

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</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>4,947</u>			<u>4,947</u>
14	TOTALS	<u>4,947</u>			<u>4,947</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.48%

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

91 (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 08/02/1991

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

YES Date 03/08/1999 NO

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

YES NO If YES, enter number
of beds certified 0 and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2008 Fiscal Year: 06/30/2008

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

Facility Name & ID Number TAYLORVILLE TERRACE

0047795

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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	23,448	2,205	2,180	27,833		27,833		27,833			1
2	Food Purchase		20,050		20,050		20,050		20,050			2
3	Housekeeping		2,893		2,893		2,893	240	3,133			3
4	Laundry		1,115	80	1,195		1,195		1,195			4
5	Heat and Other Utilities			13,045	13,045		13,045	924	13,969			5
6	Maintenance	9,251		7,120	16,371		16,371	412	16,783			6
7	Other (specify):*											7
8	TOTAL General Services	32,699	26,263	22,425	81,387		81,387	1,576	82,963			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	164,360	8,535	4,269	177,164		177,164	(507)	176,657			10
10a	Therapy											10a
11	Activities		3,127		3,127		3,127		3,127			11
12	Social Services			3,168	3,168		3,168		3,168			12
13	CNA Training	7,456	100		7,556		7,556		7,556			13
14	Program Transportation			1,754	1,754		1,754		1,754			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	171,816	11,762	13,991	197,569		197,569	(507)	197,062			16
	C. General Administration											
17	Administrative	12,687			12,687		12,687	38,455	51,142			17
18	Directors Fees			2,575	2,575		2,575	(116)	2,459			18
19	Professional Services			7,010	7,010		7,010	330	7,340			19
20	Dues, Fees, Subscriptions & Promotions			2,972	2,972		2,972	380	3,352			20
21	Clerical & General Office Expenses		2,297	7,416	9,713		9,713	1,445	11,158			21
22	Employee Benefits & Payroll Taxes			33,725	33,725		33,725	6,871	40,596			22
23	Inservice Training & Education			4,819	4,819		4,819	1,985	6,804			23
24	Travel and Seminar			693	693		693	238	931			24
25	Other Admin. Staff Transportation			1,316	1,316		1,316		1,316			25
26	Insurance-Prop.Liab.Malpractice			9,131	9,131		9,131	1,146	10,277			26
27	Other (specify):*											27
28	TOTAL General Administration	12,687	2,297	69,657	84,641		84,641	50,734	135,375			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	217,202	40,322	106,073	363,597		363,597	51,803	415,400			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 TAYLORVILLE TERRACE

#0047795

Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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				28,737	28,737	1,931	30,668			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			48,416	48,416	48,416	(8,215)	40,201			32
33	Real Estate Taxes			4,254	4,254	4,254		4,254			33
34	Rent-Facility & Grounds						1,507	1,507			34
35	Rent-Equipment & Vehicles						79	79			35
36	Other (specify):*										36
37	TOTAL Ownership			52,670	81,407	81,407	(4,698)	76,709			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			35,604	35,604	35,604		35,604			42
43	Other (specify):*			164,514	164,514	164,514	(164,514)				43
44	TOTAL Special Cost Centers			200,118	200,118	200,118	(164,514)	35,604			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	217,202	40,322	358,861	645,122	645,122	(117,409)	527,713			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 TAYLORVILLE TERRACE

0047795

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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	\$ (138,514)	43	\$	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				9
10	Interest and Other Investment Income	(7,001)	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	(42)	32		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	(27,410)	43		18
19	Entertainment				19
20	Contributions	(1,391)	32		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,000)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (175,358)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (175,358)		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

BHF USE ONLY						
48		49		50		51
						52

TAYLORVILLE TERRACE

ID# 0047795

Report Period Beginning: 07/01/2007

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAYLORVILLE TERRACE

0047795

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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	0	0	0	0	0	42	19	60	70	49	240	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	144	68	202	401	109	924	5
6	Maintenance	0	0	0	0	0	0	42	39	115	127	89	412	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	228	126	377	598	247	1,576	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	(362)	4	(38)	157	(268)	(507)	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	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	(362)	4	(38)	157	(268)	(507)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	6,546	3,104	9,676	13,469	5,660	38,455	17
18	Directors Fees	0	(5)	(5)	(20)	(44)	(42)	0	0	0	0	0	(116)	18
19	Professional Services	0	55	219	(4)	40	20	0	0	0	0	0	330	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	4	16	280	76	4	380	20
21	Clerical & General Office Expenses	0	7	18	3	13	10	259	101	384	405	245	1,445	21
22	Employee Benefits & Payroll Taxes	0	0	0	6	1	1	901	619	1,852	2,386	1,105	6,871	22
23	Inservice Training & Education	0	3	0	2	2	2	392	142	515	540	387	1,985	23
24	Travel and Seminar	0	0	0	0	0	0	0	56	153	0	29	238	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	0	0	0	0	0	196	95	285	372	198	1,146	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	60	232	(13)	12	(9)	8,298	4,133	13,145	17,248	7,628	50,734	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	60	232	(13)	12	(9)	8,164	4,263	13,484	18,003	7,607	51,803	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795

Report Period Beginning:

07/01/2007 Ending:06/30/2008

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	0	0	0	0	0	0	341	173	512	702	203	1,931	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,434)	0	0	0	2	(58)	48	23	68	8	128	(8,215)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	247	121	375	475	289	1,507	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	20	0	20	20	19	79	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,434)	0	0	0	2	(58)	656	317	975	1,205	639	(4,698)	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):*	(166,924)	0	0	0	0	0	116	129	886	862	417	(164,514)	43
44	TOTAL Special Cost Centers	(166,924)	0	0	0	0	0	116	129	886	862	417	(164,514)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(175,358)	60	232	(13)	14	(67)	8,936	4,709	15,345	20,070	8,663	(117,409)	45

Facility Name & ID Number TAYLORVILLE TERRACE

0047795

Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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
<u>PROGRESSIVE HOUSING, INC.</u>	<u>100</u>	<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		
<u>SEE ATTACHED SCHEDULE 7A</u>						

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	<u>18 BOARD FEES</u>	\$ <u>446</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	\$ <u>441</u>	\$ <u>(5)</u>	1
2	V	<u>19 PROFESSIONAL FEES</u>	<u>431</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>486</u>	<u>55</u>	2
3	V	<u>20 LICENSE, DUES</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			3
4	V	<u>21 GENERAL OFFICE</u>	<u>224</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>231</u>	<u>7</u>	4
5	V	<u>23 INSERVICE TRAVEL</u>	<u>46</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>49</u>	<u>3</u>	5
6	V	<u>32 INTEREST</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			6
7	V	<u>32 INTEREST INCOME</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			7
8	V	<u>22 EMPLOYEE BENEFITS</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>1,147</u>			\$ <u>1,207</u>	\$ * <u>60</u>	14

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008**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	18 BOARD FEES	\$ 178	PROGRESSIVE HOUSING, INC.	100.00%	\$ 173	\$ (5)	15	
16	V	19 PROFESSIONAL FEES	2,086	PROGRESSIVE HOUSING, INC.	100.00%	2,305	219	16	
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17	
18	V	21 GENERAL OFFICE	178	PROGRESSIVE HOUSING, INC.	100.00%	196	18	18	
19	V	23 INSERVICE TRAVEL	14	PROGRESSIVE HOUSING, INC.	100.00%	14		19	
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20	
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21	
22	V	22 EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%			22	
23	V							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		\$ 2,456			\$ 2,688	\$ *	232	39

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008**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	18 BOARD FEES	\$ 401	PROGRESSIVE HOUSING, INC.	100.00%	\$ 381	\$ (20)	15	
16	V	19 PROFESSIONAL FEES	1,588	PROGRESSIVE HOUSING, INC.	100.00%	1,584	(4)	16	
17	V	20 LICENSE, DUES	1	PROGRESSIVE HOUSING, INC.	100.00%	1		17	
18	V	21 GENERAL OFFICE	370	PROGRESSIVE HOUSING, INC.	100.00%	373	3	18	
19	V	23 INSERVICE TRAVEL	165	PROGRESSIVE HOUSING, INC.	100.00%	167	2	19	
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20	
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21	
22	V	22 EMPLOYEE BENEFITS	259	PROGRESSIVE HOUSING, INC.	100.00%	265	6	22	
23	V							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		\$ 2,784			\$ 2,771	\$ *	(13)	39

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008**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	18 BOARD FEES	\$ 896	PROGRESSIVE HOUSING, INC.	100.00%	\$ 852	\$ (44)	15
16	V	19 PROFESSIONAL FEES	2,244	PROGRESSIVE HOUSING, INC.	100.00%	2,284	40	16
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17
18	V	21 GENERAL OFFICE	683	PROGRESSIVE HOUSING, INC.	100.00%	696	13	18
19	V	23 INSERVICE TRAVEL	104	PROGRESSIVE HOUSING, INC.	100.00%	106	2	19
20	V	32 INTEREST	77	PROGRESSIVE HOUSING, INC.	100.00%	79	2	20
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21
22	V	22 EMPLOYEE BENEFITS	16	PROGRESSIVE HOUSING, INC.	100.00%	17	1	22
23	V							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		\$ 4,020			\$ 4,034	\$ *	14 39

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008**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	18 BOARD FEES	\$ 654	PROGRESSIVE HOUSING, INC.	100.00%	\$ 612	\$ (42)	15	
16	V	19 PROFESSIONAL FEES	661	PROGRESSIVE HOUSING, INC.	100.00%	681	20	16	
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17	
18	V	21 GENERAL OFFICE	373	PROGRESSIVE HOUSING, INC.	100.00%	383	10	18	
19	V	23 INSERVICE TRAVEL	88	PROGRESSIVE HOUSING, INC.	100.00%	90	2	19	
20	V	32 INTEREST	37	PROGRESSIVE HOUSING, INC.	100.00%	38	1	20	
21	V	32 INTEREST INCOME	(1,867)	PROGRESSIVE HOUSING, INC.	100.00%	(1,926)	(59)	21	
22	V	22 EMPLOYEE BENEFITS	84	PROGRESSIVE HOUSING, INC.	100.00%	85	1	22	
23	V							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		\$ 30			\$ (37)	\$ *	(67)	39

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008

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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 6,546	\$	6,546	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4		4	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	901		901	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	392		392	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	196		196	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	341		341	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	51		51	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	247		247	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20		20	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	144		144	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	42		42	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	116		116	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(3)		(3)	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	42		42	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	259		259	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(362)		(362)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 8,936	\$ *	8,936	39

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008

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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 3,104	\$ 3,104	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	16	16	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	619	619	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	142	142	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	56	56	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	95	95	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	173	173	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	23	23	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	121	121	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	68	68	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	39	39	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	129	129	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	19	19	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	101	101	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4	4	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 4,709	\$ *	4,709 39

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008

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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	9,676	\$	9,676	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	280		280	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,852		1,852	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	515		515	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	153		153	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	285		285	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	512		512	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	68		68	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	375		375	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20		20	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	202		202	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	115		115	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	886		886	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	60		60	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	384		384	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(38)		(38)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			15,345	\$	* 15,345	39

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008

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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	13,469	\$	13,469	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	76		76	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,386		2,386	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	540		540	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	372		372	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	702		702	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	86		86	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	475		475	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20		20	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	401		401	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	127		127	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	862		862	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(78)		(78)	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	70		70	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	405		405	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	157		157	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			20,070	\$	* 20,070	39

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

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008

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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 5,660	\$ 5,660	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	4	4	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,105	1,105	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	387	387	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	29	29	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	198	198	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	203	203	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	90	90	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	289	289	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	19	19	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	109	109	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	89	89	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	417	417	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	38	38	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	49	49	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	245	245	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(268)	(268)	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 8,663	\$ *	8,663 39

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

Facility Name & ID Number TAYLORVILLE TERRACE # 0047795 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	RONALD SCHROEDER	SECRETARY	BOARD MEMBE	NONE	505	3HRS/MTG	1.00	DIR. FEES	\$ 505	L18, C8	1
2	SHAWN JEFFERS	CHAIRMAN	BOARD MEMBE	NONE	463	3HRS/MTG	1.00	DIR. FEES	463	L18, C8	2
3	EDWARD CHILDERS	VICE CHAIRMAN	BOARD MEMBE	NONE	505	3HRS/MTG	1.00	DIR. FEES	505	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBE	NONE	272	3HRS/MTG	1.00	DIR. FEES	271	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBE	NONE	230	3HRS/MTG	1.00	DIR. FEES	230	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBE	NONE	484	3HRS/MTG	1.00	DIR. FEES	485	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,459		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 TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

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	18	BOARD FEES	290	18	\$ 8,000	\$	16	\$ 441	1
2	19	PROFESSIONAL FEES	290	18	8,801		16	486	2
3	20	LICENSE, DUES	290	18	5		16	0	3
4	21	GENERAL OFFICE	290	18	4,178		16	231	4
5	23	INSERVICE TRAVEL	290	18	883		16	49	5
6	32	INTEREST	290	18	0		16	0	6
7	32	INTEREST INCOME	290	18	0		16	0	7
8	22	EMPLOYEE BENEFITS	290	18	0		16	0	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				\$ 21,867	\$		\$ 1,207	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

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	18	BOARD FEES	296	19	\$ 3,200	\$	16	\$ 173	1
2	19	PROFESSIONAL FEES	296	19	42,639		16	2,305	2
3	20	LICENSE, DUES	296	19			16		3
4	21	GENERAL OFFICE	296	19	3,630		16	196	4
5	23	INSERVICE TRAVEL	296	19	259		16	14	5
6	32	INTEREST	296	19			16		6
7	32	INTEREST INCOME	296	19			16		7
8	22	EMPLOYEE BENEFITS	296	19			16		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				\$ 49,728	\$		\$ 2,688	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

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	18	BOARD FEES	NUMBER OF BEDS	302	20	\$ 7,200	\$ 16	\$ 381	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	20	29,894	16	1,584	2
3	20	LICENSE, DUES	NUMBER OF BEDS	302	20	15	16	1	3
4	21	GENERAL OFFICE	NUMBER OF BEDS	302	20	7,047	16	373	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	302	20	3,147	16	167	5
6	32	INTEREST	NUMBER OF BEDS	302	20		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	302	20		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	20	5,009	16	265	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					\$ 52,312	\$	\$ 2,771	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

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	18	BOARD FEES	NUMBER OF BEDS	308	21	\$ 16,400	\$ 16	\$ 852	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	21	43,975	16	2,284	2
3	20	LICENSE, DUES	NUMBER OF BEDS	308	21		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	308	21	13,407	16	696	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	308	21	2,031	16	106	5
6	32	INTEREST	NUMBER OF BEDS	308	21	1,521	16	79	6
7	32	INTEREST INCOME	NUMBER OF BEDS	308	21		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	21	320	16	17	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					\$ 77,654	\$	\$ 4,034	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

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	18	BOARD FEES	NUMBER OF BEDS	314	22	\$ 12,000	\$ 16	\$ 612	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	314	22	13,368	16	681	2
3	20	LICENSE, DUES	NUMBER OF BEDS	314	22		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	314	22	7,508	16	383	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	314	22	1,779	16	90	5
6	32	INTEREST	NUMBER OF BEDS	314	22	747	16	38	6
7	32	INTEREST INCOME	NUMBER OF BEDS	314	22	(37,805)	16	(1,926)	7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	314	22	1,680	16	85	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					\$	\$	(37)	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 CENTER FOR RESIDENTIAL MANAGEMENT
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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	17	ADMINISTRATIVE COST	290	18	\$ 118,649	\$ 105,805	16	\$ 6,546	1
2	19	PROFESSIONAL FEES	290	18			16		2
3	20	DUES, FEES	290	18	78		16	4	3
4	22	EMPLOYEE BENEFITS	290	18	16,327		16	901	4
5	23	INSERVICE EDUCATION	290	18	7,108		16	392	5
6	24	TRAVEL SEMINAR	290	18			16		6
7	26	INSURANCE	290	18	3,549		16	196	7
8	30	DEPRECIATION	290	18	6,182		16	341	8
9	32	INTEREST	290	18	920		16	51	9
10	34	RENT	290	18	4,468		16	247	10
11	35	EQUIPMENT RENTAL	290	18	356		16	20	11
12	5	UTILITIES	290	18	2,613		16	144	12
13	6	MAINTENANCE	290	18	766		16	42	13
14	43	NONALLOWABLE	290	18	2,101		16	116	14
15	32	MISC INCOME	290	18	(50)		16	(3)	15
16	3	HOUSEKEEPING	290	18	760		16	42	16
17	21	OFFICE	290	18	4,703		16	259	17
18	10	NURSING SUPPLIES	290	18	(6,566)		16	(362)	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 161,964	\$ 105,805		\$ 8,936	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 CENTER FOR RESIDENTIAL MANAGEMENT
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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	17	ADMINISTRATIVE COST	NUMBER OF BEDS	296	19	\$ 57,424	\$ 53,061	16	\$ 3,104	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	296	19			16		2
3	20	DUES, FEES	NUMBER OF BEDS	296	19	300		16	16	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	296	19	11,446		16	619	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	296	19	2,621		16	142	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	296	19	1,037		16	56	6
7	26	INSURANCE	NUMBER OF BEDS	296	19	1,765		16	95	7
8	30	DEPRECIATION	NUMBER OF BEDS	296	19	3,192		16	173	8
9	32	INTEREST	NUMBER OF BEDS	296	19	431		16	23	9
10	34	RENT	NUMBER OF BEDS	296	19	2,234		16	121	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	296	19			16		11
12	5	UTILITIES	NUMBER OF BEDS	296	19	1,263		16	68	12
13	6	MAINTENANCE	NUMBER OF BEDS	296	19	718		16	39	13
14	43	NONALLOWABLE	NUMBER OF BEDS	296	19	2,391		16	129	14
15	32	MISC INCOME	NUMBER OF BEDS	296	19			16		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	296	19	360		16	19	16
17	21	OFFICE	NUMBER OF BEDS	296	19	1,863		16	101	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	296	19	81		16	4	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 87,126	\$ 53,061		\$ 4,709	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 CENTER FOR RESIDENTIAL MANAGEMENT
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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	17	ADMINISTRATIVE COST	NUMBER OF BEDS	302	20	\$ 182,638	\$ 165,736	16	\$ 9,676	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	20			16		2
3	20	DUES, FEES	NUMBER OF BEDS	302	20	5,285		16	280	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	20	34,950		16	1,852	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	302	20	9,715		16	515	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	302	20	2,896		16	153	6
7	26	INSURANCE	NUMBER OF BEDS	302	20	5,377		16	285	7
8	30	DEPRECIATION	NUMBER OF BEDS	302	20	9,661		16	512	8
9	32	INTEREST	NUMBER OF BEDS	302	20	1,282		16	68	9
10	34	RENT	NUMBER OF BEDS	302	20	7,074		16	375	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	302	20	376		16	20	11
12	5	UTILITIES	NUMBER OF BEDS	302	20	3,822		16	202	12
13	6	MAINTENANCE	NUMBER OF BEDS	302	20	2,176		16	115	13
14	43	NONALLOWABLE	NUMBER OF BEDS	302	20	16,724		16	886	14
15	32	MISC INCOME	NUMBER OF BEDS	302	20			16		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	302	20	1,122		16	60	16
17	21	OFFICE	NUMBER OF BEDS	302	20	7,256		16	384	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	302	20	(719)		16	(38)	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 289,635	\$ 165,736		\$ 15,345	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 CENTER FOR RESIDENTIAL MANAGEMENT
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 Phone Number (309-685-0595
 Fax Number (309-685-8463

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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	17	ADMINISTRATIVE COST	NUMBER OF BEDS	308	21	\$ 259,282	\$ 236,515	16	\$ 13,469	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	21			16		2
3	20	DUES, FEES	NUMBER OF BEDS	308	21	1,456		16	76	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	21	45,935		16	2,386	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	308	21	10,397		16	540	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	308	21			16		6
7	26	INSURANCE	NUMBER OF BEDS	308	21	7,169		16	372	7
8	30	DEPRECIATION	NUMBER OF BEDS	308	21	13,522		16	702	8
9	32	INTEREST	NUMBER OF BEDS	308	21	1,639		16	86	9
10	34	RENT	NUMBER OF BEDS	308	21	9,148		16	475	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	308	21	376		16	20	11
12	5	UTILITIES	NUMBER OF BEDS	308	21	7,720		16	401	12
13	6	MAINTENANCE	NUMBER OF BEDS	308	21	2,446		16	127	13
14	43	NONALLOWABLE	NUMBER OF BEDS	308	21	16,600		16	862	14
15	32	MISC INCOME	NUMBER OF BEDS	308	21	(1,502)		16	(78)	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	308	21	1,352		16	70	16
17	21	OFFICE	NUMBER OF BEDS	308	21	7,788		16	405	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	308	21	3,022		16	157	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 386,350	\$ 236,515		\$ 20,070	25

Facility Name & ID Number TAYLORVILLE TERRACE

0047795 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 CENTER FOR RESIDENTIAL MANAGEMENT
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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	17	ADMINISTRATIVE COST	NUMBER OF BEDS	314	22	\$ 111,075	\$ 97,120	16	\$ 5,660	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	314	22			16		2
3	20	DUES, FEES	NUMBER OF BEDS	314	22	76		16	4	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	314	22	21,693		16	1,105	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	314	22	7,585		16	387	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	314	22	567		16	29	6
7	26	INSURANCE	NUMBER OF BEDS	314	22	3,894		16	198	7
8	30	DEPRECIATION	NUMBER OF BEDS	314	22	3,988		16	203	8
9	32	INTEREST	NUMBER OF BEDS	314	22	1,756		16	90	9
10	34	RENT	NUMBER OF BEDS	314	22	5,675		16	289	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	314	22	376		16	19	11
12	5	UTILITIES	NUMBER OF BEDS	314	22	2,146		16	109	12
13	6	MAINTENANCE	NUMBER OF BEDS	314	22	1,737		16	89	13
14	43	NONALLOWABLE	NUMBER OF BEDS	314	22	8,175		16	417	14
15	32	MISC INCOME	NUMBER OF BEDS	314	22	750		16	38	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	314	22	957		16	49	16
17	21	OFFICE	NUMBER OF BEDS	314	22	4,811		16	245	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	314	22	(5,261)		16	(268)	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 170,000	\$ 97,120		\$ 8,663	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	BANTERRA BANK		X	2006 DODGE CALIBER	\$441.82	12/15/06	\$ 14,075	\$	06/2008	8.0000	\$ 1,136	1								
2	IL HEALTH FAC AUTH. BONDS		X	ACQUISITION OF FACILITY	ANNUAL PMT	03/09/06	692,503	676,596	08/15/26	6.7500	47,245	2								
3												3								
4												4								
5												5								
Working Capital																				
6				OFFSET INTERST INCOME/ NONALLOWABLE INT.							(8,434)	6								
7				MISC./PARENT ALLOCATION							254	7								
8												8								
9	TOTAL Facility Related				\$441.82		\$ 706,578	\$ 676,596			\$ 40,201	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 706,578	\$ 676,596			\$ 40,201	15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.	\$	3,956	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.)	\$	4,005	2
3. Under or (over) accrual (line 2 minus line 1).	\$	49	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4,205	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.	\$	4,254	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	3,956	11
	2007	4,005	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

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, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TAYLORVILLE TERRACE COUNTY CHRISTIAN

FACILITY IDPH LICENSE NUMBER 0047795

CONTACT PERSON REGARDING THIS REPORT ROB KEIME

TELEPHONE 309-685-0595 FAX #: 306-685-0595

A. Summary of Real Estate Tax Cost

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)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-13-26-120-001-00</u>	<u>921 E. MARKET ST</u>	\$ <u>4,005.00</u>	\$ <u>4,005.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>4,005.00</u>	\$ <u>4,005.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 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 TAYLORVILLE TERRACE# 0047795 Report Period Beginning:07/01/2007 Ending:06/30/2008**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 4,300 B. General Construction Type: Exterior BRICK/WOOD SIDIN Frame WOOD Number of Stories TWOC. 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: 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>RESIDENT CARE</u>	<u>14,000</u>	<u>1999</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	14,000		\$ 20,000	3

Facility Name & ID Number TAYLORVILLE TERRACE

0047795

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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		1999	1991	\$ 730,000	\$ 18,250	40	\$ 18,250	\$	\$ 170,333	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		TRASH TANK & BAFFLES		1998	2,435	162	15	162		1,704	9
10		CARPETING		2005	2,067	138	15	138		356	10
11		BATHROOM REMODEL		2007	4,867	324	15	324		480	11
12		BATHROOM REMODEL		2008	3,024	95	15	95		95	12
13		FIRE ALARM UPGRADE		2008	1,875	11	15	11		11	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

Facility Name & ID Number TAYLORVILLE TERRACE

0047795

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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)	\$ 744,268	\$ 18,980		\$ 18,980	\$	\$ 172,979	70

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

Facility Name & ID Number TAYLORVILLE TERRACE # 0047795 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	\$ 15,162	\$ 1,883	\$ 1,883	\$	5-10 YRS	\$ 9,650	71
72	Current Year Purchases	6,042	383	383		5-10 YRS	383	72
73	Fully Depreciated Assets	10,922	405	405		5-10 YRS	10,922	73
74	ALLOCATED FROM PARENT		1,931	1,931				74
75	TOTALS	\$ 32,126	\$ 4,602	\$ 4,602	\$		\$ 20,955	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	RESIDENT TRANSPORTATION	2004 DODGE CARAVAN	2004	\$ 20,060	\$ 4,012	\$ 4,012	\$	5	\$ 17,385	76
77	RESIDENT TRANSPORTATION	2006 DODGE CALIBER	2006	15,371	3,074	3,074		5	4,868	77
78										78
79										79
80	TOTALS			\$ 35,431	\$ 7,086	\$ 7,086	\$		\$ 22,253	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)	\$	831,825	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	30,668	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	30,668	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)	\$	216,187	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.

Facility Name & ID Number TAYLORVILLE TERRACE

0047795

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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:				\$ _____			3
4	Additions				_____			4
5	SEE SCH 6E-I				1,507			5
6					_____			6
7	TOTAL				\$ 1,507			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	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 79

Description: SEE SCH 6E-I

(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>40</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>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		100		100
3	Classroom Wages (a)		2,416		2,416
4	Clinical Wages (b)		5,040		5,040
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 7,556	\$	\$ 7,556
10	SUM OF line 9, col. 1 and 2 (e)	\$	7,556		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ 10,643

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>7</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	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 prescrpts														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.

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007

Ending:

06/30/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/2008

(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	\$ 500	\$	1
2	Cash-Patient Deposits	7,696		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>10,868</u>)	171,548		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,126,451		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,306,262	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	730,000		14
15	Leasehold Improvements, at Historical Cost	14,268		15
16	Equipment, at Historical Cost	67,557		16
17	Accumulated Depreciation (book methods)	(216,187)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	111,434		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>LOAN COST</u>	16,681		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 743,753	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,050,015	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 89,553	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,696		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,289		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,108		32
33	Accrued Interest Payable	17,064		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)	\$ 134,710	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	676,596		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>DEFERRED INCOME BONDS</u>	25,516		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 702,112	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 836,822	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,213,193	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,050,015	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,093,447	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,093,447	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	119,746	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)	\$ 119,746	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)	\$ 1,213,193	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number TAYLORVILLE TERRACE# 0047795Report Period Beginning: 07/01/2007Ending: 06/30/2008**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	\$ 607,319	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 607,319	3
B. Ancillary Revenue			
4	Day Care	138,514	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 138,514	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	10,643	11
12	Gift and Coffee Shop		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)	\$ 10,643	23
D. Non-Operating Revenue			
24	Contributions	1,391	24
25	Interest and Other Investment Income***	7,001	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,392	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)	\$ 764,868	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	81,387	31
32	Health Care	197,569	32
33	General Administration	84,641	33
B. Capital Expense			
34	Ownership	81,407	34
C. Ancillary Expense			
35	Special Cost Centers	164,514	35
36	Provider Participation Fee	35,604	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 645,122	40
41	Income before Income Taxes (line 30 minus line 40)**	119,746	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 119,746	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 TAYLORVILLE TERRACE

0047795

Report Period Beginning: 07/01/2007

Ending:

06/30/2008

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	3	84	28.00	3
4	Licensed Practical Nurses	363	379	4,138	10.92	4
5	CNAs & Orderlies					5
6	CNA Trainees	864	864	7,456	8.63	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,831	2,860	23,448	8.20	15
16	Dishwashers					16
17	Maintenance Workers	998	1,026	9,251	9.02	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	283	274	12,687	46.30	20
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)					28
29	Resident Services Coordinator	2,024	2,120	24,895	11.74	29
30	Habilitation Aides (DD Homes)	14,998	15,670	135,243	8.63	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,364	23,196	\$ 217,202 *	\$ 9.36	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	26	\$ 1,781	L1, C3	35
36	Medical Director	MONTHLY	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	46	3,168	L12, C3	45
46	Other(specify) <u>PSYCHOLOGICAL</u>	42	3,344	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	114	\$ 13,093		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 **TAYLORVILLE TERRACE**

0047795

Report Period Beginning: **07/01/2007**

Ending: **06/30/2008**

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	
JOHN MIRECKI	ADMINISTRATOR	0	\$ 12,687	Workers' Compensation Insurance	\$ (942)	IDPH License Fee	\$	
				Unemployment Compensation Insurance	6,552	Advertising: Employee Recruitment	1,328	
				FICA Taxes	19,044	Health Care Worker Background Check		
				Employee Health Insurance	9,696	(Indicate # of checks performed <u>36</u>)	360	
				Employee Meals	4,871	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		VEHICLE LICENSE/SANITATION	244	
				403B CONTRIBUTIONS	133	MISCELLANEOUS DUES & FEES	462	
				DRUG TESTS	218	MES MEMBERSHIP	175	
				EMPLOYEE MORAL	1,024	NEWSPAPER SUBSCRIPTION	99	
						IHCA DUES	684	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 12,687	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 40,596		\$ 3,352		
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
N/A			\$	N/A		\$	Out-of-State Travel	\$
							In-State Travel	
							IHCA COVENTION	250
							BEST PRACTICES LISLE	25
							MISC SEMINARS	264
							Seminar Expense	
							CPI	122
							FOOD SERVICE	248
							DHS DIRECT SUPPORT COURSE	22
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ 931	
C. Professional Services								
Vendor/Payee	Type	Amount						
JONES DAY	LEGAL	\$ 110						
WELLS FARGO	BOND TRUSTEE	152						
KRIEG, DEVAULT	LEGAL	4,156						
HEINOLD-BANWART	ACCOUNTING	2,922						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 7,340					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

