

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0037036

Facility Name: Pilot House

Address: 1111 Washington Avenue, Box 369 Cairo 62914
 Number City Zip Code

County: Alexander

Telephone Number: (618) 734-3706 **Fax #** (618) 833-4993

HFS ID Number: 37-1272696001

Date of Initial License for Current Owners: 08/25/1988

Type of Ownership:

<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 checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Richard Stroh **Telephone Number:** (618) 833-5070x11

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Richard Stroh</u>	
	(Title) <u>Asst. Comptroller</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Pilot House

0037036 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 5840

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,714</u>			<u>5,714</u>
14	TOTALS	<u>5,714</u>			<u>5,714</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.84%

D. How many bed-hold days during this year were paid by the Department?

93 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

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

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1991

J. Was the facility purchased or leased after January 1, 1978?

YES Date 01/01/1991 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAAL 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 Pilot House # 0037036 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		3,740	1,846	5,586		5,586		5,586		1
2	Food Purchase		48,603		48,603		48,603		48,603		2
3	Housekeeping	21,319	3,229	243	24,791		24,791	76	24,867		3
4	Laundry		884		884		884		884		4
5	Heat and Other Utilities			15,126	15,126		15,126	219	15,345		5
6	Maintenance		1,648	2,540	4,188		4,188	3,890	8,078		6
7	Other (specify):*										7
8	TOTAL General Services	21,319	58,104	19,755	99,178		99,178	4,185	103,363		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	175,950	2,258	13,961	192,169		192,169	928	193,097		10
10a	Therapy		466	3,174	3,640		3,640		3,640		10a
11	Activities			292	292		292		292		11
12	Social Services		3,629	1,120	4,749		4,749	(874)	3,875		12
13	CNA Training	1,937		245	2,182		2,182		2,182		13
14	Program Transportation		2,895	3,894	6,789		6,789	377	7,166		14
15	Other (specify):* Day Training			145,498	145,498		145,498	(145,498)			15
16	TOTAL Health Care and Programs	177,887	9,248	171,784	358,919		358,919	(145,067)	213,852		16
	C. General Administration										
17	Administrative	24,027		5,000	29,027		29,027	4,518	33,545		17
18	Directors Fees			2,000	2,000		2,000	528	2,528		18
19	Professional Services			25,191	25,191		25,191	(23,912)	1,279		19
20	Dues, Fees, Subscriptions & Promotions			2,693	2,693		2,693	(1,050)	1,643		20
21	Clerical & General Office Expenses		1,745	3,302	5,047		5,047	8,063	13,110		21
22	Employee Benefits & Payroll Taxes			35,671	35,671		35,671	3,230	38,901		22
23	Inservice Training & Education			24	24		24		24		23
24	Travel and Seminar							41	41		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			2,882	2,882		2,882	155	3,037		26
27	Other (specify):*										27
28	TOTAL General Administration	24,027	1,745	76,763	102,535		102,535	(8,427)	94,108		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	223,233	69,097	268,302	560,632		560,632	(149,309)	411,323		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 Pilot House #0037036 Report Period Beginning: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			5,509	5,509	5,509	14,633	20,142			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			425	425	425	(425)				32
33	Real Estate Taxes			9,769	9,769	9,769	117	9,886			33
34	Rent-Facility & Grounds			38,400	38,400	38,400	(37,939)	461			34
35	Rent-Equipment & Vehicles						179	179			35
36	Other (specify):* See Pg. 25			(4,363)	(4,363)	(4,363)	4,363				36
37	TOTAL Ownership			49,740	49,740	49,740	(19,072)	30,668			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			40,814	40,814	40,814		40,814			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			40,814	40,814	40,814		40,814			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	223,233	69,097	358,856	651,186	651,186	(168,381)	482,805			45

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

Facility Name & ID Number Pilot House

0037036

Report Period Beginning: 1/1/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (145,498)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(310)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,779	30		9
10	Interest and Other Investment Income	(425)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79)	36		24
25	Fund Raising, Advertising and Promotional	(925)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	4,442	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(1,012)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (131,038)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(37,343)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (37,343)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (168,381)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Pilot House

ID# 0037036

Report Period Beginning: 1/1/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Flowers	\$ (135)	12	1
2	Gifts to Residents	(739)	12	2
3	PAC Dues	(83)	20	3
4	Chamber Dues	(55)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,012)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pilot House

0037036

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	76	0	0	0	0	0	0	0	0	0	76	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	219	0	0	0	0	0	0	0	0	0	219	5
6	Maintenance	0	310	3,580	0	0	0	0	0	0	0	0	3,890	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	605	3,580	0	0	0	0	0	0	0	0	4,185	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	928	0	0	0	0	0	0	0	0	928	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(874)	0	0	0	0	0	0	0	0	0	0	(874)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	377	0	0	0	0	0	0	0	0	0	377	14
15	Other (specify):*	(145,498)	0	0	0	0	0	0	0	0	0	0	(145,498)	15
16	TOTAL Health Care and Programs	(146,372)	377	928	0	0	0	0	0	0	0	0	(145,067)	16
	C. General Administration													
17	Administrative	0	0	4,518	0	0	0	0	0	0	0	0	4,518	17
18	Directors Fees	0	528	0	0	0	0	0	0	0	0	0	528	18
19	Professional Services	0	88	(24,000)	0	0	0	0	0	0	0	0	(23,912)	19
20	Fees, Subscriptions & Promotions	(1,073)	23	0	0	0	0	0	0	0	0	0	(1,050)	20
21	Clerical & General Office Expenses	0	1,067	6,996	0	0	0	0	0	0	0	0	8,063	21
22	Employee Benefits & Payroll Taxes	(310)	3,540	0	0	0	0	0	0	0	0	0	3,230	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	41	0	0	0	0	0	0	0	0	0	41	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	155	0	0	0	0	0	0	0	0	0	155	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,383)	5,442	(12,486)	0	0	0	0	0	0	0	0	(8,427)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(147,755)	6,424	(7,978)	0	0	0	0	0	0	0	0	(149,309)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pilot House

0037036 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	12,779	1,854	0	0	0	0	0	0	0	0	0	14,633	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(425)	0	0	0	0	0	0	0	0	0	0	(425)	32
33	Real Estate Taxes	0	117	0	0	0	0	0	0	0	0	0	117	33
34	Rent-Facility & Grounds	0	0	(37,939)	0	0	0	0	0	0	0	0	(37,939)	34
35	Rent-Equipment & Vehicles	0	0	179	0	0	0	0	0	0	0	0	179	35
36	Other (specify):*	4,363	0	0	0	0	0	0	0	0	0	0	4,363	36
37	TOTAL Ownership	16,717	1,971	(37,760)	0	(19,072)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(131,038)	8,395	(45,738)	0	(168,381)	45							

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
Jo Ann Keller	50	Mulberry Manor	Anna	kel-Tech Mgmt. Co.	Anna	Mgmt Services
James K.Keller	50	Holly Hill	Anna	JR'sCentre	Anna	Workshop
		Lincoln Square	Jonesboro	ILS 1-3	Anna	CILA
		Glen Brook	Vienna	ILS 4	Mertopolis	CILA
		Krypton	Metropolis			
		Liberty House	Marion			
		New Way	Anna			

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	3 HOUSEKEEPING	\$	kel-Tech Management Co.	25.00%	\$ 76	\$ 76 1
2	V	5 UTILITIES		kel-Tech Management Co.	25.00%	219	219 2
3	V	6 MAINTENANCE		kel-Tech Management Co.	25.00%	310	310 3
4	V	14 TRANSPORTATION		kel-Tech Management Co.	25.00%	377	377 4
5	V	18 DIRECTOR'S FEES		kel-Tech Management Co.	25.00%	528	528 5
6	V	19 PROFESSIONAL SERVICES		kel-Tech Management Co.	25.00%	88	88 6
7	V	20 DUES, FEES & SUBSCRIPTIONS		kel-Tech Management Co.	25.00%	23	23 7
8	V	21 CLERICAL & GEN. OFFICE		kel-Tech Management Co.	25.00%	1,067	1,067 8
9	V	22 EMPLOYEE BEN & TAXES		kel-Tech Management Co.	25.00%	3,540	3,540 9
10	V	24 INSERVICE TRAINING		kel-Tech Management Co.	25.00%	41	41 10
11	V	26 INSURANCE		kel-Tech Management Co.	25.00%	155	155 11
12	V	30 DEPRECIATION		kel-Tech Management Co.	25.00%	1,854	1,854 12
13	V	33 REAL ESTATE TAXES		kel-Tech Management Co.	25.00%	117	117 13
14	Total		\$			\$ 8,395	\$ * 8,395 14

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

Facility Name & ID Number Pilot House# 0037036Report Period Beginning: 1/1/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 RENT	\$	kel-Tech Management Co.	25.00%	\$ 461	\$ 461	15
16	V	35 EQUIP RENTAL		kel-Tech Management Co.	25.00%	179	179	16
17	V	10 NURSING		kel-Tech Management Co.	25.00%	928	928	17
18	V	17 ADMINISTRATION		kel-Tech Management Co.	25.00%	4,518	4,518	18
19	V	21 CLERICAL		kel-Tech Management Co.	25.00%	6,996	6,996	19
20	V	6 MAINTENANCE		kel-Tech Management Co.	25.00%	3,580	3,580	20
21	V							21
22	V	19 PROFESSIONAL SERVICES	24,000	kel-Tech Management Co.	25.00%		(24,000)	22
23	V	34 BUILDING LEASE	38,400	Pilot House Land Trust	100.00%		(38,400)	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 62,400			\$ 16,662	\$ * (45,738)	39

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

Facility Name & ID Number Pilot House # 0037036 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	Jo Ann Keller	Owner / Admin	Administrator	50.00	121,258	8	20.00	Admin	\$ 24,027	17-1	1
2	James K. Keller	Owner		50.00							2
3											3
4											4
5											5
6											6
7	kel-Tech Mgmt Co. Allocation										7
8	Diana Alley							Nursing	928	10-1	8
9	Jacob Alley							Maint.	3,487	6-1	9
10	James A. Keller							Administration	4,518	17-1	10
11											11
12											12
13								TOTAL	\$ 32,960		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 Pilot House

0037036

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

Name of Related Organization kel-Tech Mgmt Co
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contribution	374,996	10	\$ 1,192	\$ 24,000	\$ 76	1
2	5	UTILITIES ELECT/GAS-B	Mgmt Fee Contribution	374,996	10	3,077	24,000	197	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	374,996	10	349	24,000	22	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	374,996	10	537	24,000	34	4
5	6	MAINT BUILDING	Mgmt Fee Contribution	374,996	10	36	24,000	2	5
6	6	MAINTENANCE MISC-B	Mgmt Fee Contribution	374,996	10	225	24,000	14	6
7	6	MAINTENANCE SUPPLIES-B	Mgmt Fee Contribution	374,996	10	572	24,000	37	7
8	6	PREVENTATIVE MAINT-B	Mgmt Fee Contribution	374,996	10	1,964	24,000	126	8
9	6	REPAIRS BLDG-B	Mgmt Fee Contribution	374,996	10	69	24,000	4	9
10	6	REPAIRS FURN/EQUIP-B	Mgmt Fee Contribution	374,996	10	1,438	24,000	92	10
11	14	MAINTENANCE VEHICLE	Mgmt Fee Contribution	374,996	10	141	24,000	9	11
12	14	REPAIRS VEHICLES-B	Mgmt Fee Contribution	374,996	10	1,310	24,000	84	12
13	14	TRANSPORTATION-B	Mgmt Fee Contribution	374,996	10	4,445	24,000	285	13
14	18	DIRECTOR'S FEES	Mgmt Fee Contribution	374,996	10	8,250	24,000	528	14
15	19	CONTRACT SERVICES-B	Mgmt Fee Contribution	374,996	10	552	24,000	35	15
16	19	LEGAL & ACCOUNTING-B	Mgmt Fee Contribution	374,996	10	825	24,000	53	16
17	20	ADV. HELP WANTED-B	Mgmt Fee Contribution	374,996	10	25	24,000	2	17
18	20	DUES FEES SUBSCRIPTIONS-B	Mgmt Fee Contribution	374,996	10	330	24,000	21	18
19	21	EDUCATIONAL SUPPLIES-B	Mgmt Fee Contribution	374,996	10	42	24,000	3	19
20	21	BANK CHARGES-B	Mgmt Fee Contribution	374,996	10	27	24,000	2	20
21	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contribution	374,996	10	692	24,000	44	21
22	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	374,996	10	93	24,000	6	22
23	21	G & A MISC-B	Mgmt Fee Contribution	374,996	10	524	24,000	34	23
24	21	SUPPLIES STOCK	Mgmt Fee Contribution	374,996	10	415	24,000	27	24
25	TOTALS					\$ 27,127	\$	\$ 1,737	25

Facility Name & ID Number Pilot House

0037036

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

Name of Related Organization kel-Tech Mgmt Co
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	G & A SUPPLIES	Mgmt Fee Contribution	374,996	10	\$ 7,124	\$ 24,000	\$ 456	1	
2	21	POSTAGE-B	Mgmt Fee Contribution	374,996	10	2,828	24,000	181	2	
3	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	374,996	10	971	24,000	62	3	
4	21	TELEPHONE-B	Mgmt Fee Contribution	374,996	10	2,041	24,000	131	4	
5	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	374,996	10	1,506	24,000	96	5	
6	21	UTILITIES-INTERNET	Mgmt Fee Contribution	374,996	10	408	24,000	26	6	
7	22	INS EMP GROUP-B	Mgmt Fee Contribution	374,996	10	35,536	24,000	2,274	7	
8	22	INSURANCE W/C-B	Mgmt Fee Contribution	374,996	10	(559)	24,000	(36)	8	
9	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	374,996	10	20,337	24,000	1,302	9	
10	24	ADM. STAFF TRAINING	Mgmt Fee Contribution	374,996	10	643	24,000	41	10	
11	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	374,996	10	1,181	24,000	76	11	
12	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	374,996	10	1,234	24,000	79	12	
13	30	DEPRECIATION-B	Mgmt Fee Contribution	374,996	10	2,489	24,000	159	13	
14	30	DEPREC Sect 179	Mgmt Fee Contribution	374,996	10	26,475	24,000	1,694	14	
15	32	LEASE EQUIP-B	Mgmt Fee Contribution	374,996	10	2,795	24,000	179	15	
16	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	374,996	10	1,832	24,000	117	16	
17	34	LEASE BLDG-B	Mgmt Fee Contribution	374,996	10	7,200	24,000	461	17	
18	10	NURSING	Mgmt Fee Contribution	374,996	10	14,502	14,502	24,000	928	18
19	17	ADMINISTRATION	Mgmt Fee Contribution	374,996	10	70,587	70,587	24,000	4,518	19
20	21	CLERICAL	Mgmt Fee Contribution	374,996	10	109,315	109,315	24,000	6,996	20
21	6	MAINTENANCE	Mgmt Fee Contribution	374,996	10	55,944	55,944	24,000	3,580	21
22									22	
23									23	
24									24	
25	TOTALS					\$ 364,389	\$ 250,348	\$ 23,320	25	

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Southern Trust Bank		x	Vehicle Loan	\$1,004.42	1285/05	\$ 22,215	\$	12/5/07	7.0000	\$ 425	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$1,004.42		\$ 22,215	\$			\$ 425	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 22,215	\$			\$ 425	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.)

Facility Name & ID Number Pilot House

0037036 Report Period Beginning: 1/1/07

Ending: 12/31/07

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	7,713	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.)			\$	8,528	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	815	3														
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	8,954	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.			\$	9,769	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:																			
	2002	<u>6,199</u>	<u>8</u>	<table border="1"> <tr> <td colspan="2">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		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
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																	
	2003	<u>7,512</u>	<u>9</u>																
	2004	<u>7,720</u>	<u>10</u>																
	2005	<u>7,867</u>	<u>11</u>																
	2006	<u>8,528</u>	<u>12</u>																
<u>Sch. IX, Line 7</u>		<u>9769</u>																	
<u>kel-Tech Mgmt. Co. Alloc.</u>		<u>117</u>																	
<u>Sch. V, Line 33, Col. 8</u>		<u>9886</u>																	

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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 Pilot House COUNTY Alexander

FACILITY IDPH LICENSE NUMBER 0037036

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE (618) 833-5070 FAX #: (618) 833-4993

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>01-01-01-032-001</u>	<u>Lots 1-12, Lots 37&38 Blk 47 City of t</u>	<u>\$ 8,527.96</u>	<u>\$ 8,527.96</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 8,527.96	\$ 8,527.96

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 Pilot House

0037036

Report Period Beginning:

1/1/07

Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior Vinyl/Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Healthcare</u>	<u>10,000</u>	<u>1987</u>	<u>\$ 16,000</u>	1
2					2
3	TOTALS	10,000		\$ 16,000	3

Facility Name & ID Number Pilot House

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	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	
4	16		1988	1988	\$ 269,543	\$	31.5	\$ 8,558	\$ 8,558	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Sprinkler Compressor		1998	639	43	15	43		408	9
10		Vinyl Floor		2001	918		7	131	131	918	10
11		Security Alarm System		2003	700		7	100	100	700	11
12		Roof		2003	7,000	327	15	467	140	3,571	12
13		4 Emergency Lights		2004	395		7	56	56	395	13
14		Carpet & Tile Flooring		2004	8,211		7	1,173	1,173	8,211	14
15		Heating Unit		2005	1,754	307	7	251	(56)	988	15
16		Security Alarm Panel		2006	500		7	71	71	500	16
17		Hot Water heater		2006	645	43	15	92	49	64	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Pilot House

0037036

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 290,305	\$ 720		\$ 10,942	\$ 10,222	\$ 15,755	70

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

Facility Name & ID Number Pilot House # 0037036 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 8,144	\$ 544	\$ 544	\$	15	\$ 2,892	71
72	Current Year Purchases	6,054	4,245	430	(3,815)	7	4,245	72
73	Fully Depreciated Assets	17,298		1,929	1,929	7	17,298	73
74								74
75	TOTALS	\$ 31,496	\$ 4,789	\$ 2,903	\$ (1,886)		\$ 24,435	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	Healthcare	1995 Ford Windstar	995	\$ 20,720	\$	\$	\$	5	\$ 20,720	76
77	Healthcare	2001 Ford E350 Van	2001	27,655				5	27,655	77
78	Healthcare	2005 Chev. Trail Blazer	2005	22,215		4,443	4,443	5	22,215	78
79										79
80	TOTALS			\$ 70,590	\$	\$ 4,443	\$ 4,443		\$ 70,590	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)	\$ 408,391	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,509	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,288	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,779	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 110,780	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party

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

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	\$ _____

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: \$ 0 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

* 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
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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)		260		260
4	Clinical Wages (b)		506		506
5	In-House Trainer Wages (c)		1,225		1,225
6	Transportation				
7	Contractual Payments		245		245
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,236	\$	\$ 2,236
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,236		

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	<u>1</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

- (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.

Facility Name & ID Number Pilot House# 0037036

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Pilot House # 0037036 Report Period Beginning: 1/1/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 98,338	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	160,080		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	434,000		8
9	Other(specify): <u>Interest Receivable</u>	808		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 693,226	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	20,762		15
16	Equipment, at Historical Cost	102,085		16
17	Accumulated Depreciation (book methods)	(110,779)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,068	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 705,294	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 19,323	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,192		30
31	Accrued Taxes Payable (excluding real estate taxes)	973		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,954		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 39,442	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 39,442	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 665,852	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 705,294	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 614,496	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 614,496	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	51,356	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)	\$ 51,356	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)	\$ 665,852	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pilot House

0037036

Report Period Beginning: 1/1/07

Ending: 12/31/07

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	\$ 553,671	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 553,671	3
B. Ancillary Revenue			
4	Day Care	145,498	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 145,498	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,562	11
12	Gift and Coffee Shop	553	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,115	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,258	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,258	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 702,542	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	99,178	31
32	Health Care	358,919	32
33	General Administration	102,535	33
B. Capital Expense			
34	Ownership	49,740	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	40,814	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 651,186	40
41	Income before Income Taxes (line 30 minus line 40)**	51,356	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 51,356	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Pilot House

0037036

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				1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers	2,005	2,149	24,297	11.31
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	1,997	2,093	21,319	10.19
19	Laundry				19
20	Administrator	416	416	24,027	57.76
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,167	1,215	21,892	18.02
29	Resident Services Coordinator	778	810	14,594	18.02
30	Habilitation Aides (DD Homes)	13,270	13,649	117,104	8.58
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	19,633	20,332	\$ 223,233 *	\$ 10.98

* 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	41	\$ 1,846	1-3	35
36	Medical Director	36	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	337	11,800	10-3	38
39	Pharmacist Consultant	12	460	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	525	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	32	1,120	12-3	45
46	Other(specify) <u>Dental Consultant</u>	16	1,200	10-3	46
47	<u>Administrator Consultant</u>	167	5,000	17-3	47
48	<u>Psychologist</u>	40	1,811	10a-3	48
49	TOTAL (lines 35 - 48)	689	\$ 27,362		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number Pilot House

0037036

Report Period Beginning: 1/1/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jo Ann Keller	ADM	50	\$ 24,027	Workers' Compensation Insurance	\$ 5,252	IDPH License Fee	\$	
				Unemployment Compensation Insurance	1,901	Advertising: Employee Recruitment		
				FICA Taxes	16,322	Health Care Worker Background Check	32	
				Employee Health Insurance	11,886	(Indicate # of checks performed <u>2</u>)		
				Employee Meals	310	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		See Pg. 25	1,588	
				Less:		kel-Tech Mgmt Allocation	23	
				Staff Meals	(310)	Less: Public Relations Expense	()	
				kel-Tech Mgmt Allocation	3,540	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 24,027	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 38,901		\$ 1,643		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Cheryl Sherrill, ADM Consultant			\$ 5,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 5,000	TOTAL		\$	Seminar Expense	
(Attach a copy of any management service agreement)							kel-Tech Mgmt Allocation	41
C. Professional Services								
Vendor/Payee	Type	Amount						
Barnett & Levine	CPA	\$ 1,150					Entertainment Expense ()	
FMGR	Legal Services	41					(agree to Sch. V, line 24, col. 8)	
kel-Tech Management	Accting Services	24,000					TOTAL	
							\$ 41	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 25,191					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pilot House

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. IL Healthcare Assoc. \$957
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 556 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. _____
- (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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Pilot House #337871 1/1991
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,814
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? N/A
- (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. \$ 310 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. Not required of this facility
- (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.

Related Parties Schedule VII
 Owners Compensation
 Jan 1, 2007 - Dec 31, 2007

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 114,498	31,229							43,269		40,000
Denise Pippins	\$ 26,029	26,029	-								
Diana Alley	\$ 70,774	18,781	14,502		14,976		22,515				
Jo Ann Keller	\$ 145,285				121,258	24,027					
James K. Keller	\$ 14,400				14,400						
Jacob Alley	\$ -										
Jake Alley	\$ 54,488		54,488								
James A. Keller	\$ 81,420		70,587							10,833	
	\$ 506,895	\$ 76,039	\$ 139,578	\$ -	\$ 150,634	\$ 24,027	\$ 22,515	\$ -	\$ 43,269	\$ 10,833	\$ 40,000

Pilot House, Inc
Analysis of Sch. V, Line 20, Col. 8
2007

Advertising	\$ 925
Contributions	10
Resident fund Bond Renewal	240
Subscriptions	265
IL Healthcare Assoc Dues	957
PAC Dues	83
Chamber Dues	55
PO Box Fee	
Corp. Ann. Report	126
Less:	
Advertising	(925)
Contributions	(10)
PAC Dues	(83)
Chamber Dues	(55)
Total	<u>\$ 1,588</u>

Pilot House
Analysis of Sch. V, Line 36, Col. 4
2007

Bad Debt	\$ 79
State Income Tax	(4,442)
Total	<u>\$ (4,363)</u>

Pilot House
Analysis of Depreciation
2007

Sch IX, Line 83	\$ 18,288
kel-Tech Mgmt Allocation	1,854
Sch. V, Line 30, Col. 8	<u>\$ 20,142</u>
