

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2007  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2007)**

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> <hr/> <p>Address: <u>2034 Clearlake Avenue</u> <u>Springfield</u> <u>62702</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Sangamon</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>1/1/2007</u> to <u>12/31/2007</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="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Jeff Singer, C.P.A.</u></td> </tr> <tr> <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> <tr> <td></td> <td>MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</td> </tr> <tr> <td></td> <td align="right">Phone # (217) 782-1630</td> </tr> </table>	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>		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
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Facility Name Springfield SLCReport Period Beginning: 1/1/2007 Ending: 12/31/2007

## 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 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	26,692	6,726		33,418	5
6	Double Unit	2,821	710		3,531	6
7	Other					7
8	TOTALS	29,513	7,436		36,949	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 74.43%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  NOTax 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 therequired payments of interest and principle? N/AIf no, explain. N/AK. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of therequired payments of interest and principle? N/AIf no, explain. N/AL. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facilitymake all of the required payments of interest and principle? N/AIf no, explain. N/A

Facility Name: Springfield SLC

Report Period Beginning:

1/1/2007

Ending: 12/31/2007

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	142,199	236,575	1,500	380,274	(1,406)	378,868	1
2	Housekeeping, Laundry and Maintenance	145,526	26,811	29,020	201,357	(987)	200,370	2
3	Heat and Other Utilities			156,690	156,690	(23,280)	133,410	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>287,725</b>	<b>263,386</b>	<b>187,210</b>	<b>738,321</b>	<b>(25,673)</b>	<b>712,648</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	492,657	7,283	18,633	518,573	(397)	518,176	6
7	Activities and Social Services	59,915	4,644	4,226	68,785		68,785	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>552,572</b>	<b>11,927</b>	<b>22,859</b>	<b>587,358</b>	<b>(397)</b>	<b>586,961</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	144,186	14,386	369,534	528,106	(199,460)	328,646	10
11	Marketing Materials, Promotions and Advertising	42,132		9,949	52,081		52,081	11
12	Employee Benefits and Payroll Taxes			196,126	196,126		196,126	12
13	Insurance-Property, Liability and Malpractice			54,042	54,042		54,042	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>186,318</b>	<b>14,386</b>	<b>629,651</b>	<b>830,355</b>	<b>(199,460)</b>	<b>630,895</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,026,615</b>	<b>289,699</b>	<b>839,720</b>	<b>2,156,034</b>	<b>(225,530)</b>	<b>1,930,504</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			11,677	11,677	246,319	257,996	17
18	Interest			78,842	78,842	507,282	586,124	18
19	Real Estate Taxes			123,121	123,121		123,121	19
20	Rent -- Facility and Grounds			734,196	734,196	(734,196)		20
21	Rent -- Equipment			5,837	5,837		5,837	21
22	Other (specify):					5,053	5,053	22
23	<b>TOTAL Ownership</b>			<b>953,673</b>	<b>953,673</b>	<b>24,458</b>	<b>978,131</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,026,615</b>	<b>289,699</b>	<b>1,793,393</b>	<b>3,109,707</b>	<b>(201,072)</b>	<b>2,908,635</b>	<b>24</b>

Facility Name: Springfield SLC

Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.88	\$ 24.36	1
2	Licensed Practical Nurses	5.97	16.42	2
3	Certified Nurse Assistants	13.50	8.69	3
4	Activity Director & Assistants	2.79	10.33	4
5	Social Service Workers	-		5
6	Head Cook	1.00	15.07	6
7	Cook Helpers/Assistants	6.29	8.48	7
8	Dishwashers	-		8
9	Maintenance Workers	1.21	17.22	9
10	Housekeepers	6.20	7.91	10
11	Laundry	-		11
12	Managers	-		12
13	Other Administrative	1.00	26.22	13
14	Clerical	4.21	10.24	14
15	Marketing	1.23	16.46	15
16	Other	-		16
17	<b>Total (lines 1 thru 16)</b>	<b>44.28</b>	<b>\$ 11.15</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				\$	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

	Amount of Fee	
1	N/A	\$
2		\$
<b>Total</b>		<b>\$</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 <u>1</u>	City <u>2</u>
See Attached	

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
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: 1/1/2007

Ending: 12/31/2007

**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)	\$ 575,995	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	95	95	182	7	
8	Window Treatments		2006	2006	2,370		20	109	109	227	8	
9	Shelving		2006	2006	951		20	28	28	75	9	
10	Carbon Monoxide Detectors		2007	2007	2,632		20	132	132	132	10	
11											11	
12											12	
13											13	
14											14	
15											15	
16	Financial Statement Depreciation					11,677			(11,677)		16	
17	TOTAL (lines 1 thru 16)				\$ 8,071,638	\$ 304,911		\$ 230,762	\$ (74,149)	\$ 576,611	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	\$ 223,454	\$ 29,226	\$ 22,154	(7,072)	10	\$ 53,786	18
19	Vehicles	43,071		5,080	5,080	5	14,286	19
20	TOTAL (lines 18 and 19)		\$ 266,525	\$ 29,226	\$ 27,234	(1,992)	\$ 68,072	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:

1/1/2007

Ending:

12/31/2007

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
1								1				
2								2				
3								3				
4								4				
5								5				
6								6				
7								7				
8								8				
9								9				
10								10				
11								11				
12								12				
13								13				
14								14				
15								15				
16								16				
17								17				
18								18				
19								19				
20								20				
21								21				
22								22				
23								23				
24								24				
25								25				
26								26				
27								27				
28								28				
29								29				
30								30				
31								31				
32								32				
33	<b>Total Book Depreciation</b>								33			
34	<b>TOTAL (lines 1 thru 33)</b>							\$	\$	\$	\$	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: 1/1/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	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:

1/1/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	34

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

Facility Name: Springfield SLC

Report Period Beginning: 1/1/2007

Ending: 2/31/2007

**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 \$ 5,837

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		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	<b>A. Directly Facility Related Long-Term</b>									
1	Cambridge Realty		X	Mortgage	/ /	\$	\$ 7,686,529	/ /		\$ 586,124
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4	Venture Fund	X		Working Capital/Line of Credit	/ /			/ /		78,842
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$	\$ 7,686,529			\$ 664,966
	<b>B. Non-Facility Related</b>									
8	Non-Allowable Interest				/ /			/ /		(78,842)
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$ 7,686,529			\$ 586,124

\* 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.

Facility Name: Springfield SLC

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 35,871	\$ 111,275	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	437,972	437,972	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,392	20,392	6
7	Other Prepaid Expenses	6,727	6,727	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	51,115	155,256	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 552,077	\$ 731,622	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	4,382	4,382	15
16	Equipment, at Historical Cost	65,263	269,845	16
17	Accumulated Depreciation (book methods)	(25,958)	(795,454)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,650	237,095	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,650)	(24,509)	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>	\$ 43,687	\$ 7,870,365	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 595,764	\$ 8,601,987	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,554,490	\$ 1,554,490	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,819	25,819	30
31	Accrued Taxes Payable	80,160	80,160	31
32	Accrued Interest Payable		207	32
33	Deferred Compensation			33
34	Federal and State Income Taxes	10,539	10,539	34
<b>Other Current Liabilities(specify):</b>				
35				35
36			1,598,461	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 1,671,008	\$ 3,269,676	37
<b>D. Long-Term Liabilities</b>				
38	Long-Term Notes Payable			38
39	Mortgage Payable		7,686,529	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>	\$	\$ 7,686,529	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,671,008	\$ 10,956,205	45
46	<b>TOTAL EQUITY</b>	\$ (1,075,244)	\$ (2,354,218)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 595,764	\$ 8,601,987	47

\*(See instructions.)

Facility Name: Springfield SLC

Report Period Beginning: 1/1/2007

Ending:

12/31/2007

**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	\$ 2,608,643	1
2	Discounts and Allowances		2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 2,608,643	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		13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$	14
<b>D. Other Revenue (specify):</b>			
15		1,641	15
16			16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$ 1,641	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 2,610,284	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	738,321	19
20	Health Care/ Personal Care	587,358	20
21	General Administration	830,355	21
<b>B. Capital Expense</b>			
22	Ownership	953,673	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)	\$ 3,109,707	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (499,423)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (499,423)	31