

Facility Name & ID Number Eden Village Care Center

0023382 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	138	Skilled (SNF)	138	50,370	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	138	TOTALS	138	50,370	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,207	23,635	3,830	44,672	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,207	23,635	3,830	44,672	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.69%

D. How many bed-hold days during this year were paid by the Department? _____ (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 05/14/1979

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/14/1979 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 138 and days of care provided 3,830

Medicare Intermediary Mutual of Omaha, P.O. Box 1602, Omaha, NE, 68101

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	316,777	21,943	417,440	756,160		756,160	(122,147)	634,013		1
2	Food Purchase		88,450		88,450		88,450		88,450		2
3	Housekeeping	238,850	70,698	6,257	315,805	(97,900)	217,905	(78,750)	139,155		3
4	Laundry					97,900	97,900	(28,312)	69,588		4
5	Heat and Other Utilities			381,115	381,115		381,115	(190,364)	190,751		5
6	Maintenance	259,843	36,564	232,901	529,308		529,308	(181,181)	348,127		6
7	Other (specify):*										7
8	TOTAL General Services	815,470	217,655	1,037,713	2,070,838		2,070,838	(600,754)	1,470,084		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	2,276,223	150,760	97,808	2,524,791		2,524,791		2,524,791		10
10a	Therapy		2,229	457,471	459,700		459,700		459,700		10a
11	Activities	104,595	7,945	5,108	117,648		117,648	(104,595)	13,053		11
12	Social Services	34,572	116	624	35,312		35,312	(34,572)	740		12
13	CNA Training			21,773	21,773		21,773		21,773		13
14	Program Transportation	37,846	4,386	1,368	43,600		43,600	(21,287)	22,313		14
15	Other (specify):* Seniors N Motion	58,998	758		59,756		59,756	(59,756)			15
16	TOTAL Health Care and Programs	2,512,234	166,194	600,952	3,279,380		3,279,380	(220,210)	3,059,170		16
	C. General Administration										
17	Administrative	125,396	496	42,336	168,228		168,228	(106,920)	61,308		17
18	Directors Fees										18
19	Professional Services			29,949	29,949		29,949		29,949		19
20	Dues, Fees, Subscriptions & Promotions			74,265	74,265		74,265	(60,431)	13,834		20
21	Clerical & General Office Expenses	417,589	27,377	102,636	547,602		547,602	(115,313)	432,289		21
22	Employee Benefits & Payroll Taxes			1,062,002	1,062,002		1,062,002	(141,589)	920,413		22
23	Inservice Training & Education			11	11		11		11		23
24	Travel and Seminar			10,434	10,434		10,434		10,434		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			176,699	176,699		176,699	(12,625)	164,074		26
27	Other (specify):* Mktg/Development	127,938	9,647	27,955	165,540		165,540	(165,540)			27
28	TOTAL General Administration	670,923	37,520	1,526,287	2,234,730		2,234,730	(602,418)	1,632,312		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,998,627	421,369	3,164,952	7,584,948		7,584,948	(1,423,382)	6,161,566		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Eden Village Care Center

#0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			358,088	358,088		358,088		358,088			30
31	Amortization of Pre-Op. & Org.			27,767	27,767		27,767		27,767			31
32	Interest			68,563	68,563		68,563		68,563			32
33	Real Estate Taxes			70,096	70,096		70,096	(70,096)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			524,514	524,514		524,514	(70,096)	454,418			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			179,014	179,014		179,014		179,014			39
40	Barber and Beauty Shops	30,508	3,512	13,191	47,211		47,211		47,211			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,555	75,555		75,555		75,555			42
43	Other (specify):* RC & Other non-reimbursable			291,262	291,262		291,262	(291,262)				43
44	TOTAL Special Cost Centers	30,508	3,512	559,022	593,042		593,042	(291,262)	301,780			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,029,135	424,881	4,248,488	8,702,504		8,702,504	(1,784,740)	6,917,764			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Eden Village Care Center

ID# 0023382

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	RC-Dietary	\$ (122,147)	1	1
2				2
3	RC-Housekeeping	(67,725)	3	3
4	RC-Laundry	(28,312)	4	4
5	RC-Heat & Utilities	(190,364)	5	5
6	RC-Maintainance	(181,181)	6	6
7	RC-Program Transportation	(21,287)	14	7
8	RC-Administrative	(85,489)	17	8
9	RC-Clerical & Office	(108,618)	21	9
10	RC-Employee Benefits/PR Taxes	(141,589)	22	10
11	RC-Insurance	(12,625)	26	11
12	RC-Direct Expenses (Depreciation)	(264,976)	43	12
13	RC-Activities Salaries	(104,595)	11	13
14	RC-Social Services Salaries	(34,572)	12	14
15	Real Estate Taxes on RC	(70,096)	33	15
16	Marketing/Development Salaries	(165,540)	27	16
17	Lab, Xray, Ambulance services	(26,286)	43	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,625,402)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	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	(122,147)	0	0	0	0	0	0	0	0	0	0	(122,147)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(78,750)	0	0	0	0	0	0	0	0	0	0	(78,750)	3
4	Laundry	(28,312)	0	0	0	0	0	0	0	0	0	0	(28,312)	4
5	Heat and Other Utilities	(190,364)	0	0	0	0	0	0	0	0	0	0	(190,364)	5
6	Maintenance	(181,181)	0	0	0	0	0	0	0	0	0	0	(181,181)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(600,754)	0	(600,754)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(104,595)	0	0	0	0	0	0	0	0	0	0	(104,595)	11
12	Social Services	(34,572)	0	0	0	0	0	0	0	0	0	0	(34,572)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(21,287)	0	0	0	0	0	0	0	0	0	0	(21,287)	14
15	Other (specify):*	(59,756)	0	0	0	0	0	0	0	0	0	0	(59,756)	15
16	TOTAL Health Care and Programs	(220,210)	0	(220,210)	16									
	C. General Administration													
17	Administrative	(106,920)	0	0	0	0	0	0	0	0	0	0	(106,920)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(60,431)	0	0	0	0	0	0	0	0	0	0	(60,431)	20
21	Clerical & General Office Expenses	(115,313)	0	0	0	0	0	0	0	0	0	0	(115,313)	21
22	Employee Benefits & Payroll Taxes	(141,589)	0	0	0	0	0	0	0	0	0	0	(141,589)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(12,625)	0	0	0	0	0	0	0	0	0	0	(12,625)	26
27	Other (specify):*	(165,540)	0	0	0	0	0	0	0	0	0	0	(165,540)	27
28	TOTAL General Administration	(602,418)	0	(602,418)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,423,382)	0	(1,423,382)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/07 Ending: 12/31/07

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	(70,096)	0	0	0	0	0	0	0	0	0	0	(70,096) 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(70,096)	0	(70,096) 37									
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(291,262)	0	0	0	0	0	0	0	0	0	0	(291,262) 43
44	TOTAL Special Cost Centers	(291,262)	0	(291,262) 44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,784,740)	0	(1,784,740) 45									

Facility Name & ID Number

Eden Village Care Center

0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/07 Ending: 12/31/07

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									\$		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	\$		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

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

1/1/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Eden Village Care Center

0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Series 2006 Revenue Bonds		X	Construction & Equipment		12/1/2006	\$ 22,390,000	\$ 22,390,000	12/1/2036	5.00-5.85%	\$ 68,563	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 22,390,000	\$ 22,390,000			\$ 68,563	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 22,390,000	\$ 22,390,000			\$ 68,563	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	49,793	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.)		\$	58,389	2
3. Under or (over) accrual (line 2 minus line 1).		\$	8,596	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	61,500	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.		\$	70,096	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	43,587	8
	2003	44,228	9
	2004	47,704	10
	2005	44,707	11
	2006	58,389	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eden Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023382

CONTACT PERSON REGARDING THIS REPORT Ron Hassler

TELEPHONE (618) 288-5014 FAX #: (618) 288-0206

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-2-15-26-02-202-096</u>	<u>Cottonwood Trace PT Lot 3</u>	\$ <u>86.13</u>	\$ _____
2. <u>14-1-15-26-02-202-098.001</u>	<u>NE/C NE</u>	\$ <u>46.92</u>	\$ _____
3. <u>14-2-15-26-02-202-101</u>	<u>Cottonwood Trace-First Add LT PT 8</u>	\$ <u>1,074.09</u>	\$ _____
4. <u>14-2-15-26-02-202-097</u>	<u>Cottonwood Trace PT Lot 2</u>	\$ <u>8,700.66</u>	\$ _____
5. <u>14-2-15-26-02-202-165</u>	<u>Eden Village Subd 1st Addn Lot 1</u>	\$ <u>48,481.03</u>	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>58,388.83</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? X YES NO

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	138	1979	1979	\$ 2,008,520	\$ 66,951	30	\$ 66,951	\$	\$ 1,919,156	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Parking Lot - 13		1979	62,453		10			62,453	9
10	Alarm System-29		1979	1,193		10			1,193	10
11	Additions-106		1985	28,768	959	30	959		21,336	11
12	Roof-239		1989	21,453	1,073	20	1,073		19,845	12
13	Office Addition-269		1990	34,575	1,152	30	1,152		19,976	13
14	Blocks-Parking Lot-279		1991	391		15			391	14
15	Interior Office Walls-280		1991	3,102	124	25	124		2,109	15
16	Gas Pipe-283		1991	5,850	234	25	234		3,959	16
17	Floor-Kitchen-308		1991	3,046	152	20	152		2,474	17
18	Parking Lot-311		1991	8,447		15			8,447	18
19	Paved entrance Drive-330		1992	1,890	42	15	42		1,890	19
20	Buildings-CC-348		1992	104,840	4,194	25	4,194		63,604	20
21	Walkpads-365		1993	1,085	54	20	54		813	21
22	Gutters-399		1993	293	15	20	15		213	22
23	Fence-400		1993	700	47	15	47		677	23
24	Cedar Patio-Roof-401		1993	3,285	164	20	164		2,382	24
25	Roof-424		1993	10,956	548	20	548		7,806	25
26	Remodeling-Hall I-425		1993	23,174	927	25	927		13,210	26
27	Driveway Seal-433		1993	950	48	20	48		674	27
28	Signs-441		1993	6,956		12			6,956	28
29	Remodeling-Hall III-442		1993	20,060	802	25	802		11,301	29
30	Remodeling Hall 3-454		1994	10,620	425	25	425		5,877	30
31	Remodeling - Hall 5-455		1994	8,141	326	25	326		4,506	31
32	Improvements - 462		1994	2,896	193	15	193		2,655	32
33	Parking Lot-482		1994	3,188	159	20	159		2,153	33
34	Improvements-506		1994	650	43	15	43		574	34
35	Improvements-519		1994	138	9	15	9		120	35
36			1994	3,070	205	15	205		2,677	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07**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	
37	<u>Improvements-541</u>	1995	\$ 2,360	\$ 118	20	\$ 118	\$	\$ 1,514	37
38	<u>Design & engineering Costs-546</u>	1995	4,410	221	20	221		2,813	38
39	<u>Improvements Rm. 501 - 554</u>	1995	1,800	90	20	90		1,148	39
40	<u>Improvements Rms. 403, 405, 407 - 555</u>	1995	5,400	270	20	270		3,443	40
41	<u>Improvements Rms. 400 & 401</u>	1995	4,035	202	20	202		2,572	41
42	<u>Improvements Rms. 409,411,413 - 567</u>	1995	5,400	270	20	270		3,398	42
43	<u>Improvements Rms. 408,410,412 - 572</u>	1995	5,754	288	20	288		3,597	43
44	<u>Rubber Roof & Insulation-583</u>	1995	23,522	1,176	20	1,176		14,603	44
45	<u>Improvements Rms. 402,404,406 - 584</u>	1995	5,594	280	20	280		3,473	45
46	<u>Improvements - 608</u>	1995	2,841	142	20	142		1,729	46
47	<u>Rubber Roof & Insulation-609</u>	1995	23,522	1,176	20	1,176		14,309	47
48	<u>Shower Room Improvements-619</u>	1995	6,285	314	20	314		3,797	48
49	<u>Improvements-622</u>	1996	1,867	93	20	93		1,120	49
50	<u>Crash Rails-627</u>	1996	2,829	189	15	189		2,248	50
51	<u>Remodel Rooms 509, 511, 513 - 635</u>	1996	7,080	354	20	354		4,159	51
52	<u>Remodel Rooms 503, 505, 507 - 641</u>	1996	7,080	354	20	354		4,159	52
53	<u>Install Phone Jacks-645</u>	1996	210		10			210	53
54	<u>Remodel Rooms 502,504,506 - 650</u>	1996	7,080	354	20	354		4,130	54
55	<u>Install Phone Jacks-656</u>	1996	210		10			210	55
56	<u>Remodel Rooms 508,510,512 - 668</u>	1996	7,080	354	20	354		4,071	56
57	<u>Remodel Rooms 209,211,213 - 684</u>	1996	7,080	354	20	354		4,012	57
58	<u>Remodel Rooms 203, 205,207 - 699</u>	1996	7,080	354	20	354		3,982	58
59	<u>Remodel Rooms 200,202,204 - 708</u>	1996	7,080	354	20	354		3,953	59
60	<u>Remodel Rooms 206,208,210 - 715</u>	1996	7,080	354	20	354		3,924	60
61	<u>Remodel Room 212</u>	1996	2,360	118	20	118		1,307	61
62	<u>Roof Repair-769</u>	1997	3,550	178	20	178		1,834	62
63	<u>CC Expan - Carpet & Wallcovering-806</u>	1998	14,587		5			14,587	63
64	<u>CC Const.-Administration/CC-807</u>	1998	895,205	22,380	40	22,380		223,801	64
65	<u>CC Const.-Therapy Center - 850</u>	1998	522,203	13,055	40	13,055		129,462	65
66	<u>CC Const.-Eng & Architect Fees-851</u>	1998	126,455	4,215	30	4,215		41,799	66
67	<u>Admin & chapel Carpet-853</u>	1998	19,121		5			19,121	67
68	<u>Walk-Off Pad-873</u>	1998	1,514	101	15	101		1,001	68
69	<u>Wall Covering - Lobby-877</u>	1998	876	88	10	88		869	69
70	TOTAL (lines 4 thru 69)		\$ 4,119,240	\$ 126,642		\$ 126,642	\$	\$ 2,715,782	70

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

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07**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	Totals from Page 12A, Carried Forward		\$ 4,119,240	\$ 126,642		\$ 126,642	\$	\$ 2,715,782	1
2	Wall Covering-Therapy-881	1998	1,603	160	10	160		1,576	2
3	CC Roof Repair-886	1998	7,452	745	10	745		7,266	3
4	Wall Coverings-7 rooms-898	1998	17,500	1,750	10	1,750		16,625	4
5	Wallcoverings, Main Hall & Access-971	1999	1,566	157	10	157		1,410	5
6	Wallcoverings, Hall 3 & 4-972	1999	8,763	876	10	876		7,887	6
7	Crash Rails-973	1999	25,475	1,698	15	1,698		15,285	7
8	Install 17 fire/Smoke Dampers-985	1999	22,104	1,474	15	1,474		13,263	8
9	Monumental Bronze Plaque-987	1999	148	15	10	15		133	9
10	VH Design Charges-993	1999	734	24	30	24		218	10
11	Wallcoverings, Hall 1 & 2-997	1999	1,584	158	10	158		1,399	11
12	Wallcoverings-Nurse Station-1004	1999	669	67	10	67		586	12
13	Wallcoverings, Fire Doors & Nrs Stn-1008	1999	1,145	114	10	114		1,002	13
14	Wallcovering, Main dining Room-1009	1999	5,432	543	10	543		4,753	14
15	Alzheimers Corner Protectors	1999	1,701	113	15	113		982	15
16	Alz, Wallcovering-Liv/Din Area-1019	1999	4,493	449	10	449		3,893	16
17	Sprinkler System Improv.-1021	1999	3,135	209	15	209		1,794	17
18	Install Activity Room cove Base-1024	1999	60	6	10	6		52	18
19	Alarm System Repair-1025	1999	1,840	123	15	123		1,053	19
20	Alzheimers construction-1026	1999	504,922	12,623	40	12,623		108,346	20
21	Electrical Circuit Installation-1037	1999	447	30	15	30		254	21
22	Engineering Consulting-1057	1999	899	60	15	60		494	22
23	Wallcovering, Hall 1 Restroom-1060	1999	954	95	10	95		787	23
24	Custom Door, Frame, Hinges-1103	2000	555	56	10	56		440	24
25	Final CC Renovation Payment-1113	2000	11,000	275	40	275		2,132	25
26	Chair Rails-1167	2000	5,843	584	10	584		4,138	26
27	Carpet-Service Hall-1165	2000	2,444		5			2,444	27
28	Alzheimer Construction-Final-1500	2001	31,865	2,124	15	2,124		14,516	28
29	Skilled nursing Facility-1312	2005	14,928	1,493	10	1,493		4,105	29
30	Remodel Skilled Facility-3219	2005	18,720	1,872	10	1,872		5,148	30
31	Comp Activity Study-3224	2005	7,500	750	10	750		2,063	31
32	Skilled Nursing Facility-28% Work completed-3233	2005	15,720	1,572	10	1,572		4,192	32
33	50% Skilled Completed - 3249	2005	28,348	2,835	10	2,835		7,323	33
34	TOTAL (lines 1 thru 33)		\$ 4,868,789	\$ 159,692		\$ 159,692	\$	\$ 2,951,341	34

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

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07**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	Totals from Page 12B, Carried Forward		\$ 4,868,789	\$ 159,692		\$ 159,692	\$	\$ 2,951,341	1
2	Skilled Nursing Facility 70%-3265	2005	24,695	2,469	10	2,469		6,173	2
3	Care Center Review Blueprints-3268	2005	9,600	960	10	960		2,320	3
4	Consult Remodeling Campus-3272	2005	1,743	174	10	174		421	4
5	Remodel Skill Nursing Facility - 80@ Complete-3274	2005	12,941	1,294	10	1,294		3,127	5
6	Update Market Feasability Study-glen Carbon-3284	2005	2,642	264	10	264		594	6
7	Update Market Feasability Study-glen Carbon-3285	2005	3,900	390	10	390		878	7
8	Hall 2 Exit Drawings-3333	2006	1,826	183	10	183		350	8
9	Pull New Cable SNF Const. Package-3337	2006	1,512	151	10	151		290	9
10	Exit Upgrades to Code-3351	2006	82,926	4,146	20	4,146		6,910	10
11	Hall 3 remodel-3376	2006	949	95	10	95		142	11
12	Landscaping -CC-398	1993	809		10			809	12
13	Flower Bed Irrigation system-786	1997	2,450	163	15	163		1,660	13
14	Vinyl Fence-852	1997	3,731	249	15	249		2,467	14
15	Parking Lot Asphalt-922	1998	18,949	1,895	10	1,895		17,686	15
16	Upgrade Parking Lighting-CC-955	1998	3,750	250	15	250		2,271	16
17	Signage Program, 1/2 CC-1000	1999	20,523	1,368	15	1,368		12,086	17
18	Courtyard Landscaping-CC-1044	1999	8,900	890	10	890		7,491	18
19	Pond sidewalk Repair-CC-1046	1999	3,485	232	15	232		1,955	19
20	100 Ft. Vinyl Fence-CC-1069	1999	1,383	92	15	92		752	20
21	Wallpaper & Floor Covering, Activity-1150	2000	1,537		5			1,537	21
22	Linoleum-Activity Room-1161	2000	5,523		5			5,523	22
23	Sidewalk-1162	2000	4,235	212	20	212		1,518	23
24	Landscaping-Main Ent & Therapy-1543	2001	4,865	486	10	486		3,202	24
25	Painting-Main Hall & Bathrooms-1544	2001	1,774	177	10	177		1,167	25
26	RipRap (Rock)-Lake-1545	2001	1,109	111	10	111		720	26
27	Parking Lot Sealing/Striping - CC/Therapy-1546	2001	7,183	718	10	718		4,489	27
28	Install Delayed Egress on Doors-1547	2001	3,400	340	10	340		2,068	28
29	Tree Removal-1548	2001	585	59	10	59		371	29
30	Clean Nurse Stn A/C Unit-1549	2001	916	92	10	92		603	30
31	Heat Tape in Downspouts-1550	2001	4,905	491	10	491		3,230	31
32	Roof Repairs-1551	2002	3,148	315	10	315		2,072	32
33	Employee Lounge-2081	2002	3,150	126	25	126		651	33
34	TOTAL (lines 1 thru 33)		\$ 5,117,833	\$ 178,084		\$ 178,084	\$	\$ 3,046,874	34

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

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07**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	Totals from Page 12C, Carried Forward		\$ 5,117,833	\$ 178,084		\$ 178,084	\$	\$ 3,046,874	1
2	Front Receptionist Desk Area-2084	2002	2,400	96	25	96		488	2
3	New Nurses Station Hall 6-2085	2002	800	32	25	32		163	3
4	Nurses Station Hall 6-2086	2002	2,850	114	25	114		580	4
5	Removal of Nurses Station-3003	2003	875	35	25	35		175	5
6	Carpet by Aviary-CC-3021	2003	2,885	115	25	115		567	6
7	Restripe Parking Lot-3028	2003	735	74	10	74		350	7
8	Landscape Lake Area-3068	2003	671	67	10	67		279	8
9	Landscape Main entrance-3070	2003	2,625	263	10	263		1,094	9
10	Walls for Art/Music Therapy Room-3076	2003	2,170	108	20	108		442	10
11	Kitchen/Store Room/Office-3089	2004	7,201	360	20	360		1,410	11
12	Concrete Work-CC-3117	2004	1,095	110	10	110		384	12
13	Employee Smoking Area/1st Half-3145	2004	2,500	100	25	100		308	13
14	Glass Window PT Recept Desk-3147	2004	3,058	122	25	122		377	14
15	Floor for Tub Room 2,4,5-3149	2004	4,820	193	25	193		595	15
16	Floor for Two Entry Baths-3150	2004	872	35	25	35		108	16
17	Floor in Tub Room #1-3151	2004	1,221	49	25	49		151	17
18	Employee Patio-3158	2004	2,500	100	25	100		308	18
19	Lavatories 306/308-3205	2005	210	21	10	21		60	19
20	Sewer in Hallways-3206	2005	1,180	118	10	118		334	20
21	6 Insulated windows-3244	2005	2,140	214	10	214		553	21
22	Metal Doors-3245	2005	3,696	148	25	148		382	22
23	Dock foundation-3251	2005	550	37	15	37		92	23
24	Care Center Roof-3273	2005	24,639	986	25	986		2,385	24
25	Sealing & Strip Parking Lot-3278	2005	5,550	1,110	5	1,110		2,498	25
26	New Conf Room Door-3334	2006	725	73	10	73		145	26
27	Two Mute Swans-3353	2006	1,425	285	5	285		475	27
28	Sidewalk-3356	2006	1,020	102	10	102		170	28
29	Reimbursement Swan Purchase-3364	2006	625	125	5	125		198	29
30	Cooler electric to Generator-3419	2006	11,640	1,164	10	1,164		1,552	30
31	Hall 3 renovations-3431	2006	2,710	271	10	271		339	31
32	Waterblast & Prep/Paint-500C	1994	13,333		10			13,333	32
33	Asset Retirement Cost (FIN 47)	2006	20,377	679	30	679		679	33
34	TOTAL (lines 1 thru 33)		\$ 5,246,931	\$ 185,390		\$ 185,390	\$	\$ 3,077,848	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,246,931	\$ 185,390		\$ 185,390	\$	\$ 3,077,848	1
2	Anderson Windows	2007	3,273	234	5	234		234	2
3	New Doors, Smoke Dampers, other Safety Code improvements	2007	78,537	10,472	5	10,472		10,472	3
4	Hot Water Lines and Mixing Valves	2007	7,380	369	10	369		369	4
5									5
6									6
7									7
8									8
9									9
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,336,121	\$ 196,465		\$ 196,465	\$	\$ 3,088,923	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,276,505	\$ 140,693	\$ 140,693	\$	Various	\$ 698,461	71
72	Current Year Purchases	48,455	2,991	2,991		Various	2,991	72
73	Fully Depreciated Assets	945,187	11,601	11,601		Various	945,187	73
74								74
75	TOTALS	\$ 2,270,147	\$ 155,285	\$ 155,285	\$		\$ 1,646,639	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility business	1990 Van - 275	1990	\$ 40,188	\$	\$	\$	4	\$ 40,188	76
77	Facility Business	2005 Ford 20 Passenger Bus	2004	54,530	3,635	3,635		15	11,626	77
78	Facility Business	Wheelchair Accessable Van	2007	40,050	2,703	2,703		10	2,703	78
79										79
80	TOTALS			\$ 134,768	\$ 6,338	\$ 6,338	\$		\$ 54,517	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,907,331	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 358,088	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 358,088	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)	\$ 4,790,079	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	Non-Care Vehicles	\$ 61,474	\$ 2,917	\$ 61,474	86
87	RC/Apt Duplexes Land	126,596			87
88	Retirement Center Apts/Duplexes	6,801,414	262,059	4,629,476	88
89					89
90					90
91	TOTALS	\$ 6,989,484	\$ 264,976	\$ 4,690,950	91

G. Construction-in-Progress

	Description	Cost	
92	CIP-CC	\$ 20,881	92
93	CIP	12,886,009	93
94	CIP-Cap Int.	573,882	94
95		\$ 13,480,772	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: 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: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>111</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	4,214	17,559		21,773
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 4,214	\$ 17,559	\$	\$ 21,773
10	SUM OF line 9, col. 1 and 2 (e)	\$ 21,773			

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	25
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
TOTAL TRAINED	31

- (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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10A-3	hrs		\$	3,635	\$ 179,212	\$	3,635	\$	179,212					1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			1,421	64,467		1,421		64,467					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A-3	hrs			3,602	203,158		3,602		203,158					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39-3	# of prescripts							179,014					179,014	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Exceptional Care Program															12
13	Other (specify):															13
14	TOTAL				\$	8,658	\$ 446,837	\$	8,658	\$	179,014	\$	8,658	\$	625,851	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.

Facility Name & ID Number Eden Village Care Center
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0023382
 As of 12/31/07

Report Period Beginning: 1/1/07
 (last day of reporting year)

Ending: 12/31/07

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	\$ 1,163,563	\$	1
2	Cash-Patient Deposits	2,621		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 43,000)	1,054,709		3
4	Supply Inventory (priced at)	18,158		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,936		6
7	Other Prepaid Expenses	6,940		7
8	Accounts Receivable (owners or related parties)	77,498		8
9	Other(specify): <u>Interest receivable</u>	122,729		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,473,154	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	292,891		13
14	Buildings, at Historical Cost	24,972,085		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,113,281		16
17	Accumulated Depreciation (book methods)	(9,481,029)		17
18	Deferred Charges	810,303		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Bond Funds</u>	8,529,777		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 28,237,308	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 30,710,462	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,545,616	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,621		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	279,144		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,500		32
33	Accrued Interest Payable	108,109		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Prelease Deposits</u>	115,000		36
37	<u>Other Accrued Expenses</u>	436,546		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,548,536	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	22,390,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	1,821,803		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 24,211,803	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 26,760,339	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,950,123	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 30,710,462	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,180,840	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,180,840	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(230,717)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (230,717)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,950,123	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,967,706	1
2	Discounts and Allowances for all Levels	(1,456,757)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,510,949	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	14,731	5
6	Therapy	156,255	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 170,986	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	32,409	13
14	Non-Patient Meals	11,025	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	3,607	19
20	Radiology and X-Ray	277	20
21	Other Medical Services	211,044	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 258,362	23
D. Non-Operating Revenue			
24	Contributions	58,913	24
25	Interest and Other Investment Income***	84,016	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 142,929	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Apt/Garden Home Revenue</u>	1,377,895	28
28a	<u>Other Revenue</u>	10,666	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,388,561	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,471,787	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	2,070,838	31
32	Health Care	3,279,380	32
33	General Administration	2,234,730	33
B. Capital Expense			
34	Ownership	524,514	34
C. Ancillary Expense			
35	Special Cost Centers	517,487	35
36	Provider Participation Fee	75,555	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,702,504	40
41	Income before Income Taxes (line 30 minus line 40)**	(230,717)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (230,717)	43

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

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

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Eden Village Care Center

0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	4,773	4,773	\$ 115,319	\$ 24.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,228	9,228	177,452	19.23	3
4	Licensed Practical Nurses	39,844	39,844	772,954	19.40	4
5	CNAs & Orderlies	107,061	107,061	1,131,710	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,091	9,091	104,595	11.51	10
11	Social Service Workers	6,371	6,371	102,926	16.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,781	39,781	316,777	7.96	15
16	Dishwashers					16
17	Maintenance Workers	15,725	15,725	186,340	11.85	17
18	Housekeepers	20,016	20,016	164,807	8.23	18
19	Laundry	8,993	8,993	74,043	8.23	19
20	Administrator	2,407	2,407	80,300	33.36	20
21	Assistant Administrator	2,160	2,160	52,801	24.44	21
22	Other Administrative	7,383	7,383	202,925	27.49	22
23	Office Manager					23
24	Clerical	12,906	12,906	161,016	12.48	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	6,580	6,580	68,265	10.37	31
32	Other Health C: Senior Fit	4,849	4,849	58,998	12.17	32
33	Other(specify) <u>RC & Developmen</u>	15,164	15,164	257,907	17.01	33
34	TOTAL (lines 1 - 33)	312,332	312,332	\$ 4,029,135 *	\$ 12.90	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	61	\$ 2,135	1-3	35
36	Medical Director	72	16,800	9-3	36
37	Medical Records Consultant	13	596	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,040	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	146	\$ 21,571		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	34	\$ 1,342	10-3	50
51	Licensed Practical Nurses	269	7,769	10-3	51
52	Certified Nurse Assistants/Aides	2,979	56,239	10-3	52
53	TOTAL (lines 50 - 52)	3,282	\$ 65,350		53

Facility Name & ID Number Eden Village Care Center# 0023382

Report Period Beginning:

1/1/07

Ending:

12/31/07**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. LSN - \$8820
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? n/a
- (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. \$ 45,871 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. \$ 75,555
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 9,432 Has any meal income been offset against related costs? N/A Indicate the amount. \$ no
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
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? 0%
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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: LarsonAllen LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Will send when Audit is finalized
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees