

		FOR BHF USE					

LL1

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047597

Facility Name: Jerseyville Manor

Address: 1251 North State Street Jerseyville 62052
 Number City Zip Code

County: Jersey

Telephone Number: (618) 498-6441 Fax # (618) 498-9025

HFS ID Number: _____

Date of Initial License for Current Owners: 09/28/05

Type of Ownership:

<input checked="" type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
	<input checked="" type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual		<input type="checkbox"/> State
	<input type="checkbox"/> Trust		<input type="checkbox"/> Partnership		<input type="checkbox"/> County
IRS Exemption Code	<u>501 (c) (3)</u>		<input type="checkbox"/> Corporation		<input type="checkbox"/> Other _____
			<input type="checkbox"/> "Sub-S" Corp.		
			<input type="checkbox"/> Limited Liability Co.		
			<input type="checkbox"/> Trust		
			<input type="checkbox"/> Other _____		

In the event there are further questions about this report, please contact:
 Name: Ron Wilson Telephone Number: (309) 343-1550
 Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/09 to 9/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____
	(Type or Print Name) <u>Tina Calhoun</u> (Date) _____
Paid Preparer	(Title) <u>Director of Operations</u>
	(Signed) <u>See Attached Independent Accountant's Report</u> (Date) _____
	(Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main St., Suite 210</u>
	(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u>
	(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>

**MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Manor

0047597 Report Period Beginning: 10/1/09 Ending: 9/30/10

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 N/A

	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	160	Skilled (SNF)	160	58,400	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	160	TOTALS	160	58,400	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	21,696	16,171	7,423	45,290	8
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	21,696	16,171	7,423	45,290	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.55%

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 10/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/28/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 160 and days of care provided 6,526

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/10 Fiscal Year: 09/30/10

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

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	262,392	23,552	4,795	290,739		290,739		290,739		1
2	Food Purchase		362,407		362,407		362,407		362,407		2
3	Housekeeping	149,438	53,769		203,207		203,207		203,207		3
4	Laundry	70,895	12,179		83,074		83,074		83,074		4
5	Heat and Other Utilities			182,999	182,999		182,999		182,999		5
6	Maintenance	82,032	39,993	42,847	164,872		164,872		164,872		6
7	Other (specify):*										7
8	TOTAL General Services	564,757	491,900	230,641	1,287,298		1,287,298		1,287,298		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,051,051	411,107	3,223	2,465,381		2,465,381		2,465,381		10
10a	Therapy			789,358	789,358		789,358		789,358		10a
11	Activities	78,046	1,136		79,182		79,182		79,182		11
12	Social Services	41,217			41,217		41,217		41,217		12
13	CNA Training										13
14	Program Transportation			1,308	1,308	3,367	4,675		4,675		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,170,314	412,243	802,889	3,385,446	3,367	3,388,813		3,388,813		16
	C. General Administration										
17	Administrative	110,392			110,392		110,392		110,392		17
18	Directors Fees						4,430	4,430			18
19	Professional Services			301,423	301,423		301,423	2,136	303,559		19
20	Dues, Fees, Subscriptions & Promotions			106,841	106,841		106,841	(95,604)	11,237		20
21	Clerical & General Office Expenses	53,053	40,097	35,926	129,076		129,076	213	129,289		21
22	Employee Benefits & Payroll Taxes			488,759	488,759		488,759		488,759		22
23	Inservice Training & Education			1,915	1,915		1,915		1,915		23
24	Travel and Seminar			400	400		400		400		24
25	Other Admin. Staff Transportation			6,734	6,734	(3,367)	3,367		3,367		25
26	Insurance-Prop.Liab.Malpractice			109,235	109,235		109,235	28,828	138,063		26
27	Other (specify):* <u>See Att Sch V</u>	31,349		88,815	120,164		120,164	(120,164)			27
28	TOTAL General Administration	194,794	40,097	1,140,048	1,374,939	(3,367)	1,371,572	(180,161)	1,191,411		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,929,865	944,240	2,173,578	6,047,683		6,047,683	(180,161)	5,867,522		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 Manor

#0047597

Report Period Beginning:

10/1/09

Ending:

9/30/10

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			97,004	97,004		97,004	415,662	512,666			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							594,740	594,740			32
33	Real Estate Taxes			307	307		307	130,440	130,747			33
34	Rent-Facility & Grounds			875,650	875,650		875,650	(875,650)				34
35	Rent-Equipment & Vehicles			11,584	11,584		11,584		11,584			35
36	Other (specify):* See Att Sch IV							5,085	5,085			36
37	TOTAL Ownership			984,545	984,545		984,545	270,277	1,254,822			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			46,530	46,530		46,530		46,530			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			68	68		68		68			41
42	Provider Participation Fee			87,600	87,600		87,600		87,600			42
43	Other (specify):* Outpatient Care			59	59		59		59			43
44	TOTAL Special Cost Centers			134,257	134,257		134,257		134,257			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,929,865	944,240	3,292,380	7,166,485		7,166,485	90,116	7,256,601			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

Facility Name & ID Number Jerseyville Manor

0047597

Report Period Beginning:

10/1/09

Ending:

9/30/10

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				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		V-30		9
10	Interest and Other Investment Income	(940)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,211)	V-27		24
25	Fund Raising, Advertising and Promotional	(95,607)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(35,501)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (219,259)		\$	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)	302,593		34
35	Other- Attach Schedule See Att Sch III	6,782		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 309,375		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 90,116		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Jerseyville Manor

ID# 0047597

Report Period Beginning: 10/1/09

Ending: 9/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Facility Name & ID Number Jerseyville Manor# 0047597

Report Period Beginning:

10/1/09

Ending:

Summary B

9/30/10

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	302,593	0	0	0	0	0	0	0	0	0	302,593	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	0	302,593	0	0	0	0	0	0	0	0	0	302,593	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)	0	302,593	0	0	0	0	0	0	0	0	0	302,593	45

Facility Name & ID Number

Jerseyville Manor

0047597

Report Period Beginning:

10/1/09

Ending:

9/30/10

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
None	N/A	See Attached Schedule I		See Attached Schedule I		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility Rent	\$ 875,650	Jerseyville North State, LLC	N/A	\$ 1,178,243	\$ 302,593	1
2	V							2
3	V			See Att Schedule IV and Independent Accountant's Report				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 875,650			\$ 1,178,243	\$ * 302,593	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	See Attached Schedule II & III								\$ 4,430	18-7	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	\$ 4,430		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 Manor

0047597

Report Period Beginning:

10/1/09

Ending: 9/30/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Unlimited Development, Inc.

Street Address

285 S Farnham

City / State / Zip Code

Galesburg, IL 61401

Phone Number

(309) 343-1550

Fax Number

(309) 343-2857

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					\$	\$		\$	1
2	See Att Sch II & III							6,782	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				\$	\$		\$	6,782

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Jerseyville Manor

0047597

Report Period Beginning:

10/1/09

Ending:

9/30/10

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	Cambridge Realty Capital					\$	\$			\$	1								
2	LTD. of Illinois	X	Facility purchase	\$23,012.50	09/01/05	4,173,000	3,938,022	7/1/2039	5.6200	595,680	2								
3											3								
4											4								
5											5								
Working Capital																			
6	Miscellaneous	X									6								
7	Less Interest Income	X								(940)	7								
8											8								
9	TOTAL Facility Related			\$23,012.50		\$ 4,173,000	\$ 3,938,022			\$ 594,740	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 4,173,000	\$ 3,938,022			\$ 594,740	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,813 Line # 26

* 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.		\$	64,158		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.)		\$	111,236		2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	47,078		3																			
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	83,669		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.		\$	130,747		7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2005	<u>51,133</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		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
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																					
	2006	<u>50,017</u>	9																					
	2007	<u>50,415</u>	10																					
	2008	<u>53,137</u>	11																					
	2009	<u>111,236</u>	12																					
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.																								
Amount accrued includes estimated taxes for 9 months based on fiscal year end. Estimate is based on estimated real estate tax liability for 2010. Taxes paid are for the first and second half of the 2009 tax bill.																								

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 Manor COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0047597

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>04-127-014-00</u>	<u>S17 T8 R11</u>	\$ <u>110,929.00</u>	\$ <u>110,929.00</u>
2.	<u></u>	<u>PT SE 1/4 (TRACT 1 - SURVEY</u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u>IN PLAT CAB 1/54B)</u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u>04-127-014-50</u>	<u>S17 T8 R11</u>	\$ <u>307.00</u>	\$ <u>307.00</u>
6.	<u></u>	<u>TRACT IN SE1/4 (PT TRACT 2</u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u>SURVEY PC 1/54B)</u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u>111,236.00</u>	\$ <u>111,236.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 Manor

0047597

Report Period Beginning:

10/1/09

Ending:

9/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,306 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>3.5 Acres</u>	<u>2005</u>	<u>\$ 160,000</u>	<u>1</u>
2	<u>Facility Addition</u>	<u>.88 Acres</u>	<u>2008</u>	<u>14,025</u>	<u>2</u>
3	TOTALS	#VALUE!		\$ 174,025	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Manor

0047597

Report Period Beginning:

10/1/09

Ending:

9/30/10

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	92	2005		\$ 4,578,867	\$ 114,472	40	\$ 114,472	\$	\$ 581,899	4
5	68	2008		4,926,175	197,047	25	197,047		394,094	5
6										6
7										7
8										8
Improvement Type**										
9	Attic Insulation, Water Heater	2005		9,394	741	10-15 yrs	741		3,676	9
10	Parking Lot Lighting	2006		5,355	357	15	357		1,606	10
11	Furnace	2008		2,516	168	15	168		392	11
12	Wall Paper/Paint Dining/Kitchen/Beauty Shop	2008		10,556	2,111	5	2,111		4,398	12
13	Floor Scrubber	2008		8,066	1,613	5	1,613		3,495	13
14	Electric Sign	2008		44,743	4,474	10	4,474		10,439	14
15	Parking Lot	2008		244,322	30,540	8	30,540		61,080	15
16	Retention Pond	2008		37,026	1,851	20	1,851		3,702	16
17	Sidewalks	2008		64,009	4,267	15	4,267		8,534	17
18	Landscaping	2008		39,235	3,924	10	3,924		7,848	18
19	Fence	2008		8,442	563	15	563		1,126	19
20	Waterheater	2008		4,158	416	10	416		800	20
21	Electric Install, Rcliner Wheelchairs, Baskets	2008		37,076	2,852	13	2,852		5,466	21
22	Dish Truck, Steamable, Convect. Steamer, Wiring Convec Over	2008		15,149	1,515	10	1,515		2,777	22
23	Roof	2008		116,316	11,632	10	11,632		22,294	23
24	Paint & Wallpaper	2008		6,491	1,298	5	1,298		2,596	24
25	Paint and Wallpaper	2008		7,295	1,459	5	1,459		2,918	25
26	Fence	2008		2,655	332	8	332		609	26
27	Window Decorations	2009		70,822	14,164	5	14,164		23,607	27
28	Duct Work	2009		15,739	1,574	10	1,574		2,492	28
29	Veranda	2009		2,987	199	15	199		315	29
30	Outside Lights (Building & Parking Lot)	2009		44,204	2,947	15	2,947		4,420	30
31	Jerseyville Parking Lot - Asphalt	2009		131,323	16,415	8	16,415		16,415	31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
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54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	10,432,921	\$	416,931	\$	416,931	\$	1,166,998	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 Manor

0047597

Report Period Beginning:

10/1/09

Ending:

9/30/10

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	\$ 819,820	\$ 86,532	\$ 86,532	\$	5-15 yrs	\$ 259,969	71
72	Current Year Purchases	22,356	2,363	2,363		5-10 yrs	2,363	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 842,176	\$ 88,895	\$ 88,895	\$		\$ 262,332	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	Patient Care	2003 GMC G3500 Van	2006	\$ 29,848	\$ 6,840	\$ 6,840	\$	4	\$ 29,848	76
77										77
78										78
79										79
80	TOTALS			\$ 29,848	\$ 6,840	\$ 6,840	\$		\$ 29,848	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)	\$ 11,478,970	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 512,666	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 512,666	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,459,178	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	2005 Ford E350 - 2005	\$ 47,110	\$	\$ 47,110	86
87	2006 Toyota Corolla - 2006	15,288	2,548	15,288	87
88					88
89					89
90					90
91	TOTALS	\$ 62,398	\$ 2,548	\$ 62,398	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: Jerseyville North State, LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			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 N/A N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 11,584 Description: See Attached Schedule XII

(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 _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2011 \$ N/A

13. /2012 \$ N/A

14. /2013 \$ N/A

* 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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	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 Manor

0047597

Report Period Beginning: 10/1/09

Ending: 9/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/10

(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	\$ 241,069	\$ 786,117	1
2	Cash-Patient Deposits	18,645	18,645	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	779,229	779,229	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	116,548	115,186	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	1,842,939	1,889,519	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,998,430	\$ 3,588,696	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		174,025	13
14	Buildings, at Historical Cost		9,898,076	14
15	Leasehold Improvements, at Historical Cost	534,845	534,845	15
16	Equipment, at Historical Cost	278,896	934,422	16
17	Accumulated Depreciation (book methods)	(259,383)	(1,521,576)	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): <u>See Att Sch VII</u>		220,879	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 554,358	\$ 10,240,671	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,552,788	\$ 13,829,367	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 98,476	\$ 98,476	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,645	18,645	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,563	66,563	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,911	10,911	31
32	Accrued Real Estate Taxes(Sch.IX-B)		83,669	32
33	Accrued Interest Payable		104,522	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>		997,822	36
37	<u>Current maturities of mortgage</u>		56,268	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 194,595	\$ 1,436,876	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		5,738,601	39
40	Mortgage Payable		3,881,754	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	46,500	46,500	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 46,500	\$ 9,666,855	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 241,095	\$ 11,103,731	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,311,693	\$ 2,725,636	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,552,788	\$ 13,829,367	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,425,614	1
2	Restatements (describe):		2
3	See Attached Schedule X	(14,154)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,411,460	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	900,233	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 900,233	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)	\$ 3,311,693	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Manor# 0047597Report Period Beginning: 10/1/09Ending: 9/30/10

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	\$ 7,645,798	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,645,798	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	402,520	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 402,520	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	1,327	12
13	Barber and Beauty Care	4,478	13
14	Non-Patient Meals	141	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	1,893	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,839	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	940	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 940	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schedule XI	9,621	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,621	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,066,718	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,287,298	31
32	Health Care	3,385,446	32
33	General Administration	1,374,939	33
B. Capital Expense			
34	Ownership	984,545	34
C. Ancillary Expense			
35	Special Cost Centers	46,657	35
36	Provider Participation Fee	87,600	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,166,485	40
41	Income before Income Taxes (line 30 minus line 40)**	900,233	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 900,233	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Manor

0047597

Report Period Beginning:

10/1/09

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9/30/10

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	1,805	1,920	\$ 64,621	\$ 33.66	1
2	Assistant Director of Nursing	1,988	2,115	58,165	27.50	2
3	Registered Nurses	19,835	21,101	450,087	21.33	3
4	Licensed Practical Nurses	17,947	19,093	325,532	17.05	4
5	CNAs & Orderlies	94,600	100,639	1,012,426	10.06	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director	210	210	2,834	13.50	9
10	Activity Assistants	7,325	7,793	75,212	9.65	10
11	Social Service Workers	3,229	3,435	41,217	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,456	28,144	262,392	9.32	15
16	Dishwashers					16
17	Maintenance Workers	6,140	6,532	82,032	12.56	17
18	Housekeepers	15,363	16,343	149,438	9.14	18
19	Laundry	7,981	8,490	70,895	8.35	19
20	Administrator	1,933	2,056	74,143	36.06	20
21	Assistant Administrator	1,946	2,070	36,249	17.51	21
22	Other Administrative	1,965	2,090	31,349	15.00	22
23	Office Manager					23
24	Clerical	3,661	3,895	53,053	13.62	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	2,041	2,172	24,606	11.33	31
32	Other Health Care(specify)	6,337	6,741	115,614	17.15	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,762	234,839	\$ 2,929,865 *	\$ 12.48	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	\$ 4,795	1-3	35
36	Medical Director	9,000	9-3	36
37	Medical Records Consultant	803	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	2,420	10-3	39
40	Physical Therapy Consultant	358,689	10a-3	40
41	Occupational Therapy Consultant	317,006	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	113,663	10a-3	43
44	Activity Consultant		11-3	44
45	Social Service Consultant		12-3	45
46	Other(specify) <u>Dental Consultant</u>	0	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 806,376		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)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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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	
Dana Bainter	Administrator	None	\$ 74,143	Workers' Compensation Insurance	\$ 116,358	IDPH License Fee	\$	
Mary Mosby	Asst Admin	None	36,249	Unemployment Compensation Insurance	32,098	Advertising: Employee Recruitment	3,012	
				FICA Taxes	215,565	Health Care Worker Background Check		
				Employee Health Insurance	112,339	(Indicate # of checks performed <u>175</u>)	1,750	
				Employee Meals		Patient Background Checks <u>175</u>	1,750	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promotion	95,607	
				401 (k)	9,858	Subscriptions	679	
				Other Employee Benefits	2,541	IHCA Dues	3,474	
						Other Licenses & Fees	569	
						Indirect Costs - See Att Sch III	3	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(95,607)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 488,759	\$ 11,237		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description	Line #	Amount	Description	Amount
							Out-of-State Travel	\$
							In-State Travel	
							Staff use of personal vehicle on facility	
							business and meals (under \$250 per	
							travel voucher)	0
							Seminar Expense	400
							Less: non-allowable out-of-state travel	0
							Indirect costs - See Att Sch III	0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$	TOTAL	\$ 400

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,448 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. \$ 87,600
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? 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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (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? None
- 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? 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: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT