

		FOR BHF USE			

LL2

**Supportive Living Facility**  
**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE & FAMILY SERVICES**  
**COST REPORT FOR**  
**SUPPORTIVE LIVING FACILITIES**  
**(FISCAL YEAR 2006)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p><b>I.</b></p> <p>Facility Name: <u>Springfield Slc</u></p> <p>Address: <u>2034 Clearlake Avenue</u> <u>Springfield</u> <u>62702</u>          Number City Zip Code</p> <p>County: <u>Sanagamon</u></p> <p>Telephone Number: <u>(217) 522-8843</u> Fax # <u>(217) 522-8803</u></p> <p>Federal Employer ID Number: <u>36-4455055</u></p> <p>Date Current Owners were Certified: <u>8/3/2005</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact:          Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input 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 _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2006</u> to <u>12/31/2006</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="0"> <tr> <td style="border: 1px solid black; width: 150px;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td style="border: 1px solid black;">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Jeff Singer, C.P.A.</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> Fax <u>(847) 236-1155</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE          IL DEPT OF HEALTHCARE AND FAMILY SERVICES          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>Jeff Singer, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax <u>(847) 236-1155</u>
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Facility Name Springfield Slc

Report Period Beginning: 1/1/2006 Ending: 12/31/2006

**III. STATISTICAL DATA**

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	123	Single Unit Apartment	123	44,895	1
2	13	Double Unit Apartment	13	4,745	2
3		Other			3
4	136	TOTALS	136	49,640	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit	24,535	4,958		29,493	5
6	Double Unit	2,593	523		3,116	6
7	Other					7
8	TOTALS	27,128	5,481		32,609	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 65.69%

D. Indicate the number of paid bed-hold days the SLF had during this year Not Tracked Also, indicate the number of unpaid bed-hold days the SLF had during this year. Not Tracked (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES  NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES  NO

G. List all services provided by your facility for non-residents.

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

None

H. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

## STATE OF ILLINOIS

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Facility Name: Springfield Slc

Report Period Beginning:

1/1/2006

Ending: 12/31/2006

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total		
		Salary/Wage	Supplies	Other	Total				
	A. General Services	1	2	3	4	5	6		
1	Dietary and Food Purchase	157,601	182,452	2,128	342,181		342,181	1	
2	Housekeeping, Laundry and Maintenance	123,174	32,121	22,442	177,737		177,737	2	
3	Heat and Other Utilities			103,045	103,045	(11,669)	91,376	3	
4	Other (specify):							4	
5	<b>TOTAL General Services</b>	<b>280,775</b>	<b>214,573</b>	<b>127,615</b>	<b>622,963</b>	<b>(11,669)</b>	<b>611,294</b>	<b>5</b>	
<b>B. Health Care and Programs</b>									
6	Health Care/ Personal Care	425,878	8,210	12,008	446,096		446,096	6	
7	Activities and Social Services	57,666	3,963	2,694	64,323		64,323	7	
8	Other (specify):							8	
9	<b>TOTAL Health Care and Programs</b>	<b>483,544</b>	<b>12,173</b>	<b>14,702</b>	<b>510,419</b>		<b>510,419</b>	<b>9</b>	
<b>C. General Administration</b>									
10	Administrative and Clerical	110,222	16,328	198,010	324,560	(33,257)	291,303	10	
11	Marketing Materials, Promotions and Advertising	40,980		13,303	54,283	(52,112)	2,171	11	
12	Employee Benefits and Payroll Taxes			158,601	158,601		158,601	12	
13	Insurance-Property, Liability and Malpractice			28,939	28,939	5,301	34,240	13	
14	Other (specify):							14	
15	<b>TOTAL General Administration</b>	<b>151,202</b>	<b>16,328</b>	<b>398,853</b>	<b>566,383</b>	<b>(80,068)</b>	<b>486,315</b>	<b>15</b>	
16	<b>TOTAL Operating Expense</b> (Sum of lines 5, 9 and 15)	<b>915,521</b>	<b>243,074</b>	<b>541,170</b>	<b>1,699,765</b>	<b>(91,737)</b>	<b>1,608,028</b>	<b>16</b>	
<b>Capital Expenses</b>									
<b>D. Ownership</b>									
17	Depreciation			10,052	10,052	250,852	260,904	17	
18	Interest			60,898	60,898	584,535	645,433	18	
19	Real Estate Taxes			44,000	44,000	15,687	59,687	19	
20	Rent -- Facility and Grounds			305,915	305,915	(305,915)		20	
21	Rent -- Equipment			6,161	6,161	(454)	5,707	21	
22	Other (specify):					1,007	1,007	22	
23	<b>TOTAL Ownership</b>			<b>427,026</b>	<b>427,026</b>	<b>545,712</b>	<b>972,738</b>	<b>23</b>	
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>915,521</b>	<b>243,074</b>	<b>968,196</b>	<b>2,126,791</b>	<b>453,975</b>	<b>2,580,766</b>	<b>24</b>	

Springfield Slc

Report Period Beginning: 11/2006  
 Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Non-Straight Line Depreciation	(71,688) 17 1
2	Prize Period Water and Power Expense	(1,692) 83 2
3	Interest Income	121 18 3
4	Marketing Coordinator Wages	(40,980) 11 4
5	Cable Television	(9,977) 83 5
6	Advertising and Promotions	(27,378) 10 6
7	Bank Charges	(108) 10 7
8	Political Contributions	(500) 10 8
9	Charitable Contributions	(66) 10 9
10	Bad Debt	(4,300) 10 10
11	Franchise Tax	(250) 10 11
12	Finance Charge	(454) 21 12
13	Meals and Entertainment	(143) 10 13
14	Public Relations	(290) 10 14
15	Marketing Expense	(14,132) 14 15
16	Open House Expense	(252) 10 16
17	Non-Allowable Interest	(60,890) 18 17
18	Building Company	
19	Rental Income	(308,915) 20 19
20	Amortization of Permanent Mortgage Costs	842 22 20
21	Amortization of Organizational Costs	165 22 21
22	Depreciation	322,460 17 22
23	Interest Expense	643,435 18 23
24	Insurance Expense	5,301 13 24
25	Real Estate Tax	15,887 19 25
26		
27		
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101	Total	453,975 101

Facility Name: Springfield Slc

Report Period Beginning 1/1/2006 Ending: 12/31/2006

V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.60	\$ 22.06	1
2	Licensed Practical Nurses	3.47	19.70	2
3	Certified Nurse Assistants	11.67	8.66	3
4	Activity Director & Assistants	2.61	10.64	4
5	Social Service Workers			5
6	Head Cook	0.68	19.14	6
7	Cook Helpers/Assistants	7.92	7.93	7
8	Dishwashers			8
9	Maintenance Workers	0.98	19.42	9
10	Housekeepers	4.79	8.38	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.05	26.21	13
14	Clerical	2.80	9.14	14
15	Marketing	1.07	18.48	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>38.62</b>	<b>\$ 11.40</b>	<b>17</b>

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period		
1	N/A			\$	1	
2					2	
3					3	
4					4	
5					5	
				<b>Total</b>	<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	NAME and FUNCTION	Amount of Fee		
1	N/A	\$	1	
2			2	
		<b>Total</b>	<b>\$</b>	<b>3</b>

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES	
Name 1	City 2
See Attached	

OTHER RELATED BUSINESS ENTITIES		
Name 3	City 4	Type of Business 5
Springfield Property LLC		Building Co.
See Attached		See Attached

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES  NO

Name of related entity: \_\_\_\_\_ If yes, what is the value of those services? \$ \_\_\_\_\_  
 (Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES  NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Springfield Slc

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

## VIII. OWNERSHIP COSTS

A. Purchase price of land \$ Year land was acquired

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

\*Total units on this schedule must agree with page 2.

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation		
1	136		2005	2005	\$ 8,063,935	\$ 293,234	35	\$ 230,398	\$ (62,836)	\$ 345,597	1	
2											2	
3											3	
4											4	
5											5	
<b>Improvement Type</b>												
6	Total From Supplemental Page 5's											6
7	Fence		2005	2005	1,750		20	88	88	88	7	
8	Window Treatments		2006	2006	2,370		20	119	119	119	8	
9	Shelving		2006	2006	951		20	48	48	48	9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16	Financial Statement Depreciation					10,052			(10,052)		16	
17	TOTAL (lines 1 thru 16)					\$ 8,069,006	\$ 303,286		\$ 230,652	\$ (72,634)	\$ 345,851	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 216,383	\$ 29,226	\$ 21,638	(7,588)	10	\$ 31,867	18
19	Vehicles	43,071		8,614	8,614	5	8,614	19
20	TOTAL (lines 18 and 19)	\$ 259,454	\$ 29,226	\$ 30,253	1,027		\$ 40,482	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name & ID Number Springfield Slc

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1									1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Springfield Slc

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1									1
2									2
3									3
4									4
5									5
6									6
7									7
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Springfield Slc

Report Period Beginning:

1/1/2006

Ending:

12/31/2006

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1									1
2									2
3									3
4									4
5									5
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28									28
29									29
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name: Springfield Slc

Report Period Beginning: 1/1/2006

Ending: 2/31/2006

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

	1	2	3	4	5	6	
	Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building		/ /	\$			3
4	Additions		/ /				4
5			/ /				5
6			/ /				6
7	<b>TOTAL</b>			\$			7

8. Is movable equipment rental included in building rental?  
 YES  NO

9. Rental amount for movable equipment \$ 5,707

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

**X. INTEREST EXPENSE**

	1	2		3	4	6		7	8	9	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
<b>A. Directly Facility Related</b>											
<b>Long-Term</b>											
1	Cambridge Realty		X	Mortgage	/ /	\$	7,736,007			\$ 645,435	1
2					/ /			/ /			2
3					/ /			/ /			3
<b>Working Capital</b>											
4	Venture Fund	X		Working Capital/Line of Credit	/ /		989,837	/ /		60,898	4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$	8,725,844			\$ 706,333	7
<b>B. Non-Facility Related</b>											
8	Interest Income		X		/ /			/ /		(2)	8
9	Non-Allowable Interest				/ /			/ /		(60,898)	9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	8,725,844			\$ 645,433	10

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

\*\* If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.



## STATE OF ILLINOIS

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Facility Name: Springfield Slc

Report Period Beginning: 1/1/2006

Ending:

12/31/2006

12/31/2006

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

	1	2		
	Operating	After Consolidation*		
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 11,554	\$ 24,481	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	537,730	537,730	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,967	16,967	6
7	Other Prepaid Expenses	8,882	8,882	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	6,325	60,722	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 581,458	\$ 648,782	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		115,071	13
14	Buildings, at Historical Cost		8,063,935	14
15	Leasehold Improvements, at Historical Cost	1,750	1,750	15
16	Equipment, at Historical Cost	58,193	262,775	16
17	Accumulated Depreciation (book methods)	(14,281)	(461,317)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,650	237,095	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,650)	(13,119)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 45,662	\$ 8,206,190	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 627,120	\$ 8,854,972	25

\*(See instructions.)

	1	2		
	Operating	After Consolidation*		
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 110,228	\$ 110,228	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,581	22,581	30
31	Accrued Taxes Payable	44,789	44,789	31
32	Accrued Interest Payable	35,500	35,500	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36			1,553,771	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 213,098	\$ 1,766,869	37
<b>D. Long-Term Liabilities</b>				
38	Long-Term Notes Payable	989,837	989,837	38
39	Mortgage Payable		7,736,007	39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 989,837	\$ 8,725,844	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,202,935	\$ 10,492,713	45
46	<b>TOTAL EQUITY</b>	\$ (575,815)	\$ (1,637,741)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 627,120	\$ 8,854,972	47

<b>Other Current Assets:</b>	<u>Operating</u>	<u>After Consolidation</u>	<b>Other Current Liabilities</b>	<u>Operating</u>	<u>After Consolidation</u>
09A 1498.0 · Exchange	325	325	36A Adv- Venture Fund Llc	-	1,541,096
09B 1213.5 · Escrowed Real Estate Taxes	6,000	6,000	36B Lessee Deposit- Ret & Ins	-	8,000
09C Real Estate Escrow	-	12,000	36C Lessee Deposit- Replacement Re	-	4,675
09D Replacement Reserve Escrow	-	4,675	36D Replacement Reserve Escrow	-	-
09E Mip Escrow	-	6,557	36E	-	-
09F Mechanics Lien Escrow	-	6,300	36F	-	-
09G Wage Escrow	-	24,865	36G	-	-
09H	-	-	36H	-	-
09I	-	-	36I	-	-
09J	-	-	36J	-	-
	<u>6,325</u>	<u>60,722</u>		<u>-</u>	<u>1,553,771</u>
	<u>6,325</u>	<u>60,722</u>		<u>-</u>	<u>1,553,771</u>

  

<b>Other Non-Current Assets:</b>	<u>Operating</u>	<u>After Consolidation</u>	<b>Other Non-Current Liabilities</b>	<u>Operating</u>	<u>After Consolidation</u>
23A	-	-	43A	-	-
23B	-	-	43B	-	-
23C	-	-	43C	-	-
23D	-	-	43D	-	-
23E	-	-	43E	-	-
23F	-	-	43F	-	-
23G	-	-	43G	-	-
23H	-	-	43H	-	-
23I	-	-	43I	-	-
23J	-	-	43J	-	-
	<u>-</u>	<u>-</u>		<u>-</u>	<u>-</u>
	<u>-</u>	<u>-</u>		<u>-</u>	<u>-</u>

Facility Name: Springfield Slc

Report Period Beginning: 1/1/2006

Ending: 12/31/2006

## XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,897,482	1
2	Discounts and Allowances		2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 1,897,482	3
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		2 13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$ 2	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,897,484	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	622,963	19
20	Health Care/ Personal Care	510,419	20
21	General Administration	566,383	21
<b>B. Capital Expense</b>			
22	Ownership	427,026	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 2,126,791	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (229,307)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (229,307)	31

- 15A
- 15B
- 15C
- 15D
- 15E
- 15F
- 15G
- 15H
- 15I
- 15J
- 15K
- 15L
- 15M
- 15N
- 15O
- 15P
- 15Q
- 15R
- 15S

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