

Facility Name & ID Number Tillers Health Care Residence

0018002 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,850</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>9</u>	Intermediate (ICF)	<u>9</u>	<u>3,285</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</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	Total	
8	SNF	<u>1,464</u>	<u>19,235</u>	<u>8,386</u>	<u>29,085</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,464</u>	<u>19,235</u>	<u>8,386</u>	<u>29,085</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.49%

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)

None

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

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

YES NO

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

YES NO

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

Date started 08/01/72

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 38 and days of care provided 8,272

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Tillers Health Care Residence # 0018002 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	338,292	36,579	6,589	381,460		381,460		381,460		1
2	Food Purchase		197,145		197,145		197,145	(1,575)	195,570		2
3	Housekeeping	298,818	38,275		337,093		337,093		337,093		3
4	Laundry		11,704		11,704		11,704		11,704		4
5	Heat and Other Utilities			169,929	169,929		169,929		169,929		5
6	Maintenance	173,609	64,726	116,806	355,141		355,141		355,141		6
7	Other (specify):*										7
8	TOTAL General Services	810,718	348,428	293,324	1,452,470		1,452,470	(1,575)	1,450,895		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,607,074	161,495	46,623	2,815,192		2,815,192		2,815,192		10
10a	Therapy	80,897			80,897		80,897		80,897		10a
11	Activities	97,115	14,737	2,457	114,309		114,309		114,309		11
12	Social Services	60,520		2,209	62,729		62,729		62,729		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,845,606	176,232	63,289	3,085,127		3,085,127		3,085,127		16
	C. General Administration										
17	Administrative	355,994			355,994		355,994		355,994		17
18	Directors Fees										18
19	Professional Services			120,240	120,240		120,240	(368)	119,872		19
20	Dues, Fees, Subscriptions & Promotions			70,550	70,550		70,550	(46,099)	24,452		20
21	Clerical & General Office Expenses	212,263	9,519	198,740	420,521		420,521	(102,773)	317,748		21
22	Employee Benefits & Payroll Taxes			869,052	869,052		869,052	(7,812)	861,240		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,081	8,081		8,081		8,081		24
25	Other Admin. Staff Transportation			1,037	1,037		1,037		1,037		25
26	Insurance-Prop.Liab.Malpractice			53,262	53,262		53,262		53,262		26
27	Other (specify):*										27
28	TOTAL General Administration	568,257	9,519	1,320,963	1,898,738		1,898,738	(157,052)	1,741,686		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,224,582	534,179	1,677,575	6,436,336		6,436,336	(158,627)	6,277,709		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 Tillers Health Care Residence #0018002 Report Period Beginning: 01/01/08 Ending: 12/31/08

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			145,024	145,024	145,024	163,761	308,785			30
31	Amortization of Pre-Op. & Org.						(0)	(0)			31
32	Interest						(0)	(0)			32
33	Real Estate Taxes			73,373	73,373	73,373		73,373			33
34	Rent-Facility & Grounds			384,988	384,988	384,988	(384,988)				34
35	Rent-Equipment & Vehicles			17,174	17,174	17,174	(11,316)	5,858			35
36	Other (specify):*										36
37	TOTAL Ownership			620,558	620,558	620,558	(232,544)	388,014			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		361,209	785,227	1,146,436	1,146,436		1,146,436			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			54,204	54,204	54,204		54,204			42
43	Other (specify):*			23,240	23,240	23,240	(23,240)				43
44	TOTAL Special Cost Centers		361,209	862,671	1,223,880	1,223,880	(23,240)	1,200,640			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,224,582	895,388	3,160,804	8,280,773	8,280,773	(414,410)	7,866,363			45

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

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	(1,575)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,893)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	73,631	30		9
10	Interest and Other Investment Income	(8,859)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,375)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,841)	21		19
20	Contributions	(1,681)	20		20
21	Owner or Key-Man Insurance	(7,812)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,459)	21		24
25	Fund Raising, Advertising and Promotional	(20,034)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(24,384)	20		28
29	Other-Attach Schedule	(76,181)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (147,463)		\$	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)	(266,947)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (266,947)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (414,410)		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

Tillers Health Care Residence

ID# 0018002

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	State Replacement Tax	\$ (9,905)	21	1
2	Marketing Sales Call Expense	(1,144)	43	2
3	Trade/Health Fairs	(3,307)	43	3
4	Marketing Sponsorships	(1,003)	43	4
5	Marketing Website	(12,859)	21	5
6	Center Based Special Events	(17,786)	43	6
7	Auto Lease Expense	(11,316)	35	7
8	Non-Allowable Legal Fees	(1,398)	19	8
9	Other Miscellaneous Income	(945)	21	9
10				10
11				11
12	Building Partnership - Accounting Fees	(6,000)	19	12
13	Building Partnership - Bank Fees	(165)	21	13
14	Building Partnership - State Replacement Tax	(4,933)	21	14
15	Building Partnership - Life Insurance	(5,241)	21	15
16	Building Partnership - Amortization	(180)	31	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	(76,181)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tillers Health Care Residence

0018002

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	(1,575)	0	0	0	0	0	0	0	0	0	0	(1,575)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,575)	0	0	0	0	0	0	0	0	0	0	(1,575)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	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	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,398)	7,030	0	0	0	0	0	0	0	0	0	(368)	19
20	Fees, Subscriptions & Promotions	(46,099)	0	0	0	0	0	0	0	0	0	0	(46,099)	20
21	Clerical & General Office Expenses	(114,616)	11,843	0	0	0	0	0	0	0	0	0	(102,773)	21
22	Employee Benefits & Payroll Taxes	(7,812)	0	0	0	0	0	0	0	0	0	0	(7,812)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(175,924)	18,873	0	(157,052)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(177,499)	18,873	0	(158,627)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tillers Health Care Residence

0018002

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	73,631	90,130	0	0	0	0	0	0	0	0	0	163,761	30
31	Amortization of Pre-Op. & Org.	(180)	180	0	0	0	0	0	0	0	0	0	(0)	31
32	Interest	(8,859)	8,859	0	0	0	0	0	0	0	0	0	(0)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(384,988)	0	0	0	0	0	0	0	0	0	(384,988)	34
35	Rent-Equipment & Vehicles	(11,316)	0	0	0	0	0	0	0	0	0	0	(11,316)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	53,276	(285,820)	0	(232,544)	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):*	(23,240)	0	0	0	0	0	0	0	0	0	0	(23,240)	43
44	TOTAL Special Cost Centers	(23,240)	0	0	0	0	0	0	0	0	0	0	(23,240)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(147,463)	(266,947)	0	(414,410)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Robert Saxon	33.34%			Tillers Real Estate	Oswego, Illinois	Building Co.
Sally Saxon	22.22%					
Karla Stone	22.22%					
Kathryn Rivero	22.22%					

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 Rental Income	\$ 384,988	Tillers Real Estate, LLC		\$	\$ (384,988)	1
2	V	32 Interest Income	451	Tillers Real Estate, LLC			(451)	2
3	V	21 Office and Supplies		Tillers Real Estate, LLC		1,504	1,504	3
4	V	21 Bank Service Fees		Tillers Real Estate, LLC		165	165	4
5	V	21 Replacement Tax		Tillers Real Estate, LLC		4,933	4,933	5
6	V	21 Life Insurance		Tillers Real Estate, LLC		5,241	5,241	6
7	V	32 Interest Expense		Tillers Real Estate, LLC		9,309	9,309	7
8	V	19 Professional Fees		Tillers Real Estate, LLC		7,030	7,030	8
9	V	30 Depreciation		Tillers Real Estate, LLC		90,130	90,130	9
10	V	31 Amortization		Tillers Real Estate, LLC		180	180	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 385,439			\$ 118,492	\$ * (266,947)	14

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

Facility Name & ID Number Tillers Health Care Residence # 0018002 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	Robert Saxon	Owner	Administrator	33.34	None	40	100.00	Salary	\$ 178,939	17 - 01	1
2	Brett Saxon	Relative	Asst. Admin.	0.00	None	40	100.00	Salary	111,658	17 - 01	2
3	Brooke Saxon - Spencer	Relative	Assoc. Admin.	0.00	None	30	100.00	Salary	65,397	17 - 01	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 355,994		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 Tillers Health Care Residence

0018002

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Tillers Health Care Residence # 0018002 Report Period Beginning: 01/01/08 Ending: 12/31/08

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											
										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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related									9										
B. Non-Facility Related*																				
10	Allied Bank		X	Therapy Gym				1,600,000		10										
11	Allied Bank		X	Construction - Therapy Gym					9,309	11										
12	Int. Income - Tillers R.E.		X						(451)	12										
13	Int. income - Tillers N.H.		X						(8,858)	13										
14	TOTAL Non-Facility Related							1,600,000		14										
15	TOTALS (line 9+line14)							1,600,000		15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* 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.		\$	75,961	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.)		\$	73,564	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,397)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,770	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.		\$	73,373	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	63,328	8	
	2004	69,180	9	
	2005	69,292	10	
	2006	70,760	11	
	2007	73,564	12	
2008 Real Estate Tax Accrual = \$73,564 * 1.03 = \$75,770				
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 Tillers Health Care Residence COUNTY Kendall

FACILITY IDPH LICENSE NUMBER 0018002

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune

TELEPHONE (779) 875-3979 FAX #: (866)

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>03-17-456-001</u>	<u>Long Term Care Property</u>	\$ <u>4,687.80</u>	\$ <u>4,687.80</u>
2. <u>03-20-202-004</u>	<u>Long Term Care Property</u>	\$ <u>52,821.54</u>	\$ <u>52,821.54</u>
3. <u>03-17-456-002</u>	<u>Long Term Care Property</u>	\$ <u>16,053.80</u>	\$ <u>16,053.80</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>73,563.14</u>	\$ <u>73,563.14</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 Tillers Health Care Residence

0018002 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,500 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1985</u>	<u>\$ 77,820</u>	1
2	<u>Tillers Real Estate</u>			<u>100,000</u>	2
3	TOTALS			\$ 177,820	3

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	99		1972	1972	\$ 1,157,892	\$	35	\$	\$	\$ 1,157,892	4
5			1981	1981	134,813		20			134,813	5
6			1985	1985	177,791		20			177,791	6
7			1986	1986	613,142		20			613,142	7
8			1987	1987	22,646		20			22,646	8
Improvement Type**											
9	Various			1981	4,707		20			4,707	9
10	Various			1982	19,113		20			19,113	10
11	Various			1983	6,133		20			6,133	11
12	Various			1984	5,223		20			5,223	12
13	Various			1985	21,935		20			21,935	13
14	Various			1986	87,912		20			87,912	14
15	Various			1987	11,128		20			11,128	15
16	Various			1988	8,744		20			8,744	16
17	Various			1989	17,312		20	866	866	17,312	17
18	Various			1990	113,441		20	5,672	5,672	107,769	18
19	Various			1991	34,778		20	1,739	1,739	31,300	19
20	Various			1992	11,969		20	598	598	10,174	20
21	Various			1993	14,346		20	717	717	11,477	21
22	Various			1995	32,441		20	1,622	1,622	22,709	22
23	Various			1996	21,503		20	1,075	1,075	13,977	23
24	Various			1997	3,235		20	162	162	1,941	24
25	Various			1998	69,777		20	3,489	3,489	38,377	25
26	Various			1999	158,719		20	7,936	7,936	79,360	26
27	Various			2000	67,355		20	3,368	3,368	30,310	27
28	Various			2001	45,387		20	2,269	2,269	18,155	28
29	Various			2002	56,267		20	2,813	2,813	19,693	29
30	Various			2003	34,778		20	1,739	1,739	10,433	30
31	Various			2004	147,448		20	7,372	7,372	36,862	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 Tillers Health Care Residence

0018002

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Window Treatments	2005	\$ 4,533	\$	20	\$ 227	\$ 227	\$ 907	37
38	Emergency Call System	2005	4,550		20	228	228	910	38
39	Wallpaper	2005	1,872		20	94	94	374	39
40	Canopy Fire Sprinklers & Smoke Detectors	2005	14,004		20	700	700	2,801	40
41	Generator Room Ventilation	2005	9,385		20	469	469	1,877	41
42	Carpeting	2005	13,927		20	696	696	2,785	42
43	Fence	2005	2,210		20	111	111	442	43
44	Lights	2005	5,792		20	290	290	1,158	44
45	Automatic Door	2005	4,882		20	244	244	976	45
46	Storm inlet Parking Log	2005	1,718		20	86	86	344	46
47	Concrete	2005	2,000		20	100	100	400	47
48	Custom Cabinets	2005	14,906		20	745	745	2,981	48
49	Roofing	2005	58,620		20	2,931	2,931	11,724	49
50	Sprinklers	2005	500		20	25	25	100	50
51	Concrete Sidewalks	2005	12,932		20	647	647	2,586	51
52	24 Doors and Installation	2005	10,000		20	500	500	2,000	52
53	Door Locks	2005	3,141		20	157	157	628	53
54	Flooring	2005	1,242		20	62	62	248	54
55	Front Lounge Caninets	2005	16,600		20	830	830	3,320	55
56	Concrete	2006	5,830		20	292	292	875	56
57	Sidewalks	2006	5,360		20	268	268	804	57
58	Fire Spinkler Sysem	2006	9,984		20	499	499	1,498	58
59	Fence	2006	7,391		20	370	370	1,109	59
60	Sprinkler Alarm System	2006	6,200		20	310	310	930	60
61	Roofing	2006	51,480		20	2,574	2,574	7,722	61
62	Sprinkler System	2006	21,394		20	1,070	1,070	3,209	62
63	Wall Coverings	2006	16,748		20	837	837	2,512	63
64	Flooring	2006	11,094		20	555	555	1,664	64
65	Carpeting	2006	16,060		20	803	803	2,409	65
66	Heat Exchanger	2006	3,073		20	154	154	461	66
67	Water Heater	2006	2,815		20	141	141	422	67
68	Folding Partition	2006	2,765		20	138	138	415	68
69	Water Heater	2006	8,065		20	403	403	1,210	69
70	TOTAL (lines 4 thru 69)		\$ 3,451,008	\$		\$ 58,991	\$ 58,991	\$ 2,782,829	70

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

Facility Name & ID Number Tillers Health Care Residence

0018002

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,451,008	\$		\$ 58,991	\$ 58,991	\$ 2,782,829	1
2	Dishwasher Room Doorway & Dining Room Floor	2007	3,438		20	172	172	344	2
3	Door Locks	2007	2,841		20	142	142	284	3
4	Door Alarms	2007	5,892		20	295	295	589	4
5	Door Alarms	2007	5,500		20	275	275	550	5
6	Door Alarms	2007	236		20	12	12	24	6
7	Door Alarms - Touchpads	2007	465		20	23	23	47	7
8	Door Alarms - Touchpads	2007	3,480		20	174	174	348	8
9	Door Alarms	2007	665		20	33	33	67	9
10	Door Alarm System	2007	2,051		20	103	103	205	10
11	Door Alarm System	2007	337		20	17	17	34	11
12	Doors	2007	3,075		20	154	154	308	12
13	Door Alarm	2007	623		20	31	31	62	13
14	Door Alarm	2007	700		20	35	35	70	14
15	Roof	2007	68,720		20	3,436	3,436	6,872	15
16	Laminate Flooring	2007	1,393		20	70	70	139	16
17	Door Alarm - Access System	2007	11,770		20	589	589	1,177	17
18	Thermostat	2007	1,951		20	98	98	195	18
19	Repair Hot Water System	2007	3,712		20	186	186	371	19
20	Repair Water Lines & Plumbing	2007	10,426		20	521	521	1,043	20
21	Repair Broken Sewer Line	2007	6,814		20	341	341	681	21
22	Repair Pipes in Kitchen	2007	4,218		20	211	211	422	22
23	Nurses' Office	2007	17,484		20	874	874	1,748	23
24	Heater, Tin Work on Gas Pipe for Laundry	2007	16,045		20	802	802	1,605	24
25	Gait Door and Lock	2008	2,445		20	122	122	122	25
26	Gait Lock	2008	1,285		20	64	64	64	26
27	Roofing	2008	34,980		20	1,749	1,749	1,749	27
28	Flooring	2008	7,000		20	350	350	350	28
29	Alarm System	2008	4,080		20	204	204	204	29
30	Therapy Gym Construction	2008	1,452,534		20	72,627	72,627	72,627	30
31	Landscaping	2008	35,827		20	1,791	1,791	1,791	31
32									32
33	Book Depreciation			235,154			(235,154)		33
34	TOTAL (lines 1 thru 33)		\$ 5,160,995	\$ 235,154		\$ 144,491	\$ (90,663)	\$ 2,876,920	34

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

Facility Name & ID Number Tillers Health Care Residence # 0018002 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,455,125	\$	\$ 145,513	\$ 145,513	10	\$ 1,298,414	71
72	Current Year Purchases	142,818		14,282	14,282	10	14,282	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,597,943	\$	\$ 159,794	\$ 159,794		\$ 1,312,695	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Dodge Van	1989	\$ 18,762	\$	\$	\$	5	\$ 18,762	76
77	Facility	Dodge Truck	1998	20,000				5	20,000	77
78	Facility	Chevy Silverado - 02	2006	22,500		4,500	4,500	5	13,500	78
79										79
80	TOTALS			\$ 61,262	\$	\$ 4,500	\$ 4,500		\$ 52,262	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)	\$ 6,998,020	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 235,154	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 308,785	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 73,631	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,241,878	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	Automobile - 1985	\$ 19,557	\$	\$ 19,557	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 19,557	\$	\$ 19,557	91

G. Construction-in-Progress

	Description	Cost	
92	Interior Renovations	\$ 421,638	92
93	500 Wing Improvements	163,990	93
94			94
95		\$ 585,627	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 Tillers Health Care Residence

0018002

Report Period Beginning: 01/01/08

Ending: 12/31/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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: \$ 5,858

Description: Copier

(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	Facility	2007 Honda	\$ 365.00	\$ 4,065	17
18	Facility	2008 Acura	604.24	7,251	18
19	Pg. 5 Adjustment			(11,316)	19
20					20
21	TOTAL		\$ 969.24	\$ (0)	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 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
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)	\$			

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	

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

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

Facility Name & ID Number Tillers Health Care Residence# 0018002

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 346,332	\$		\$ 346,332	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			63,457			63,457	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			336,617			336,617	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				351,329		351,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Medical Supplies</u>	39 - 02					9,880		9,880	12
13	Other (specify): <u>Lab / X-Ray / Other</u>	39 - 03				38,821			38,821	13
14	TOTAL			\$		\$ 785,227	\$ 361,209		\$ 1,146,436	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 Tillers Health Care Residence# 0018002Report Period Beginning: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(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	\$ 181,541	\$ 199,575	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,234,809	1,234,809	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	29,750	29,750	5
6	Prepaid Insurance	87,393	87,393	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	842		8
9	Other(specify): <u>See Attachment</u>	40,735	40,735	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,575,071	\$ 1,592,262	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	77,820	177,820	13
14	Buildings, at Historical Cost	1,020,122	3,442,007	14
15	Leasehold Improvements, at Historical Cost	642,647	678,475	15
16	Equipment, at Historical Cost	2,274,669	2,339,609	16
17	Accumulated Depreciation (book methods)	(3,502,840)	(4,470,509)	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): <u>See Attachment</u>	585,627	606,989	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,098,046	\$ 2,774,391	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,673,116	\$ 4,366,653	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 300,110	\$ 300,110	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,695	284,695	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,770	75,770	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,905	9,905	35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 670,480	\$ 670,480	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,600,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,600,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 670,480	\$ 2,270,480	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,002,636	\$ 2,096,173	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,673,116	\$ 4,366,653	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,415,995	1
2	Restatements (describe):		2
3	Depreciation Restatement - GAAP to Tax Basis	(644,430)	3
4	State Replacement Tax	(12,209)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,759,356	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	566,780	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	(323,500)	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)	\$ 243,280	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)	\$ 2,002,636	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Tillers Health Care Residence# 0018002Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 8,610,444	1
2	Discounts and Allowances for all Levels	(1,621,112)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,989,332	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,176,863	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,176,863	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,584	13
14	Non-Patient Meals	1,575	14
15	Telephone, Television and Radio	8,893	15
16	Rental of Facility Space		16
17	Sale of Drugs	328,140	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	74,174	19
20	Radiology and X-Ray	13,570	20
21	Other Medical Services	207,203	21
22	Laundry	27,596	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 666,736	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,679	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,679	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income - ADJ Pg. 5 to Line 21	945	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 945	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,847,554	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,452,470	31
32	Health Care	3,085,127	32
33	General Administration	1,898,738	33
B. Capital Expense			
34	Ownership	620,558	34
C. Ancillary Expense			
35	Special Cost Centers	1,169,676	35
36	Provider Participation Fee	54,204	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,280,773	40
41	Income before Income Taxes (line 30 minus line 40)**	566,780	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 566,780	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? [See Attached](#) 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 Tillers Health Care Residence

0018002

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	2,000	2,080	\$ 92,764	\$ 44.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,317	32,933	996,812	30.27	3
4	Licensed Practical Nurses	11,719	12,564	332,415	26.46	4
5	CNAs & Orderlies	74,919	81,293	1,147,672	14.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,531	3,064	80,897	26.40	8
9	Activity Director	2,050	2,130	38,950	18.29	9
10	Activity Assistants	4,650	5,100	58,165	11.40	10
11	Social Service Workers	3,329	3,500	60,520	17.29	11
12	Dietician					12
13	Food Service Supervisor	4,524	4,684	86,394	18.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,288	23,709	251,898	10.62	15
16	Dishwashers					16
17	Maintenance Workers	8,411	8,846	173,609	19.63	17
18	Housekeepers	22,064	24,456	298,818	12.22	18
19	Laundry					19
20	Administrator	2,000	2,080	178,939	86.03	20
21	Assistant Administrator	2,000	2,080	111,658	53.68	21
22	Other Administrative	1,500	1,560	65,397	41.92	22
23	Office Manager					23
24	Clerical	9,572	9,803	212,263	21.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,540	2,620	37,410	14.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,414	222,502	\$ 4,224,582 *	\$ 18.99	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	Monthly \$ 6,589	01 - 03	35
36	Medical Director	Monthly 12,000	09 - 03	36
37	Medical Records Consultant	Quarterly 1,536	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 3,780	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly 2,457	11 - 03	44
45	Social Service Consultant	Monthly 2,209	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 28,571		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	113 \$ 6,794	10 - 03	50
51	Licensed Practical Nurses	18 944	10 - 03	51
52	Certified Nurse Assistants/Aides	666 18,634	10 - 03	52
53	TOTAL (lines 50 - 52)	797 \$ 26,371		53

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. IHCA - \$5,465
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,814 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,204
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,575
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: No The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

The Tillers Nursing and Rehabilitaiton Center, Inc.
Supplemental Schedule - Page 19
Cost Report to Tax Return Reconciliatoin
FYE 12/31/08

Medicaid Cost Report - Net Income	566,780
Reconciling Items:	
Accrued Vacation	30,012
Officers Life Insurance Premium	2,696
Meals and Entertainment	2,920
Federal Tax Return - Net Income	<u>602,408</u>

The Tillers Nursing and Rehabilitaiton Center, Inc.

Supplemental Schedule - Page 17

Cost Report to Tax Return Reconciliatoin

FYE 12/31/08

	<u>Operating</u>	<u>Building</u>	<u>Total</u>
Current Assets - Line 9 Other Assets			
Life Insurance - Cash Surrendar Value	<u>40,735</u>	<u>-</u>	<u>40,735</u>
Long Term Assets - Line 23 Other Assets			
Construction In Progress - Interior Improvements	421,638	-	421,638
Construction In Progrss - 500 Wing	163,990	-	163,990
Loan and Title Fees (Net of Amortization of \$178)	-	21,362	21,362
	<u>585,627</u>	<u>21,362</u>	<u>606,989</u>

The Tillers Nursing and Rehabilitaiton Center, Inc.

Supplemental Schedule - Page 21

Cost Report to Tax Return Reconciliatoin

FYE 12/31/08

Seminar Schedule

Acct. #	Payee	Description	Amount
4112	Upstairs Solutions	Online Internet Training	2,745
4112	Brett Saxon	Education Sessions	1,042
4212	Upstairs Solutions	Online Internet Training	832
4212	Brett Saxon	Education Sessions	167
4212	Linda Roberts and Associates	Education Sessions	149
4312	Upstairs Solutions	Online Internet Training	504
5112	Upstairs Solutions	Online Internet Training	664
5112	Brett Saxon	Education Sessions	260
5112	Robert Saxon	Education Sessions	1,170
5112	Wessels and Sherman	Education Sessions	45
5212	Upstairs Solutions	Online Internet Training	202
5312	Upstairs Solutions	Online Internet Training	101
5312	IAPA	Education Sessions	25
5512	Brooke Saxon - Spencer	Education Sessions	175
			<u>8,081</u>

The Tillers Nursing and Rehabilitaiton Center, Inc.

Supplemental Schedule - Page 21

Cost Report to Tax Return Reconciliatoin

FYE 12/31/08

Legal Schedule

Payee	Invoice Date	Invoice Number	Invoice Total	Non- Allowable	Allowable
Duane Morris	02/07/08	1368218	1,697		1,697
Duane Morris	02/07/08	1368215	594		594
Duane Morris	03/14/08	1377509	4,406		4,406
Duane Morris	03/14/08	1377507	1,989		
Duane Morris	04/16/08	1384364	5,396		5,396
Duane Morris	04/16/08	1385260	2,413		2,413
Duane Morris	05/13/08	1392857	665		665
Duane Morris	05/13/08	1392858	143		143
Duane Morris	06/19/08	1401499	1,670		1,670
Duane Morris	07/10/08	1405662	99		99
Duane Morris	11/21/08	1436906	1,598		1,598
Duane Morris	12/09/08	1441224	2,752		2,752
Duane Morris	01/21/09	1449198	347		347
Wessels and Sherman	Various	Various	600	600	-
Latimer LeVay Jurasek, LLC	01/31/08	23540	462	462	-
Latimer LeVay Jurasek, LLC	01/31/08	23541	781		781
Latimer LeVay Jurasek, LLC	01/31/08	23545	93	93	-
Latimer LeVay Jurasek, LLC	03/31/08	24105	81		81
Latimer LeVay Jurasek, LLC	07/31/08	25137	735		735
Latimer LeVay Jurasek, LLC	09/30/08	25679	244	244	-
Latimer LeVay Jurasek, LLC	10/31/08	25909	353		353
Latimer LeVay Jurasek, LLC	11/30/08	26157	2,113		2,113
Latimer LeVay Jurasek, LLC	12/31/08	26417	691		691
Latimer LeVay Jurasek, LLC	12/31/08	26416	244		244
			<u>30,164</u>	<u>1,398</u>	<u>26,776</u>

The Tillers Nursing and Rehabilitaiton Center, Inc.

Supplemental Schedule - Page 19

Cost Report to Tax Return Reconciliatoin

FYE 12/31/08
