

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0039339

Facility Name: Jerseyville Nursing & Rehabilitation Center

Address: 101 South State Street Jerseyville 62052

County: Jersey

Telephone Number: (618) 498-6496 Fax # (618) 498-7435

HFS ID Number:

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

X

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling Telephone Number: (618) 465-7717
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 01/01/2011 to 12/31/2011 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) J. Terry Dooling

(Title) Treasurer

Paid Preparer

(Signed) See Accountants Compilation Report

(Print Name and Title) J. Terry Dooling Partner

(Firm Name & Address) C.J. Schlosser & Company, L.L.C. 233 East Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax # (618) 465-7710

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 Nursing & Rehabilitation Center

0039339 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>111</u>	Skilled (SNF)	<u>111</u>	<u>40,515</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>111</u>	TOTALS	<u>111</u>	<u>40,515</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>886</u>	<u>815</u>	<u>6,592</u>	<u>8,293</u>	8
9	SNF/PED					9
10	ICF	<u>12,475</u>	<u>15,223</u>	<u>147</u>	<u>27,845</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,361</u>	<u>16,038</u>	<u>6,739</u>	<u>36,138</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.20%

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 6,588

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: 12/31/2011 Fiscal Year: 12/31/2011
* 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: 01/01/2011 Ending: 12/31/2011

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	241,324	25,722	7,462	274,508		274,508		274,508			1
2	Food Purchase		242,022		242,022		242,022	(943)	241,079			2
3	Housekeeping	118,220	26,219		144,439		144,439		144,439			3
4	Laundry	107,176	19,120		126,296		126,296		126,296			4
5	Heat and Other Utilities			145,478	145,478		145,478		145,478			5
6	Maintenance	66,675	27,430	40,304	134,409		134,409	650	135,059			6
7	Other (specify):* Waste Removal			7,091	7,091		7,091		7,091			7
8	TOTAL General Services	533,395	340,513	200,335	1,074,243		1,074,243	(293)	1,073,950			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,894,335	185,152	70,100	2,149,587	(5,964)	2,143,623	(240)	2,143,383			10
10a	Therapy	34,012			34,012		34,012		34,012			10a
11	Activities	56,479	2,933	7,853	67,265	132	67,397		67,397			11
12	Social Services	69,328		1,952	71,280		71,280		71,280			12
13	CNA Training			146	146	5,964	6,110	(146)	5,964			13
14	Program Transportation		7,613		7,613		7,613		7,613			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,054,154	195,698	89,651	2,339,503	132	2,339,635	(386)	2,339,249			16
	C. General Administration											
17	Administrative	90,140	6,934	704,031	801,105	(1,777)	799,328	(497,684)	301,644			17
18	Directors Fees			60,000	60,000		60,000	(60,000)				18
19	Professional Services			17,986	17,986	1,090	19,076	390	19,466			19
20	Dues, Fees, Subscriptions & Promotions			50,727	50,727		50,727	(33,422)	17,305			20
21	Clerical & General Office Expenses	60,531	23,610	102,893	187,034	555	187,589	55,455	243,044			21
22	Employee Benefits & Payroll Taxes			379,583	379,583		379,583	15,246	394,829			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,080	12,080		12,080	1,612	13,692			24
25	Other Admin. Staff Transportation							2,384	2,384			25
26	Insurance-Prop.Liab.Malpractice			53,326	53,326		53,326	2,539	55,865			26
27	Other (specify):*											27
28	TOTAL General Administration	150,671	30,544	1,380,626	1,561,841	(132)	1,561,709	(513,480)	1,048,229			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,738,220	566,755	1,670,612	4,975,587		4,975,587	(514,159)	4,461,428			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.

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			325,897	325,897		325,897	(19,353)	306,544			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			340,610	340,610		340,610	(3,435)	337,175			32
33	Real Estate Taxes			67,388	67,388		67,388		67,388			33
34	Rent-Facility & Grounds							10,727	10,727			34
35	Rent-Equipment & Vehicles			5,316	5,316		5,316	624	5,940			35
36	Other (specify):* Mortgage Ins.			27,789	27,789		27,789		27,789			36
37	TOTAL Ownership			767,000	767,000		767,000	(11,437)	755,563			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			(12)	(12)		(12)		(12)			38
39	Ancillary Service Centers		244,201	889,034	1,133,235		1,133,235	(18,618)	1,114,617			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,773	60,773		60,773		60,773			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		244,201	949,795	1,193,996		1,193,996	(18,618)	1,175,378			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,738,220	810,956	3,387,407	6,936,583		6,936,583	(544,214)	6,392,369			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(943)	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	(3,532)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,527)	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	(1,791)	24		19
20	Contributions	(1,398)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(872)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,059)	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	(22,445)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,567)		\$	30

BHF USE ONLY							
48		49		50		51	

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 Amount	2 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)	(481,647)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (481,647)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (544,214)		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 Yes	2 No	3 Amount	4 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

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Offset C.N.A. Book Reimbursement	\$(146)	131
2	Offset Medical Supplies Reimbursement	(240)	102
3	Eliminate PAC Dues, including Lobbying portion	(2,651)	203
4	Add expense for 2011 IDPH license paid in 2010	995	204
5	Eliminate non-allowable dues	(1,050)	205
6	Eliminate depreciation Exp for non-medicaid assets	(6,268)	306
7	Eliminate depreciation exp for non-care related asset	(13,085)	307
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
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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	(22,445)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(943)	0	0	0	0	0	0	0	0	0	0	(943)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	650	0	0	0	0	0	0	0	0	0	650	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(943)	650	0	0	0	0	0	0	0	0	0	(293)	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	(240)	0	0	0	0	0	0	0	0	0	0	(240)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(146)	0	0	0	0	0	0	0	0	0	0	(146)	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	(386)	0	0	0	0	0	0	0	0	0	0	(386)	16
	C. General Administration													
17	Administrative	0	84,592	(582,276)	0	0	0	0	0	0	0	0	(497,684)	17
18	Directors Fees	0	0	(60,000)	0	0	0	0	0	0	0	0	(60,000)	18
19	Professional Services	(872)	3,811	(2,549)	0	0	0	0	0	0	0	0	390	19
20	Fees, Subscriptions & Promotions	(35,690)	2,268	0	0	0	0	0	0	0	0	0	(33,422)	20
21	Clerical & General Office Expenses	0	55,455	0	0	0	0	0	0	0	0	0	55,455	21
22	Employee Benefits & Payroll Taxes	0	15,246	0	0	0	0	0	0	0	0	0	15,246	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,791)	3,403	0	0	0	0	0	0	0	0	0	1,612	24
25	Other Admin. Staff Transportation	0	2,384	0	0	0	0	0	0	0	0	0	2,384	25
26	Insurance-Prop.Liab.Malpractice	0	2,539	0	0	0	0	0	0	0	0	0	2,539	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(38,353)	169,698	(644,825)	0	0	0	0	0	0	0	0	(513,480)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(39,682)	170,348	(644,825)	0	0	0	0	0	0	0	0	(514,159)	29

Summary B

Facility Name & ID Number	Jerseyville Nursing & Rehabilitation Center	#	0039339	Report Period Beginning:	01/01/2011	Ending:	12/31/2011
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>John H. Rothert</u>	<u>60.00</u>	<u>Montgomery Nursing & Rehabilitation Center</u>	<u>Hillsboro, IL</u>	<u>Wellington Mgt. Co.</u>	<u>Alton, IL</u>	<u>Management Co.</u>
<u>David L. Kamler</u>	<u>20.00</u>	<u>Westwood Hills Health Care Center</u>	<u>Poplar Bluff, MO</u>	<u>Health Care Fin.</u>	<u>Alton, IL</u>	<u>Management Co.</u>
<u>J. Terry Dooling</u>	<u>20.00</u>	<u>Spanish Lake Nursing & Rehabilitation Center</u>	<u>Florissant, MO</u>	<u>C.J. Schlosser & Co.</u>	<u>Alton, IL</u>	<u>Public Accountants</u>
				<u>NW Rehab, L.L.C.</u>	<u>Alton, IL</u>	<u>Therapy Co.</u>
				<u>Three Amigos, L.L.C.</u>	<u>Alton, IL</u>	<u>Real Estate Co.</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	<u>See Schedule VIII</u>	\$	<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>\$ 650</u>	<u>\$ 650</u>	1
2	V	17	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>84,592</u>	<u>84,592</u>	2
3	V	19	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>3,811</u>	<u>3,811</u>	3
4	V	20	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>2,268</u>	<u>2,268</u>	4
5	V	21	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>55,455</u>	<u>55,455</u>	5
6	V	22	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>15,246</u>	<u>15,246</u>	6
7	V	24	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>3,403</u>	<u>3,403</u>	7
8	V	25	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>2,384</u>	<u>2,384</u>	8
9	V	26	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>2,539</u>	<u>2,539</u>	9
10	V	32	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>97</u>	<u>97</u>	10
11	V	34	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>10,727</u>	<u>10,727</u>	11
12	V	35	<u>See Schedule VIII</u>		<u>Wellington Management Co.</u>	<u>60.00%</u>	<u>624</u>	<u>624</u>	12
13	V								13
14	Total			\$			<u>\$ 181,796</u>	<u>\$ * 181,796</u>	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	\$ 422,419	Wellington Management Co.	60.00%	\$	(422,419)	15
16	V	17	Management Fees	281,612	Health Care Financial, LLC	40.00%	121,755	(159,857)	16
17	V	39	Therapy Services	845,684	NW Rehab, LLC	100.00%	827,066	(18,618)	17
18	V	10	Nurse Consultant	23,081	Wellington Management Co.	60.00%	23,081		18
19	V	18	Director's Fees	36,000	John H. Rothert	60.00%		(36,000)	19
20	V	18	Director's Fees	12,000	J. Terry Dooling	20.00%		(12,000)	20
21	V	18	Director's Fees	12,000	David L. Kamler	20.00%		(12,000)	21
22	V	21	Clerical	13,935	Wellington Management Co.	60.00%	13,935		22
23	V	19	Professional Services	2,549	C.J. Schlosser & Company, L.L.C.	40.00%		(2,549)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,649,280			\$ 985,837	\$ * (663,443)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

SEE ACCOUNTANTS' COMPILATION REPORT

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	260,408	9.81	24.53	Salary	\$ 84,592	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	\$ 84,592		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: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Accumulated Costs	22,211,336	6	\$ 2,652	\$	5,446,074	\$ 650	1
2	17	Administrative	Accumulated Costs	22,211,336	6	345,000	345,000	5,446,074	84,592	2
3	19	Professional Services	Accumulated Costs	22,211,336	6	15,542		5,446,074	3,811	3
4	20	Dues, Fees, Subs, & Promos	Accumulated Costs	22,211,336	6	9,250		5,446,074	2,268	4
5	21	Clerical & General Office Exp.	Accumulated Costs	22,211,336	6	226,167	160,270	5,446,074	55,455	5
6	22	Employee Benefits & PR Taxes	Accumulated Costs	22,211,336	6	62,180		5,446,074	15,246	6
7	24	Travel & Seminar	Accumulated Costs	22,211,336	6	13,877		5,446,074	3,403	7
8	25	Other Admin Staff Transport	Accumulated Costs	22,211,336	6	9,724		5,446,074	2,384	8
9	26	Insurance - Prop, Liab, Malprac	Accumulated Costs	22,211,336	6	10,354		5,446,074	2,539	9
10	32	Interest Expense	Accumulated Costs	22,211,336	6	395		5,446,074	97	10
11	34	Rent - Facility and Grounds	Accumulated Costs	22,211,336	6	43,750		5,446,074	10,727	11
12	35	Vehicle Lease	Accumulated Costs	22,211,336	6	2,545		5,446,074	624	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					\$ 741,436	\$ 505,270		\$ 181,796	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		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Berkadia Finance, Inc.		X	Refinance Loan		10/31/06	\$ 3,720,700	\$ 3,525,569	10/31/41	5.8500	\$ 205,645	1
2	Berkadia Finance, Inc.-Sec 241		X	Building Addition		7/31/10	2,032,500	2,007,076	1/31/44	6.4500	130,098	2
3									Home Office Interest		97	3
4									Interest Income		(3,532)	4
5									Loan Cost Amortization		4,867	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 5,753,200	\$ 5,532,645			\$ 337,175	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,753,200	\$ 5,532,645			\$ 337,175	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 27,789 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.)

HFS 3745 (N-4-99)

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 2010 report.		\$	60,000		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.)		\$	63,388		2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,388		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	64,000		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.		\$	67,388		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	50,620	8		
	2007	51,022	9		
	2008	53,479	10		
	2009	55,609	11		
	2010	63,388	12		
Line 2 : 2010 Taxes Paid				FOR BHF USE ONLY	
Line 4 : Accrual is based on 2010 taxes paid plus approx. 2%				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 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

2010 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 2010 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 2010.

(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, & 64 S PT Outlot 6</u>	\$ <u>59,479.10</u>	\$ <u>59,479.10</u>
2. <u>04-208-017-00</u>	<u>S28 T8 R11 Unplatted Parcels</u>	\$ <u>3,908.92</u>	\$ <u>3,908.92</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><u>63,388.02</u></u>	\$ <u><u>63,388.02</u></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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,823

B. General Construction Type: Exterior Brick & SidingFrame Steel & BrickNumber 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	Facility	158,994	1994	\$ 71,664	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:

01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	\$	\$ 838,274	4
5	10			2010	2,040,612	81,619	25	81,619		129,312	5
6											6
7											7
8											8
	Improvement Type**										
9	Exterior Remodeling			1994	10,000		15			10,000	9
10	Electrical			1994	11,690	585	20	585		10,080	10
11	Air Conditioners			1994	25,830		10			25,830	11
12	Interior Remodeling			1994	20,598	42	5-20	42		20,496	12
13	Hearla Shed			1994	3,267		10			3,267	13
14	Nurses Station			1994	6,055	303	20	303		5,323	14
15	Painting			1995	7,392		5			7,392	15
16	Electrical Work			1995	3,382		10			3,382	16
17	Call Lights			1995	1,564		15			1,564	17
18	Storage Building			1996	3,500		10			3,500	18
19	Boiler			1996	7,400	370	20	370		5,889	19
20	Roof Repairs			1996	3,619		10			3,619	20
21	Ceiling Tiles and End Caps			1996	3,506		12			3,506	21
22	Storage Building			1997	3,356		10			3,356	22
23	Alarm System			1997	1,750		10			1,750	23
24	Ceiling Tiles			1997	1,485		12			1,485	24
25	3 Windows & Sills & 1 Door Replaced			1997	4,108	274	15	274		3,925	25
26	Air Conditioners			1997	2,185		10			2,185	26
27	Concrete Patio & Sidewalk			1997	1,842	123	15	123		1,760	27
28	Roofing			1998	2,592		10			2,592	28
29	Shower Room Remodeling			1998	1,437		10			1,437	29
30	Air Conditioners			1998	13,420	71	10-20	71		13,043	30
31	Air Conditioners			1999	2,841		10			2,841	31
32	New Roof			1999	35,386		10			35,386	32
33	Air Conditioners			2000	2,118		10			2,118	33
34	Chair Rails			2000	6,267	418	15	418		4,628	34
35	Constr. Of 400 Wing - Design, Architecture & Engineering			2001	65,216	2,561	25	2,561		28,149	35
36	Constr. Of 400 Wing - Contractor Costs			2001	874,589	33,682	25	33,682		388,226	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:

01/01/2011 Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 Constr. Of 400 Wing - Drawing, Surety Bond, & Misc.	2001	\$ 11,223	\$ 449	25	\$ 449	\$	\$ 4,714	37
38 Constr. Of 400 Wing - Interest & Mortgage Ins. Premium	2001	83,401	3,225	25	3,225		36,817	38
39 400 Wing - Nurse Call System	2001	10,104	674	15	674		7,073	39
40 400 Wing Cable TV System Cabling	2001	1,962	98	10	98		1,962	40
41 400 Wing - Fire Alarm System	2001	13,326	784	15	784		9,896	41
42 400 Wing - Telecommunication System	2001	4,025	201	10	201		4,025	42
43 400 Wing - Door Monitoring System	2001	2,640	132	10	132		2,640	43
44 400 Wing - TV Wall Mounts	2001	5,851	212	10	212		5,851	44
45 400 Wing - Signage	2001	1,161		5			1,161	45
46 400 Wing - Handrails and Wall Guards	2001	2,319	155	15	155		1,623	46
47 400 Wing - Chair Rail	2001	4,208		5			4,208	47
48 400 Wing - Door Guards	2001	607		5			607	48
49 400 Wing Cubicle Tracks, Curtains, Window Treatments	2001	7,169	358	20	358		3,764	49
50 Landscaping, Shrubs, Trees, Grass	2001		293	10	293			50
51 Fencing	2001	4,200		8			4,200	51
52 Storage Building	2001	3,268	54	10	54		3,268	52
53 Nurse Call System Upgrades	2001	3,700	246	15	246		2,611	53
54 Fire Alarm System Control Panel	2001	3,903	260	15	260		2,862	54
55 Replacement Signage	2001	3,656		5			3,656	55
56 Door Guards	2001	1,979		5			1,979	56
57 400 Wing - Vinyl Flooring	2001		581	10	581			57
58 Overbed Lights	2001	1,625	95	10	95		1,625	58
59 Painting	2001	8,932		5			8,932	59
60 2P 50 Amp Disconnect	2001	955	48	20	48		497	60
61 Mini Blinds	2001	14,744		5			14,744	61
62 Asphalt Paving of Parking Lot	2001	14,193	473	10	473		14,193	62
63 Air Conditioners	2001	3,424	156	10	156		3,424	63
64 Overbed Lights	2002	3,055	306	10	306		3,007	64
65 Cubicle Curtains	2002	6,155		5			6,155	65
66 Air Conditioners	2002	1,398	140	10	140		1,351	66
67 Security Camera System	2002	1,010		5			1,010	67
68 Fire Doors	2002	1,543	103	15	103		977	68
69 Roofing - North Entrance	2002	1,680	168	10	168		1,540	69
70 TOTAL (lines 4 thru 69)		\$ 4,575,091	\$ 176,486		\$ 176,486	\$	\$ 1,724,687	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:

01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 Totals from Page 12A, Carried Forward		\$ 4,575,091	\$ 176,486		\$ 176,486	\$	\$ 1,724,687	1
2 Wall Guard and End Caps	2002	1,497	100	15	100		915	2
3 Door Canopy	2002	3,800	253	15	253		2,280	3
4 Landscaping	2002	1,729	173	10	173		1,599	4
5 Landscaping	2003	18,903	1,890	10	1,890		15,900	5
6 Air Conditioners	2003	5,551	555	10	555		4,737	6
7 Landscaping, Plants, Trees	2004	4,371	437	10	437		3,315	7
8 100 Amp Transfer Switch to Generator	2004	11,865	791	15	791		6,130	8
9 Smoke Detectors	2004	1,600	160	10	160		1,227	9
10 Extend Activities Wall/Replace Doors	2004	2,002	133	15	133		1,023	10
11 Air Conditioners	2004	1,814	181	10	181		1,361	11
12 Cove Base	2004	2,188	219	10	219		1,641	12
13 Hollow Metal Double Door	2004	8,520	426	20	426		3,018	13
14 New Wall/Flooring - Kitchen	2004	2,983	298	10	298		2,088	14
15 Cubicle Curtains	2005	289		5			289	15
16 Generator Control Panel	2005	3,689	307	12	307		1,921	16
17 Resident Room Doors	2005	19,393	1,293	15	1,293		8,155	17
18 Fire Doors	2005	4,955	249	5-15 yrs	249		2,960	18
19 Water Heater	2005	4,000	400	10	400		2,633	19
20 Replace Generator	2005	5,690	474	12	474		2,884	20
21 Air Conditioners	2005	1,753	175	10	175		1,052	21
22 Electrical Wiring	2005	4,862	243	20	243		1,499	22
23 Dishwasher Booster Heater	2005	1,766	177	10	177		1,060	23
24 Kitchen & Laundry Flooring	2005	2,556	256	10	256		1,555	24
25 4-Door Monitor System	2006	2,696	270	10	270		1,460	25
26 2 Door Awnings - Side & Back Entrance	2006	1,671	111	15	111		594	26
27 Built-In Waterfall	2006	3,499	350	10	350		1,954	27
28 Drywall	2006	1,234	82	15	82		446	28
29 Wallpaper	2006	5,219	829	5	829		5,219	29
30 Lobby Remodeling	2006	17,774	1,185	15	1,185		6,122	30
31 4- Ton Heat Pump	2006	5,580	558	10	558		2,837	31
32 Glass Doors	2006	47,653	3,285	10-15 yrs	3,285		18,050	32
33 Air Conditioners	2006	9,474	824	10-15 yrs	824		4,441	33
34 TOTAL (lines 1 thru 33)		\$ 4,785,667	\$ 193,170		\$ 193,170	\$	\$ 1,835,052	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:

01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 Totals from Page 12B, Carried Forward		\$ 4,785,667	\$ 193,170		\$ 193,170	\$	\$ 1,835,052	1
2 Vinyl Flooring	2006	6,924	692	10	692		3,884	2
3 Kitchen Tile	2006	4,411	467	8-10 yrs	467		2,396	3
4 Sprinkler System Improvements	2006	5,025	201	25	201		1,146	4
5 Carpet	2006	2,775	516	5	516		2,775	5
6 Electrical Wiring	2006	15,869	793	20	793		4,091	6
7 Smoke Damper Motor	2006	1,793	90	20	90		523	7
8 Vinyl Fencing	2006	12,359	1,236	10	1,236		6,386	8
9 Concrete Patio & Sidewalk	2006	10,744	716	15	716		3,701	9
10 Landscaping, Rock, Mulch	2006	4,325	433	10	433		2,523	10
11 Wallpaper	2007	12,135	2,427	5	2,427		10,037	11
12 Air Conditioners	2007	16,341	1,618	5-15 yrs	1,618		7,119	12
13 Flooring	2007	31,280	3,128	10	3,128		13,428	13
14 Alarm System	2007	4,732	516	7-10 yrs	516		2,422	14
15 Handrails	2007	11,039	1,259	5-15 yrs	1,259		5,093	15
16 Roof	2007	5,700	273	20-25 yrs	273		1,167	16
17 Satellite System	2007	16,581	829	20	829		3,593	17
18 Electrical for HV AC Unit	2007	3,964	198	20	198		875	18
19 Courtyard Landscaping	2007	3,800	380	10	380		1,742	19
20 Courtyard Pavilion Constructed	2007	9,870	658	15	658		2,906	20
21 Asphalt, Seal, Stripe Parking Lot	2007	13,500	1,688	8	1,688		7,031	21
22 Stainless Steel Backsplash	2007	2,523	126	20	126		536	22
23 Drywall	2007	3,790	253	15	253		1,137	23
24 Flooring	2008	23,598	2,241	10-20 yrs	2,241		7,358	24
25 Wallpaper	2008	31,055	6,211	5	6,211		21,853	25
26 Hot Water Heaters	2008	14,000	1,400	10	1,400		4,667	26
27 Network Cabling	2008	2,646	132	20	132		507	27
28 Front Porch Entrance	2008	63,826	3,191	20	3,191		11,435	28
29 Sprinkler System	2008	16,900	676	25	676		2,479	29
30 Electric Installation on Trailer	2008	3,236	162	20	162		634	30
31 Facility Signage	2008	3,212	642	5	642		2,195	31
32 Landscaping	2008	5,700	570	10	570		1,805	32
33 Flooring	2009	71,018	6,934	10-20 yrs	6,934		16,790	33
34 TOTAL (lines 1 thru 33)		\$ 5,220,338	\$ 233,826		\$ 233,826	\$	\$ 1,989,286	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,220,338	\$ 233,826		\$ 233,826	\$	\$ 1,989,286	1
2	300 KW Cummins Generator - Whole Bldg	2009	104,540	5,227	20	5,227		13,068	2
3	Needler Remodeling - Wallpaper & Paint	2009	12,345	2,469	5	2,469		6,378	3
4	Replace 2" Drain Line	2009	4,111	164	25	164		480	4
5	Roofing	2009	3,000	300	10	300		825	5
6	Flooring-Existing Facility	2010	21,980	2,198	10	2,198		4,170	6
7	Pt Room Remodeling-Patching/Painting	2010	2,925	585	5	585		1,024	7
8	Roofing-Mansard Wall	2010	2,222	222	10	222		407	8
9	Replace 55 sprinkler heads	2010	2,100	84	25	84		119	9
10	2 AC/Heat Units	2010	1,396	279	5	279		396	10
11	Dr's Room Sink	2010	1,356	68	20	68		90	11
12	400S Hall Facility Signage	2010	1,041	208	5	208		243	12
13	Wall Guards & Hand Rails	2010	4,749	317	15	317		343	13
14	2 New Entrance Signs & Installation	2010	8,704	870	10	870		1,306	14
15	Landscaping	2010	21,337	2,134	10	2,134		3,334	15
16	Retaining Wall	2010	8,829	441	20	441		699	16
17	Asphalt, Seal, Stripe 400S wing lots	2010	44,132	5,517	8	5,517		8,735	17
18	Bumper guards & Hand Rails	2011	2,392	239	10	239		239	18
19	Flooring	2011	5,077	261	10	261		261	19
20	2 Nurses Stations	2011	3,590	105	20	105		105	20
21	Hair Salon/Conference Room	2011	12,215	204	20	204		204	21
22	2 Electric Heaters & A/C unit	2011	1,396	256	5	256		256	22
23	Compressor for A/C Unit	2011	5,747	239	10	239		239	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)		\$ 5,495,522	\$ 256,213		\$ 256,213	\$	\$ 2,032,207	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)								
C. Equipment Costs-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	\$403,011	\$35,825	\$35,825	\$	5-20 yrs	\$174,093	71
72	Current Year Purchases	95,237	6,344	6,344		3-12 yrs	6,344	72
73	Fully Depreciated Assets	373,084	1,731	1,731		3-20 yrs	373,084	73
74								74
75	TOTALS	\$871,332	\$43,900	\$43,900	\$		\$553,521	75

D. Vehicle Costs. (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	\$2,186	\$2,186	\$	4	\$52,471	76
77	Facility Use	2007 Hyundai Vera Cruz	2007	29,106	4,245	4,245		4	29,106	77
78										78
79										79
80	TOTALS			\$81,577	\$6,431	\$6,431	\$		\$81,577	80

E. Summary of Care-Related Assets		1	2	
		Reference	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)	\$ 6,520,095	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 306,544	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 306,544	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)	\$ 2,667,305	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	2010 Ford E450 Wheelchair Van	\$52,340	\$13,085	\$30,532	86
87					87
88					88
89					89
90					90
91	TOTALS	\$52,340	\$13,085	\$30,532	91

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: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: \$5,941
- Description: Copier \$4,726; Postage Machine \$591; H.O. Vehicle Lease \$624
- (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	Section N/A		\$	\$	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 EndingAnnual Rent
12. /2012\$
13. /2013\$
14. /2014\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA40

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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)		5,964		5,964
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,964	\$	\$ 5,964
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,964			

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	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	14

(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		
	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	39-2	# of prescripts				233,051		233,051	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Attached Schedule</u>				22,414	870,416	11,150	22,414	881,566	12
13	Laboratory Fees Other (specify): <u> </u>									13
14	TOTAL			\$	22,414	\$ 870,416	\$ 244,201	22,414	\$ 1,114,617	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

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	\$24,485	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,275,190		3
4	Supply Inventory (priced at)	14,519		4
5	Short-Term Investments			5
6	Prepaid Insurance	45,153		6
7	Other Prepaid Expenses	20		7
8	Accounts Receivable (owners or related parties)	102,528		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$1,461,895	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	263,801		13
14	Buildings, at Historical Cost	5,342,114		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,001,849		16
17	Accumulated Depreciation (book methods)	(2,686,870)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	181,364		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	190,056		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$4,312,514	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$5,774,409	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$417,520	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,962		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,407		31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(463)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$672,426	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	73,000		39
40	Mortgage Payable	5,591,119		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$5,664,119	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$6,336,545	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$(562,136)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$5,774,409	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$(248,954)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$(248,954)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	78,165	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	(391,347)	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)	\$(313,182)	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)	\$(562,136)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing & Rehabilitation Center# 0039339Report Period Beginning: 01/01/2011Ending: 12/31/2011**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**

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,046,078	1
2	Discounts and Allowances for all Levels	(1,440,038)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,606,040	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	11,494	5
6	Therapy	1,377,078	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,388,572	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	193	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7	13
14	Non-Patient Meals	943	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	32,657	19
20	Radiology and X-Ray	4,448	20
21	Other Medical Services	11,647	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 49,895	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,532	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,532	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine	1,936	28
28a	Miscellaneous & Loss on fixed asset disposal	(35,227)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (33,291)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,014,748	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,074,243	31
32	Health Care	2,339,503	32
33	General Administration	1,561,841	33
	B. Capital Expense		
34	Ownership	767,000	34
	C. Ancillary Expense		
35	Special Cost Centers	1,133,223	35
36	Provider Participation Fee	60,773	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,936,583	40
41	Income before Income Taxes (line 30 minus line 40)**	78,165	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 78,165	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.

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	1,748	2,054	\$ 59,710	\$ 29.07	1
2	Assistant Director of Nursing	1,838	2,070	53,233	25.72	2
3	Registered Nurses	15,622	16,381	360,298	21.99	3
4	Licensed Practical Nurses	20,945	22,588	447,777	19.82	4
5	CNAs & Orderlies	91,056	95,355	945,358	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,891	3,230	34,012	10.53	8
9	Activity Director					9
10	Activity Assistants	5,329	5,621	56,479	10.05	10
11	Social Service Workers	3,744	4,121	69,328	16.82	11
12	Dietician	25,304	26,838	241,324	8.99	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,816	5,076	66,675	13.14	17
18	Housekeepers	12,371	12,917	118,220	9.15	18
19	Laundry	10,608	11,396	107,176	9.40	19
20	Administrator	1,978	2,148	90,140	41.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,583	4,898	60,531	12.36	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	1,724	1,954	27,959	14.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,557	216,647	\$ 2,738,220 *	\$ 12.64	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	\$ 7,462	1, 3	35
36	Medical Director	Contract	9,600	9, 3	36
37	Medical Records Consultant	20	1,323	10, 3	37
38	Nurse Consultant	N/A	23,281	10, 3	38
39	Pharmacist Consultant	Contract	7,024	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	28	1,952	11, 3	44
45	Social Service Consultant	28	1,952	12, 3	45
46	Other(specify) Compliance Consultant	475	23,937	10, 3	46
47	Clerical	N/A	13,935	21, 3	47
48	Quality Assurance Doctor	N/A	600	10, 3	48
49	TOTAL (lines 35 - 48)	743	\$ 91,066		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			
Name	Function	%	Amount
Terrie Weible	Administrator		\$ 90,140
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,140
B. Administrative - Other			
Description			Amount
Wellington Management Co., LLC		\$	422,419
Health Care Financial, LLC			281,612
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$	704,031
C. Professional Services			
Vendor/Payee	Type		Amount
C.J. Schlosser & Co., LLC	Accounting Services	\$	2,549
May, Cocagne, & King	Audit Fees		8,778
R.J. Tolliver, C.P.A.	401 (K) Audit Fees		221
Sandberg, Phoenix, & Von Gontard,	Legal Fees		1,631
Giffin, Winning, Cohen & Bodewes,	Legal Fees		1,591
Duane Morris, LLP	Legal Fees		2,159
Strang & Parish, LTD	Legal Fees-eliminated 872		1,057
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$	17,986
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	77,525
Unemployment Compensation Insurance			27,489
FICA Taxes			204,267
Employee Health Insurance			62,910
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Disability Insurance			975
Staff Relations			6,385
Employee Dental/Vision Insurance			101
Home Office Employee Benefits			15,246
Employee Physicals			(69)
TOTAL (agree to Schedule V, line 22, col.8)		\$	394,829
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
Section N/A		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	995
Advertising: Employee Recruitment			2,045
Health Care Worker Background Check (Indicate # of checks performed 151)			2,416
Patient Background Checks			
Licenses & Fees			1,696
Dues & Subscriptions			2,628
IHCA Dues			4,009
Bank Service Charges			1,248
Home Office Dues & Subscriptions			2,268
Less: Public Relations Expense		(	
Non-allowable advertising		(	
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)		\$	17,305
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			6,248
Seminar Expense			4,041
Home Office Travel & Seminar			3,403
Entertainment Expense		(	
TOTAL (agree to Sch. V, line 24, col. 8)		\$	13,692

*** 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	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					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

Facility Name & ID NumberJerseyville Nursing & Rehabilitation Center

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. Illinois Healthcare Association \$4,009

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(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.

\$ 25,502

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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 60,773

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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

#0039339

Report Period Beginning:01/01/2011

Ending:12/31/2011

Page 23

(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 benefit on Schedule V.

\$ None

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 943

(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?

38.49%

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

JERSEYVILLE NURSING AND REHABILITATION CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2011

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
ADMINISTRATIVE	17	(1,777)
ACTIVITIES	11	132
PROFESSIONAL SERVICES	19	1,090
CLERICAL & GENERAL OFFICE EXPENSE	21	555
To reclass various expenses to proper lines		
NURSE AIDE TRAINING	13	5,964
NURSING & MEDICAL RECORDS	10	(5,964)
To reclass CNA trainer wages		

Jerseyville Nursing and Rehabilitation Center
Attachment to Sch. XVII
December 31, 2011

BOOK TO TAX NET INCOME RECONCILIATION:

BOOK NET INCOME (LOSS)	78,165.00
CONVERSION TO CASH BASIS ADJUSTMENTS	<u>(103,909.00)</u>
SUBTOTAL	(25,744.00)
DEPRECIATION ADJUSTMENT	68,688.00
LOSS ON DISPOSAL OF FIXED ASSETS ADJUSTMENT	(55,016.00)
MISC. NON-DEDUCTIBLE EXPENSES	2,502.00
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>(9,570.00)</u></u>

JERSEYVILLE NURSING AND REHABILITATION CENTER
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/2011

Miscellaneous Income	892
CNA Book Reimbursement	250
Reimb for copies of medical records & nursing supplies	240
	<u>1,382</u>
	<u>(36,609)</u> loss on F/A disposal
	(35,227) In 28A p.19

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2011

<u>SEMINAR PARTICIPANT</u>	<u>JOB TITLE</u>	<u>DATE(S)</u>	<u>CITY</u>	<u>TITLE OF SEMINAR</u>	<u>SPONSOR</u>	<u>COST</u>	<u>SEMINAR LODGING/ TRAVEL/MEALS</u>
Terrie Weible	Administrator	6/16/2011	Online	Emergency Preparedness - Building Evacuation	Missouri Association of Nursing Home Administrators	40	10
Terrie Weible	Administrator	6/16/2011	Online	Resident Rights	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/23/2011	Online	Working with the Alzheimers Patient in a Long Term Care Facility	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/23/2011	Online	Handwashing	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/24/2011	Online	Urinary Tract Infections	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/28/2011	Online	Death and Dying	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/28/2011	Online	Bloodborne Pathogen	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/29/2011	Online	Emergency Preparedness - Protect in Place	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/29/2011	Online	Safety and Prevention	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/29/2011	Online	Fire Prevention - Response to a Fire	Missouri Association of Nursing Home Administrators	40	
Terrie Weible	Administrator	6/29/2011	Online	Nutritional Intake	Missouri Association of Nursing Home Administrators	40	
Holly Jensen	Billing	12/15/2011	Fenton, MO	Advance to ICD-10-CM-Learn the Basics to be Ready	Cross Country Education	120	104
Erica Riechmann	Registered Nurse	8/8/11 - 8/12/11	Springfield, IL	Annual C.N.A Instructor Conference	Lincoln Land Community College	480	
Total Seminars						1,040	114
Total Seminar Lodging/Travel/Meals						114	
Online CPE Service for Nurses						2,887	
Other Travel Expense <\$250 each						2,819	
Reimburse other facility for employees mileage to train new employee						1,977	
Lodging for employees during winter storm						1,452	
Home Office Travel & Seminar						3,403	
Total Travel and Seminar, Line 24						13,692	

Jerseyville Nursing & Rehabilitation Center
 Attachment to Schedule XIV
 12/31/2011

		1	2	3	4	5	6	7	8
			Staff		Outside Practitioner (other Than Consultant)		Supplies (Actual or Allocated)	Total Units (Col 2 + 4)	Total Cost (Col 3 + 5 +6)
Line #	Service	Schuler V Line & Column Reference	Units of Service	Cost	Units of Service	Cost	Cost		

12 Other:									
	Licensed Occupational Therapist	39,8			11,088	384,696	308	11,088	385,004
	Licensed Speech Therapist	39,8			3,309	151,549		3,309	151,549
	Licensed Physical Therapist	39,8			8,017	290,821	1,841	8,017	292,662
	X-Ray	39,3				35,671			35,671
	Laboratory	39,3				7,679			7,679
	Specialty Mattresses/Overlaid	39,3					9,001		9,001
Total to Schedule XIV, Line 12			-	-	22,414	870,416	11,150	22,414	881,566