

		FOR BHF USE				

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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.

<p>I. IDPH License ID Number: <u>0047944</u></p> <p>Facility Name: <u>Pittsfield Manor</u></p> <p>Address: <u>610 Lowry Street</u> <u>Pittsfield</u> <u>62363</u> Number City Zip Code</p> <p>County: <u>Pike</u></p> <p>Telephone Number: <u>(800) 373-5202</u> Fax # <u>(217) 285-5212</u></p> <p>HFS ID Number: <u>36-4560807001</u></p> <p>Date of Initial License for Current Owners: <u>04/26/06</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501(c)(3)</u>	<input 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	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/07</u> to <u>9/30/08</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date)</td> </tr> <tr> <td>(Type or Print Name) <u>Tim Bledsoe</u></td> </tr> <tr> <td></td> <td>(Title) <u>Director of Operations</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>See Attached Independent Accountant's Report</u> (Date)</td> </tr> <tr> <td>(Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main St., Suite 210</u></td> </tr> <tr> <td>(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u></td> </tr> <tr> <td>(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ (Date)	(Type or Print Name) <u>Tim Bledsoe</u>		(Title) <u>Director of Operations</u>	Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Date)	(Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main St., Suite 210</u>	(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u>	(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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Facility Name & ID Number Pittsfield Manor# 0047944 Report Period Beginning: 10/01/07 Ending: 9/30/08

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 N/A

	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	89	Skilled (SNF)	89	32,574	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	89	TOTALS	89	32,574	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	14,653	9,903	
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	14,653	9,903	4,518	29,074	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.26%D. How many bed-hold days during this year were paid by the Department?
0 (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)
NoneF. Does the facility maintain a daily midnight census? YesG. 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 4/26/06J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/06 NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 89 and days of care provided 4,518Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 09/30/08 Fiscal Year: 09/30/08

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

Facility Name & ID Number Pittsfield Manor # 0047944 Report Period Beginning: 10/01/07 Ending: 9/30/08

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs 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
A. General Services											
1	Dietary	234,250	26,069	3,889	264,208		264,208	(40,438)	223,770		1
2	Food Purchase		249,833		249,833		249,833	(38,706)	211,127		2
3	Housekeeping	129,420	39,999		169,419		169,419	(33,578)	135,841		3
4	Laundry	37,837	28,964		66,801		66,801	(13,239)	53,562		4
5	Heat and Other Utilities			115,988	115,988		115,988	(21,850)	94,138		5
6	Maintenance	66,992	54,192	47,102	168,286		168,286	(33,355)	134,931		6
7	Other (specify):*										7
8	TOTAL General Services	468,499	399,057	166,979	1,034,535		1,034,535	(181,166)	853,369		8
B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,469,768	187,493	1,940	1,659,201		1,659,201		1,659,201		10
10a	Therapy			336,430	336,430		336,430	(235,104)	101,326		10a
11	Activities	54,799	6,917	14	61,730		61,730	(23,891)	37,839		11
12	Social Services	16,184			16,184		16,184		16,184		12
13	CNA Training			11,370	11,370		11,370		11,370		13
14	Program Transportation			2,803	2,803	2,850	5,653		5,653		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,540,751	194,410	358,557	2,093,718	2,850	2,096,568	(258,995)	1,837,573		16
C. General Administration											
17	Administrative	101,887			101,887		101,887		101,887		17
18	Directors Fees							2,482	2,482		18
19	Professional Services			265,485	265,485		265,485	1,964	267,449		19
20	Dues, Fees, Subscriptions & Promotions			64,526	64,526		64,526	(52,108)	12,418		20
21	Clerical & General Office Expenses	47,221	33,850	31,954	113,025		113,025	(1,931)	111,094		21
22	Employee Benefits & Payroll Taxes			373,032	373,032		373,032	(56,562)	316,470		22
23	Inservice Training & Education			1,848	1,848		1,848		1,848		23
24	Travel and Seminar			2,772	2,772		2,772	(1,002)	1,770		24
25	Other Admin. Staff Transportation			5,700	5,700	(2,850)	2,850	(64)	2,786		25
26	Insurance-Prop.Liab.Malpractice			46,374	46,374		46,374	20,847	67,221		26
27	Other (specify):* <u>See Att Sch VI</u>	27,162		13,370	40,532		40,532	(40,532)			27
28	TOTAL General Administration	176,270	33,850	805,061	1,015,181	(2,850)	1,012,331	(126,906)	885,425		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,185,520	627,317	1,330,597	4,143,434		4,143,434	(567,067)	3,576,367		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

Pittsfield Manor

#0047944

Report Period Beginning:

10/01/07

Ending:

9/30/08

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			19,337	19,337		19,337	158,759	178,096			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							259,888	259,888			32
33	Real Estate Taxes							52,800	52,800			33
34	Rent-Facility & Grounds			539,052	539,052		539,052	(539,052)				34
35	Rent-Equipment & Vehicles			494	494		494		494			35
36	Other (specify):* See Att Sch V							6,173	6,173			36
37	TOTAL Ownership			558,883	558,883		558,883	(61,432)	497,451			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			17,313	17,313		17,313		17,313			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			6,154	6,154		6,154		6,154			41
42	Provider Participation Fee			48,862	48,862		48,862		48,862			42
43	Other (specify):*			200	200		200		200			43
44	TOTAL Special Cost Centers			72,529	72,529		72,529		72,529			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,185,520	627,317	1,962,009	4,774,846		4,774,846	(628,499)	4,146,347			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 **Pittsfield Manor**

0047944

Report Period Beginning: **10/01/07**

Ending: **9/30/08**

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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		V-30		9
10	Interest and Other Investment Income	(1,464)	V-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		V-27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,348)	V-27		24
25	Fund Raising, Advertising and Promotional	(50,999)	V-20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule See Att Sch VII	(662,123)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (725,934)		\$	30

BHF USE ONLY							
48		49		50		51	52

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)	90,791		34
35	Other- Attach Schedule See Att Sch III	6,644		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 97,435		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (628,499)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Pittsfield Manor

ID# 0047944

Report Period Beginning: 10/01/07

Ending: 9/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			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	0	49

Facility Name & ID Number Pittsfield Manor

0047944

Report Period Beginning: 10/01/07

Ending: 9/30/08

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
None	N/A	See Attached Schedule I		See Attached Schedule I		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Facility rent	\$ 539,052	Pittsfield Lowry, LLC	N/A	\$ 629,843	\$	90,791	1
2	V								2
3	V								3
4	V								4
5	V			See Att Schedule 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		\$ 539,052			\$ 629,843	\$ *	90,791	14

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

Facility Name & ID Number Pittsfield Manor # 0047944 Report Period Beginning: 10/01/07 Ending: 9/30/08

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	See Attached Schedule II & III								\$ 2,482	18-7	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	\$ 2,482		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 Pittsfield Manor # 0047944 Report Period Beginning: 10/01/07 Ending: 9/30/08

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 Unlimited Development, Inc.
 Street Address 285 S Farnham
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-1550
 Fax Number (309) 343-2857

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					\$	\$		\$	1
2	See Att Schedule II & III							6,644	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				\$	\$		\$	6,644

Facility Name & ID Number Pittsfield Manor # 0047944 Report Period Beginning: 10/01/07 Ending: 9/30/08

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Realty Capital						\$	\$			\$	1
2	LTD. Of Illinois		X	facility purchase	\$26,010.00	04/01/06	4,557,600	4,444,160	05/01/39	5.8500	261,352	2
3				SNF portion								3
4												4
5												5
	Working Capital											
6	Miscellaneous		X									6
7	Less Interest Income										(1,464)	7
8												8
9	TOTAL Facility Related				\$26,010.00		\$ 4,557,600	\$ 4,444,160			\$ 259,888	9
	B. Non-Facility Related*											
10	Cambridge Realty Capital											10
11	LTD. Of Illinois		X	facility purchase	\$6,502.00	04/01/06	1,139,400	1,111,040	05/01/39	5.8500		11
12				ALC portion							65,338	12
13												13
14	TOTAL Non-Facility Related				\$6,502.00		\$ 1,139,400	\$ 1,111,040			\$ 65,338	14
15	TOTALS (line 9+line14)						\$ 5,697,000	\$ 5,555,200			\$ 325,226	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 27,920 Line # 26

* 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 **Pittsfield Manor**

0047944 Report Period Beginning: **10/01/07** Ending: **9/30/08**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2007 report.		\$ 81,363	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.)		\$ 98,955	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ 17,592	3																																	
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 48,408	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.		\$ 66,000	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>N/A</td><td>8</td></tr> <tr><td>2004</td><td>N/A</td><td>9</td></tr> <tr><td>2005</td><td>N/A</td><td>10</td></tr> <tr><td>2006</td><td>63,605</td><td>11</td></tr> <tr><td>2007</td><td>67,152</td><td>12</td></tr> </table>	2003	N/A	8	2004	N/A	9	2005	N/A	10	2006	63,605	11	2007	67,152	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2007	\$	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	N/A	8																																		
2004	N/A	9																																		
2005	N/A	10																																		
2006	63,605	11																																		
2007	67,152	12																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
<p>This facility was purchased from unrelated for-profit entity during 2006. A tax exemption has not yet been obtained.</p> <p>Amt accrued: estimated 9 mo. Accrual, based on 2007 bill. Real estate taxes reported on Sch V line 33 have been reduced by an allocation of expenses relating to ALC services based on an estimate of 20%. See Att Sch VII.</p> <p>PY report accrual differs from 2007 cost report due to adj made after filing. CY pymt: entire amt for CY and 1/2 PY.</p>																																				

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: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pittsfield Manor COUNTY Pike

FACILITY IDPH LICENSE NUMBER 0047944

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. <u>54-130-01</u>	<u>RNG/BLK:2 TWP:54</u>	\$ <u>65,561.00</u>	\$ <u>52,489.00</u>
2. _____	<u>SECT/LOT:3 PT LOT 1,2,3 EX. SW</u>	\$ _____	\$ _____
3. _____	<u>COR 2 NORRIS SD E SIDE SEC</u>	\$ _____	\$ _____
4. _____	<u>25-PITTSF</u>	\$ _____	\$ _____
5. _____	<u>TD041006B723P127#06-1203</u>	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. <u>54-129-13</u>	<u>RNG/BLK:2 TWP:54 SEC/LOT:4</u>	\$ <u>1,591.00</u>	\$ <u>1,273.00</u>
8. _____	<u>PT LOT 1,2,3 AND PT LOT 4</u>	\$ _____	\$ _____
9. _____	<u>N OF LOWRY ST BLK2</u>	\$ _____	\$ _____
10. <u>See Att Sch VII</u>	<u>NORRIS SD E SIDE SEC 25-PITTSI</u>	\$ _____	\$ _____
TOTALS		\$ <u>67,152.00</u>	\$ <u>53,762.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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 Pittsfield Manor# 0047944 Report Period Beginning:10/01/07 Ending:9/30/08**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 41,400 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. 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 ground (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)

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility- SNF</u>	<u>2.6 Acres</u>	<u>2006</u>	<u>\$ 144,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 144,000	3

Facility Name & ID Number Pittsfield Manor

0047944

Report Period Beginning:

10/01/07

Ending:

9/30/08

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	89	2006	1990	\$ 5,262,410	\$ 131,560	40	\$ 131,560		\$ 328,900	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Landscaping	2006		4,720	472	10	472		1,180	9
10	Water Heater	2008		3,690	215	10	215		215	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

*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

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			\$	\$		\$	\$	\$		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)		\$ 5,270,820	\$ 132,247		\$ 132,247	\$	\$ 330,295		70

**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	\$ 325,633	\$ 33,210	\$ 33,210	\$	3-12 yrs	\$ 81,174	71
72	Current Year Purchases	37,191	4,467	4,467		3-15 yrs	4,467	72
73	Fully Depreciated Assets							73
74	Indirect costs		710	710				74
75	TOTALS	\$ 362,824	\$ 38,387	\$ 38,387	\$		\$ 85,641	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	Patient Care	2003 GMC G3500 Van	2006	\$ 29,848	\$ 7,462	\$ 7,462	\$	4	\$ 15,546	76
77										77
78										78
79										79
80	TOTALS			\$ 29,848	\$ 7,462	\$ 7,462	\$		\$ 15,546	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,807,492	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 178,096	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,096	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)	\$ 431,482	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	2006 Toyota Corolla	\$ 14,900	\$ 3,725	\$ 8,692	86
87	Land ALC-2006	36,000			87
88	Facility ALC- 2006	1,315,602	32,890	82,225	88
89					89
90					90
91	TOTALS	\$ 1,366,502	\$ 36,615	\$ 90,917	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: _____

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:			\$ See Attached			3
4	Additions			Schedule V			4
5				Related Party			5
6				Lease			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. _____ /2009 \$ N/A

13. _____ /2010 \$ N/A

14. _____ /2011 \$ N/A

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 N/A N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 494 Description: See Attached Schedule XIII

(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.

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 type="checkbox"/> YES <input checked="" 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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

- (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 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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	Other (specify):													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.

STATE OF ILLINOIS

Facility Name & ID Number Pittsfield Manor

0047944

Report Period Beginning: 10/01/07

Ending:

9/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/08

(last day of reporting year)

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	\$ 139,288	\$ 266,417	1
2	Cash-Patient Deposits	9,910	9,910	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 48,842)	1,765,200	1,765,200	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,596	77,814	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VIII	216,471	246,939	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,186,465	\$ 2,366,280	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		6,578,012	14
15	Leasehold Improvements, at Historical Cost	8,410	8,410	15
16	Equipment, at Historical Cost	105,439	407,572	16
17	Accumulated Depreciation (book methods)	(35,740)	(522,399)	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): See Att Sch VIII	80,415	633,365	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 158,524	\$ 7,284,960	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,344,989	\$ 9,651,240	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 89,651	\$ 93,629	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,910	9,910	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,081	50,081	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,465	7,465	31
32	Accrued Real Estate Taxes(Sch.IX-B)		48,408	32
33	Accrued Interest Payable		27,082	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>	1,272,631	3,240,491	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,429,738	\$ 3,477,066	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,555,200	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security deposits</u>	41,200	41,200	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 41,200	\$ 5,596,400	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,470,938	\$ 9,073,466	46
47	TOTAL EQUITY(page 18, line 24)	\$ 874,051	\$ 577,774	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,344,989	\$ 9,651,240	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 755,878	1
2	Restatements (describe):		2
3	See Att Schedule XI	(80,854)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 675,024	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	199,027	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)	\$ 199,027	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)	\$ 874,051	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Pittsfield Manor

0047944

Report Period Beginning: 10/01/07

Ending:

Page 19
9/30/08

VII. 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	\$ 4,800,587	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,800,587	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,342	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 149,342	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	5,133	12
13	Barber and Beauty Care	6,682	13
14	Non-Patient Meals	665	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	225	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)	\$ 12,705	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,464	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,464	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	8,700	28
28a	See Att Schedule XII	1,075	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,775	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,973,873	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,034,535	31
32	Health Care	2,093,718	32
33	General Administration	1,015,181	33
B. Capital Expense			
34	Ownership	558,883	34
C. Ancillary Expense			
35	Special Cost Centers	23,667	35
36	Provider Participation Fee	48,862	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,774,846	40
41	Income before Income Taxes (line 30 minus line 40)**	199,027	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 199,027	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Pittsfield Manor

0047944

Report Period Beginning: 10/01/07

Ending: 9/30/08

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	1,946	2,093	\$ 51,313	\$ 24.52	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,202	5,593	115,109	20.58	3
4	Licensed Practical Nurses	15,773	16,960	259,997	15.33	4
5	CNAs & Orderlies	93,214	100,230	935,146	9.33	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	5,989	6,439	54,799	8.51	10
11	Social Service Workers	1,584	1,704	16,184	9.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,644	26,499	234,250	8.84	15
16	Dishwashers					16
17	Maintenance Workers	5,105	5,489	66,992	12.20	17
18	Housekeepers	14,143	15,200	129,420	8.51	18
19	Laundry	4,355	4,685	37,837	8.08	19
20	Administrator	1,934	2,080	71,595	34.42	20
21	Assistant Administrator	1,878	2,019	30,292	15.00	21
22	Other Administrative	1,943	2,089	27,162	13.00	22
23	Office Manager					23
24	Clerical	4,439	4,773	47,221	9.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,928	2,073	24,874	12.00	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,897	2,040	17,340	8.50	31
32	Other Health Care(specify)	3,959	4,257	65,989	15.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,933	204,223	\$ 2,185,520 *	\$ 10.70	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	***	\$ 3,889	1-3	35
36	Medical Director	***	6,000	9-3	36
37	Medical Records Consultant	***	440	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,500	10-3	39
40	Physical Therapy Consultant	***	169,523	10a-3	40
41	Occupational Therapy Consultant	***	143,943	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	22,964	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) <u>Dental Consultants</u>	***	0	10-3	46
47					47
48	*** Monthly fee				48
49	TOTAL (lines 35 - 48)		\$ 348,259		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

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	
Vickie Summers	Administrator	None	\$ 71,595	Workers' Compensation Insurance	\$ 49,277	IDPH License Fee	\$ 0	
Angie Fundel-Baker	Asst Admin	None	30,292	Unemployment Compensation Insurance	6,169	Advertising: Employee Recruitment	1,206	
				FICA Taxes	160,882	Health Care Worker Background Check	350	
				Employee Health Insurance	122,970	(Indicate # of checks performed <u>35</u>)	0	
				Employee Meals		Patient Background Checks	52	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promotion	50,999	
				401(k)	23,566	Subscriptions	7,327	
				Other Employee Benefits	10,168	IHCA Dues	3,153	
						Other Licenses & Fees	964	
						Ind Costs-Att Sch III, ALC- Att Sch VII	(1,109)	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(50,999)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,887			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,418	
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Staff use of personal vehicle on facility business and meals (uner \$250 per travel voucher	0
							Seminar Expense	2,772
							Less: non-allowable out-of-state travel	(1,002)
							Indirect costs - See Att Sch III	0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 1,770
C. Professional Services			Amount					
Vendor/Payee	Type							
RFMS, Inc.	Administrative Services		\$ 132,000					
McGladrey & Pullen, LLP	Accounting Services		13,830					
LTC Support Services, LLC	Support Services		112,080					
Management Performance Assoc.	Demand Analysis Services		7,575					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 265,485					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pittsfield Manor# 0047944Report Period Beginning: 10/01/07Ending: 9/30/08**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. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political organization? Yes - IHCA dues 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? N/A
- (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? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,973 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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,862
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 benefit: on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, 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. Audit not yet completed
- (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.