</u>	N/A	2,400	10, 3	48
49	TOTAL (lines 35 - 48)	286	\$ 68,911		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Terrie Weible	Administrator		\$ 93,826	Workers' Compensation Insurance	\$ 75,643	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	21,174	Advertising: Employee Recruitment	10,565	
				FICA Taxes	193,510	Health Care Worker Background Check (Indicate # of checks performed 194)	3,104	
				Employee Health Insurance	54,958	Patient Background Checks		
				Employee Meals		Licenses & Fees	784	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,290	
				Employee Disability Insurance	724	IHCA Dues	3,824	
				Staff Relations	7,372	Bank Service Charges	2,876	
				Employee Dental/Vision Insurance	1,711	Home Office Dues & Subscriptions	1,274	
				Home Office Employee Benefits	12,656	Less: Public Relations Expense	()	
				Employee Physicals	547	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,826	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 368,295		\$ 25,712		
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Wellington Management Co., LLC			\$ 396,277	Section N/A		\$	Out-of-State Travel	\$
Health Care Financial, LLC			203,909					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 600,186				In-State Travel	4,507
C. Professional Services								
Vendor/Payee	Type		Amount					
C.J. Schlosser & Co., LLC	Accounting Services		\$ 63,327				Seminar Expense	3,028
May, Cocagne, & King	Audit Fees		12,050				Home Office Travel & Seminar	4,005
Droege & Associates	401(k) Audit Fees		224					
Donohoo, McCalley, & Associates	HUD Cost Certification		2,000				Entertainment Expense	()
McMahon, Berger, P.C.	Legal Fees		61				(agree to Sch. V, line 24, col. 8)	
Sandberg, Phoenix, & Von Gontard	Legal Fees		2,584					
Duane Morris, LLP	Legal Fees-5513 added		9,842					
Strang & Parish, LTD	Legal Fees-eliminated 2,331		4,380					
Husch, Blackwell, Sanders, LLP	Legal Fees		663					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 95,131	TOTAL		\$	TOTAL	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Helathcare Association \$3,824
- (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? Yes If YES, what is the capacity? 111
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,040 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. \$ 58,463
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. \$ 3,278
- (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? 44.28%
 - 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
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Detail of Line 79: Home Office Admin Vehicles

<u>Model, Make & Year</u>	<u>Year</u> <u>Acquired</u>	<u>Cost</u>	<u>Current Book</u> <u>Depreciation</u>	<u>Straight Line</u> <u>Depreciation</u>	<u>Adjustments</u>	<u>Life In</u> <u>Years</u>	<u>Accumulated</u> <u>Depreciation</u>
2000 Taurus	2000	5,563	-	-	-	4	5,563
2008 Hyundai Sonata	2008	3,969	-	992	992	4	2,563
2003 Infiniti I-35	2008	4,090	-	1,022	1,022	4	2,130
2008 Land Rover	2010	10,971	-	686	686	4	686
		<u>24,593</u>	-	<u>2,700</u>	<u>2,700</u>		<u>10,942</u>

JERSEYVILLE NURSING AND REHABILITATION CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2010

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
ADMINISTRATIVE	17	(1,451)
HOUSEKEEPING	3	10
ACTIVITIES	11	103
PROFESSIONAL SERVICES	19	597
CLERICAL & GENERAL OFFICE EXPENSE	21	741
To reclass various expenses to proper lines		
NURSE AIDE TRAINING	13	2,982
NURSING & MEDICAL RECORDS	10	(2,982)
To reclass CNA trainer wages		
TRAVEL & SEMINAR	24	241
NURSE AIDE TRAINING	13	49
PROFESSIONAL SERVICES	20	300
ADMINISTRATIVE	17	91
NURSING & MEDICAL RECORDS	10	(681)
To reclass various expenses to the correct lines		
TRAVEL & SEMINAR	24	(252)
ACTIVITIES	11	126
SOCIAL SERVICES	12	126
To reclass activities and social svervices consultant expenses to the proper lines.		

Jerseyville Nursing and Rehabilitation Center
Attachment to Sch. XVII
December 31, 2010

BOOK TO TAX NET INCOME RECONCILIATION:

BOOK NET INCOME (LOSS)	47,629.00
CONVERSION TO CASH BASIS ADJUSTMENTS	<u>6,660.00</u>
SUBTOTAL	54,289.00
DEPRECIATION ADJUSTMENT	(54,005.00)
MISC. NON-DEDUCTIBLE EXPENSES	13,966.00
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>14,250.00</u></u>

JERSEYVILLE NURSING AND REHABILITATION CENTER
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/2010

Miscellaneous Income	
CNA Book Reimbursement	250
Reimb for copies of medical records & nursing supplies	603
Refund from Home Depot	137
Reimb for activities	604
Reimb for Therapy Supplies	37
Reimb on cakes for BBQ	78
Buffer Rental Income	400
Reimb of overpayments from vendors	155
Miscellaneous Income	23
Void checks from patient trust	343
Resident Reimb for services	43
	<u>2,673</u>

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
 TRAVEL AND SEMINAR SCHEDULE
 ATTACHMENT TO SCHEDULE XIX PART G
 12/31/2010

<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>
Terrie Weible, Cindy Bloodworth, Jenny Stewart	Administrator, Act. Director, Soc Svc Director	9/1/2010	Carlyle, IL	MDS 3.0 Seminar	Outcome Services of Illinois	250
Kurt Weaver	Maintenance Supervisor	5/11/2010	Springfield, IL	The Most Frequent Life Safety Code Violations	Illinois Health Care Association	75
Kathy McElroy	Registered Nurse	4/16/2010	Springfield, IL	Annual C.N.A. Instructor Conference	Lincoln Land Community College	80
John Rothert, Terry Dooling	President, Treasurer	10/19/2010	St. Louis, MO	National Health Care Reform	Missouri Association of Nursing Home Administrators	38
John Rothert, Terry Dooling, Holly Jensen	President, Treasurer, Billing	5/24/2010	St. Louis, MO	MDS 3.0 for Management	Missouri League for Nursing, Inc	81
Amy Elik, Cindy Tefteller	Corporate Accountants	5/24/2010	St. Louis, MO	MDS 3.0 for Management	Missouri League for Nursing, Inc	
Melissa Goodwin	Registered Nurse	10/21/2010	Online	Test for R.N. License	N/A	200
Robin White, Lisa Yates	Quality Assurance Nurse, LPN from JNRC	10/18-10/22/10	Brookfield, WI	MDS 3.0 Resident Assessment Coordinator Certification	Americian Association of Nurse Assessment Coordinators	828
Terrrie Weible, Robin White	Administrator, Quality Assurance Nurse	6/9-6/10/10	East Peoria, IL	Improving the Quality of Life of the LTC Resident	Illinois Nursing Home Administrators Association	414

Total Seminars 1,966

Total Seminar Lodging/Travel/Meals 0
 CPR Training 20
 Online CPE Service for Nurses 1,050
 Credit for 2009 Seminar -8
 Other Travel Expense <\$250 each 4,507
 Home Office Travel & Seminar 4,005

Total Travel and Seminar, Line 24 11,540