

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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

I. IDPH Facility ID Number: 0044289

Facility Name: Somerset Place

Address: 5009 North Sheridan Road Chicago 60640
 Number City Zip Code

County: Cook

Telephone Number: (773) 561-0700 **Fax #** (773) 561-9843

HFS ID Number: 364269377001

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Edward N. Slack, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289 Report Period Beginning: 01/01/05 Ending: 12/31/05

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	450	Intermediate (ICF)	450	164,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	450	TOTALS	450	164,250	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	148,261	443		148,704
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	148,261	443		148,704

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.54%

D. How many bed-hold days during this year were paid by the Department? 6,559 (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 2/1/99

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/99 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	455,138	72,204	38,306	565,648		565,648	(4,866)	560,782			1
2	Food Purchase		583,760		583,760		583,760	(17)	583,743			2
3	Housekeeping	382,621	79,752	9,867	472,240		472,240	(7,278)	464,962			3
4	Laundry	13,457	4,366	85,570	103,393		103,393		103,393			4
5	Heat and Other Utilities			393,653	393,653		393,653	5,878	399,531			5
6	Maintenance	368,642		162,028	530,670		530,670	18,374	549,044			6
7	Other (specify):*							3,650	3,650			7
8	TOTAL General Services	1,219,858	740,082	689,424	2,649,364		2,649,364	15,741	2,665,105			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,685,932	84,120	26,716	2,796,768		2,796,768	(7,162)	2,789,606			10
10a	Therapy	24,073			24,073		24,073	1,404	25,477			10a
11	Activities	307,374	20,831	299	328,504		328,504		328,504			11
12	Social Services	687,408	5,671	7,200	700,279		700,279		700,279			12
13	CNA Training											13
14	Program Transportation			90	90		90		90			14
15	Other (specify):*							402	402			15
16	TOTAL Health Care and Programs	3,704,787	110,622	46,305	3,861,714		3,861,714	(5,356)	3,856,358			16
	C. General Administration											
17	Administrative	156,870		322,000	478,870		478,870	(222,594)	256,276			17
18	Directors Fees											18
19	Professional Services			644,671	644,671		644,671	(542,120)	102,551			19
20	Dues, Fees, Subscriptions & Promotions			117,500	117,500		117,500	(49,715)	67,785			20
21	Clerical & General Office Expenses	235,500	21,376	364,380	621,256		621,256	163,960	785,216			21
22	Employee Benefits & Payroll Taxes			853,117	853,117		853,117	(2,528)	850,589			22
23	Inservice Training & Education			205	205		205		205			23
24	Travel and Seminar			1,575	1,575		1,575	12,172	13,747			24
25	Other Admin. Staff Transportation			12,787	12,787		12,787	(10,140)	2,647			25
26	Insurance-Prop.Liab.Malpractice			258,756	258,756		258,756	4,382	263,138			26
27	Other (specify):*							74,778	74,778			27
28	TOTAL General Administration	392,370	21,376	2,574,991	2,988,737		2,988,737	(571,805)	2,416,932			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,317,015	872,080	3,310,720	9,499,815		9,499,815	(561,421)	8,938,394			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			74,688	74,688		74,688	378,348	453,036			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,925	8,925		8,925	1,599,556	1,608,481			32
33	Real Estate Taxes							556,471	556,471			33
34	Rent-Facility & Grounds			2,958,000	2,958,000		2,958,000	(2,935,109)	22,891			34
35	Rent-Equipment & Vehicles			10,806	10,806		10,806	4,125	14,931			35
36	Other (specify):*			8,212	8,212		8,212	146,892	155,104			36
37	TOTAL Ownership			3,060,631	3,060,631		3,060,631	(249,717)	2,810,914			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			246,375	246,375		246,375		246,375			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			246,375	246,375		246,375		246,375			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,317,015	872,080	6,617,726	12,806,821		12,806,821	(811,138)	11,995,683			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(374,526)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	02		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	(4,173)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(58,012)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,701)	20		28
29	Other-Attach Schedule	(324,173)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (763,602)		\$	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)	(47,535)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (47,535)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (811,138)		37

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

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

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

OHF USE ONLY					
48		49	50	51	52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
1 Other Income	\$ (1,925)	21 1
2 Jury Duty	608	10 2
3 Patient Clothing	(69)	10 3
4 Theft Loss	(525)	21 4
5 Collection Expense	(125)	21 5
6 Illinois Replacement Tax	(1,500)	21 6
7 Capitalized R&M	(8,937)	6 7
8 2006 Seminar	196	24 8
9 C-CPI Fees	(1,637)	20 9
10 Building Company - Accounting Fees	(8,500)	19 10
11 Building Company - License & Fees	(250)	20 11
12 Non-Allowable Expense	(300,000)	21 12
13		13
14		14
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92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(324,173)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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				(29)	934		(5,771)					(4,866)	1
2	Food Purchase	(17)											(17)	2
3	Housekeeping				(7,278)								(7,278)	3
4	Laundry													4
5	Heat and Other Utilities					5,878							5,878	5
6	Maintenance	(8,937)			(15)	14,367		12,959					18,374	6
7	Other (specify):*						258	3,392					3,650	7
8	TOTAL General Services	(8,954)			(7,322)	21,179	258	10,580					15,741	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(679)			(6,483)								(7,162)	10
10a	Therapy							1,404					1,404	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						210	192					402	15
16	TOTAL Health Care and Programs	(679)			(6,483)		210	1,596					(5,356)	16
	C. General Administration													
17	Administrative				(300,366)			77,772					(222,594)	17
18	Directors Fees													18
19	Professional Services	(8,500)	8,500			(542,120)							(542,120)	19
20	Fees, Subscriptions & Promotions	(62,600)	250			12,635							(49,715)	20
21	Clerical & General Office Expenses	(308,248)				46,961		425,247					163,960	21
22	Employee Benefits & Payroll Taxes				(48)		(2,480)						(2,528)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(95)				12,267							12,172	24
25	Other Admin. Staff Transportation					(10,140)							(10,140)	25
26	Insurance-Prop.Liab.Malpractice					4,382							4,382	26
27	Other (specify):*						2,608	72,170					74,778	27
28	TOTAL General Administration	(379,443)	8,750		(48)	(776,381)	128	575,189					(571,805)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(389,076)	8,750		(13,853)	(755,202)	596	587,365					(561,421)	29

STATE OF ILLINOIS

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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	(374,526)	691,638			61,236							378,348	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		1,589,333			10,223							1,599,556	32
33	Real Estate Taxes		551,638			4,833							556,471	33
34	Rent-Facility & Grounds		(2,958,000)			22,891							(2,935,109)	34
35	Rent-Equipment & Vehicles					4,125							4,125	35
36	Other (specify):*		146,892										146,892	36
37	TOTAL Ownership	(374,526)	21,501			103,308							(249,717)	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													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(763,602)	30,251		(13,853)	(651,894)	596	587,365					(811,138)	45

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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
See Attached		See Attached		Somerset Real Estate, L.L.C.		Building Company
				See Attached		

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 Rent	\$ 2,958,000	Somerset Real Estate, L.L.C.		\$	\$ (2,958,000)	1
2	V	32 Interest	7,032			1,596,365	1,589,333	2
3	V	19 Accounting Fees				8,500	8,500	3
4	V	20 License & Fees				250	250	4
5	V	36 MIP Insurance				141,330	141,330	5
6	V	33 Real Estate Tax				551,638	551,638	6
7	V	36 Amortization Closing Fees				5,562	5,562	7
8	V	30 Depreciation				691,638	691,638	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,965,032			\$ 2,995,283	\$ * 30,251	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 243,058	\$ 243,058	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	243,058	CCS EMPLOYEE BENEFIT GROUP	100.00%		(243,058)	19
20	V								20
21	V								21
22	V								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			\$ 243,058			\$ 243,058	\$ *	39

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

Facility Name & ID Number Somerset Place# 0044289Report Period Beginning: 01/01/05Ending: 12/31/05**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	01 DIETARY	\$ 291	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 263	\$	(29)	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%				16
17	V	03 HOUSEKEEPING	73,406	XCEL MEDICAL SUPPLY, LLC	100.00%	66,128		(7,278)	17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%				18
19	V	06 REPAIRS & MAINTENANCE	152	XCEL MEDICAL SUPPLY, LLC	100.00%	137		(15)	19
20	V	10 NURSING	65,396	XCEL MEDICAL SUPPLY, LLC	100.00%	58,913		(6,483)	20
21	V	11 ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%				21
22	V	20 DUES, FEES, SUBSCRIPTIONS & PROM		XCEL MEDICAL SUPPLY, LLC	100.00%				22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%				23
24	V	22 EMPLOYEE BENEFITS	488	XCEL MEDICAL SUPPLY, LLC	100.00%	439		(48)	24
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%				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		\$ 139,733			\$ 125,880	\$ *	(13,853)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 934	\$ 934	15
16	V	05 Utilities		Care Centers, Inc.	100.00%	5,878	5,878	16
17	V	06 Maintenance		Care Centers, Inc.	100.00%	14,367	14,367	17
18	V			Care Centers, Inc.	100.00%			18
19	V	17 Administration	310,000	Care Centers, Inc.	100.00%	9,634	(300,366)	19
20	V	19 Professional Fees	596,063	Care Centers, Inc.	100.00%	53,943	(542,120)	20
21	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	12,635	12,635	21
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	46,961	46,961	22
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	12,267	12,267	23
24	V	26 Insurance		Care Centers, Inc.	100.00%	4,382	4,382	24
25	V	30 Depreciation		Care Centers, Inc.	100.00%	61,236	61,236	25
26	V	32 Interest		Care Centers, Inc.	100.00%	10,223	10,223	26
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	4,833	4,833	27
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	22,891	22,891	28
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	4,125	4,125	29
30	V	25 Bus Reimbursement	10,140	Care Centers, Inc.	100.00%		(10,140)	30
31	V	02 Food		Care Centers, Inc.	100.00%			31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 916,203			\$ 264,309	\$ * (651,894)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289Report Period Beginning: 01/01/05Ending: 12/31/05

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	06 Maintenance Salary	\$ 1,875	Care Centers, Inc.	100.00%	\$ 1,875		15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	258	258	16
17	V	10 Nursing Salary	1,487	Care Centers, Inc.	100.00%	1,487		17
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%			18
19	V							19
20	V							20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	210	210	21
22	V	17 Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21 Office Salary	13,516	Care Centers, Inc.	100.00%	13,516		23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	2,608	2,608	24
25	V	22 Employee Benefits	2,480	Care Centers, Inc.	100.00%		(2,480)	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		\$ 19,358			\$ 19,954	\$ *	596

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289Report Period Beginning: 01/01/05Ending: 12/31/05

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	01 Dietary Salary	\$ 16,425	Care Centers, Inc.	100.00%	\$ 10,654	\$ (5,771)	15
16	V							16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	12,959	12,959	17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	3,392	3,392	18
19	V							19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	1,404	1,404	20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	192	192	21
22	V							22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	77,772	77,772	23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	425,247	425,247	24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	72,170	72,170	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		\$ 16,425			\$ 603,790	\$ * 587,365	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/05

Ending: 12/31/05

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/05

Ending: 12/31/05

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/05

Ending: 12/31/05

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/05

Ending: 12/31/05

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Adam Vales	Owner	Clerical	1.78%	See Attached	1.61	4.03%	Alloc Salary	\$ 1,981	22-7	1
2	Kimberly Rudolph	Owner	Clerical	1.78%	See Attached	1.70	4.86%	Alloc Salary	2,729	22-7	2
3	Eric Rothner	Relative	Administrative	0.00%	See Attached	3.15	46.15%	Alloc Salary	7,588	17-7	3
4	Gale Rothner	Relative	Administrative	0.00%	See Attached	3.48	9.94%	Alloc Salary	7,747	17-7	4
5	Mark Steinberg	Relative	Administrative	0.00%	See Attached	5.46	9.93%	Alloc Salary	7,307	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,352		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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	<u>22</u>	<u>EMPLOYEE HEALTH INSURANCE</u>	<u>DIRECT ALLOCATION</u>		\$	\$		\$ <u>243,058</u>	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				\$	\$		\$ 243,058	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 W. MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	01	DIETARY	Direct Allocation		\$	\$		263	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					66,128	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					137	5
6	10	NURSING	Direct Allocation					58,913	6
7	11	ACTIVITIES	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation					439	10
11	39	ANCILLARY	Direct Allocation						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				\$	\$		125,880	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Patient Days	1,497,287	32	\$ 9,406	\$ 148,704	\$ 934	1
2	05	Utilities	Patient Days	1,497,287	32	59,188	148,704	5,878	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661	148,704	14,367	3
4									4
5	17	Administration	Patient Days	1,497,287	32	97,000	148,704	9,634	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148	148,704	53,943	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217	148,704	12,635	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845	148,704	46,961	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511	148,704	12,267	9
10	26	Insurance	Patient Days	1,497,287	32	44,126	148,704	4,382	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575	148,704	61,236	11
12	32	Interest	Patient Days	1,497,287	32	102,930	148,704	10,223	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662	148,704	4,833	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488	148,704	22,891	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530	148,704	4,125	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,661,288	\$	\$ 264,309	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	06	Maintenance Salary	Direct Cost		301,710	301,710		1,875	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost		46,639			258	2
3	10	Nursing Salary	Direct Cost		425,833	425,833		1,487	3
4	10a	Rehab Salary	Direct Cost		55,464	55,464			4
5									5
6									6
7	15	Emp. Ben. - Healthcare	Direct Cost		67,757			210	7
8	17	Administration Salary	Direct Cost		5,566	5,566			8
9	21	Office Salary	Direct Cost		419,879	419,879		13,516	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost		71,906			2,608	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				\$ 1,394,755	\$ 1,208,453		\$ 19,954	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	148,704	10,654	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	148,704	12,959	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		148,704	3,392	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	148,704	1,404	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		148,704	192	7
8										8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	148,704	77,772	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	148,704	425,247	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		148,704	72,170	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,079,517	\$ 5,316,753		\$ 603,790	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	HUD Loan		X	Mortgage			\$	28,118,996		\$	1,596,365	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Diawa		X	Line of Credit				676,549			8,925	6								
7	Allocated from Care Centers		X								10,223	7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related						\$	28,795,545		\$	1,615,513	9								
B. Non-Facility Related*																				
10	Interest Income - Bldg Co		X								(7,032)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$			\$	(7,032)	14								
15	TOTALS (line 9+line14)						\$	28,795,545		\$	1,608,481	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 141,330 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

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

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

Facility Name & ID Number Somerset Place# 0044289 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	554,030	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.)			\$	544,201	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	(9,829)	3														
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	566,300	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.			\$	556,471	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:																			
2000	<u>559,809</u>	<u>8</u>	<table border="1"> <thead> <tr> <th colspan="2">FOR OHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </tbody> </table>			FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2004 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR OHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
2001	<u>574,368</u>	<u>9</u>																	
2002	<u>580,808</u>	<u>10</u>																	
2003	<u>527,647</u>	<u>11</u>																	
2004	<u>539,368</u>	<u>12</u>																	
<u>2005 Accrual = 2004 Tax \$539,368 x 1.05 = \$566,300 (rounded)</u>																			
<u>Allocated from Care Centers \$4,833</u>																			

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Somerset Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-08-408-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>531,336.36</u>	\$ <u>531,336.36</u>
2. <u>14-08-408-031-0000</u>	<u>Long Term Care Property</u>	\$ <u>8,032.06</u>	\$ <u>8,032.06</u>
3. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>113,458.70</u>	\$ <u>4,832.94</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>652,827.12</u>	\$ <u>544,201.36</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Somerset Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

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 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Somerset Place

0044289 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 184,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 9

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).

None

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>1999</u>	<u>\$ 1,100,000</u>	1
2	<u>2201 Main LLC allocation</u>			<u>34,929</u>	2
3	TOTALS			\$ 1,134,929	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1999	37,488		20	1,876	1,876	12,469	9
10	Various			2000	615,158		20	31,359	31,359	179,966	10
11	Various			2001	168,415		20	8,424	8,424	40,902	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	Related Building Company (Pages 12-BLDG & 12A-BLDG)	15,434,423	691,638		295,271	(396,367)	1,948,994	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	137,083	5,617		5,617		16,930	68
69	Financial Statement Depreciation		74,688			(74,688)		69
70	TOTAL (lines 4 thru 69)	\$ 16,392,567	\$ 771,943		\$ 342,547	\$ (429,396)	\$ 2,199,261	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

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		\$ 16,392,567	\$ 771,943		\$ 342,547	\$ (429,396)	\$ 2,199,261	1
2	Nurse Call System	2002	17,000		20	1,133	1,133	4,533	2
3	Knob Lock	2002	840		20	84	84	336	3
4	Plumbing Supplies	2002	610		20	61	61	239	4
5	Door Curtains	2002	1,068		20	107	107	418	5
6	Sewer Lines	2002	5,237		20	524	524	2,051	6
7	Tuckpointing	2002	1,000		20	100	100	392	7
8	Plaster Caulking, Tuckpointing	2002	8,000		20	800	800	3,067	8
9	Canopy	2002	3,494		20	349	349	1,339	9
10	Window Shades	2002	723		20	72	72	277	10
11	Magnetic Door Repair	2002	680		20	68	68	261	11
12	Metal Door Installation	2002	670		20	67	67	257	12
13	Fire Alarm Repair	2002	1,530		20	219	219	838	13
14	Paint	2002	1,032		20	103	103	387	14
15	Shower Faucet	2002	596		20	40	40	149	15
16	Boiler Repair	2002	1,535		20	128	128	480	16
17	Exhaust Motor Replacement	2002	2,950		20	295	295	1,082	17
18	Tamper Valve Replacement	2002	950		20	95	95	348	18
19	Adt Unimode Fire Alarm	2002	20,693		20	2,956	2,956	10,839	19
20	Canopy Rental	2002	1,648		20	165	165	604	20
21	Door	2002	1,775		20	178	178	651	21
22	Landscaping	2002	1,317		20	88	88	315	22
23	Ac Repair	2002	1,556		20	130	130	454	23
24	Electric Wiring	2002	1,750		20	175	175	613	24
25	Timeclocks Installation	2002	506		20	51	51	173	25
26	Fire System Repair	2002	1,352		20	193	193	660	26
27	Nurse Call System	2002	552		20	37	37	126	27
28	Nurse Call System	2002	586		20	39	39	133	28
29	Nurse Call System	2002	1,554		20	104	104	354	29
30	Boiler Repair	2002	15,665		20	1,305	1,305	4,351	30
31	Paint	2002	589		20	59	59	196	31
32	Tiles	2002	708		20	47	47	157	32
33	Fire Alarm Repair	2002	646		20	92	92	308	33
34	TOTAL (lines 1 thru 33)		\$ 16,491,379	\$ 771,943		\$ 352,411	\$ (419,532)	\$ 2,235,649	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 16,491,379	\$ 771,943		\$ 352,411	\$ (419,532)	\$ 2,235,649	1
2	Roof Cement	2002	523		20	52	52	170	2
3	Boiler Repair	2002	2,849		20	237	237	772	3
4	Boiler Repair	2002	2,000		20	167	167	542	4
5	Reroofing	2002	3,500		20	350	350	1,138	5
6	New Front Door	2002	800		20	80	80	260	6
7	Structural Engineer Service	2002	750		20	75	75	244	7
8	Sewer Study	2002	600		20	60	60	195	8
9	Cast Iron Piping Repair	2002	6,110		20	611	611	1,935	9
10	Cast Iron Piping Repair	2002	560		20	56	56	177	10
11	New Front Door	2002	800		20	80	80	253	11
12	Nurse Call System	2002	2,392		20	159	159	505	12
13	Paint & Tile	2002	2,671		20			2,671	13
14	Plumbing Work	2002	16,800		20	1,680	1,680	6,720	14
15	Paint	2003	1,079		20	108	108	324	15
16	Plumbing Supplies	2003	960		20	96	96	288	16
17	Plumbing Supplies	2003	509		20	51	51	153	17
18	Roof Ladder Installation	2003	1,500		20	150	150	450	18
19	Sewer Line Repair	2003	3,590		20	359	359	1,047	19
20	Sewer Line Repair	2003	3,800		20	190	190	554	20
21	Second Floor Doors	2003	1,870		20	187	187	530	21
22	Tuckpointing	2003	3,200		20	320	320	880	22
23	Doors Repair	2003	925		20	93	93	254	23
24	Doors Repair	2003	890		20	89	89	245	24
25	Elevator Repair	2003	3,858		20	193	193	530	25
26	Roof Fan	2003	4,924		20	492	492	1,313	26
27	Plumbing Work	2003	9,300		20	930	930	2,480	27
28	Leasehold Improvements	2003	3,346		20	335	335	864	28
29	Duct Work	2003	2,615		20	262	262	676	29
30	Landscaping	2003	1,317		20	132	132	340	30
31	Ac Repair	2003	4,047		20	337	337	815	31
32	Blinds For 9Th Floor	2003	1,470		20	147	147	343	32
33	Replacement For 2 Doors Nad Sidelights	2003	2,700		20	270	270	630	33
34	TOTAL (lines 1 thru 33)		\$ 16,583,634	\$ 771,943		\$ 360,759	\$ (411,184)	\$ 2,263,947	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 16,583,634	\$ 771,943		\$ 360,759	\$ (411,184)	\$ 2,263,947	1
2	Paint	2003	969		20	48	48	109	2
3	Cabinet Doors, Shower Rods	2003	1,059		20	53	53	119	3
4	Boiler Repair	2003	15,987		20	1,332	1,332	2,887	4
5	4 Toilet Kits	2003	822		20	82	82	178	5
6	Heat/Cooling System	2003	661		20	55	55	165	6
7	Door Locks	2003	1,281		20	128	128	384	7
8	Motor Repair	2003	668		20	67	67	200	8
9	Gutters And Downspouts	2003	950		20	95	95	285	9
10	Repair Pump	2004	855		20	86	86	171	10
11	New Motor For Grundfos Pump	2004	2,860		20	286	286	572	11
12	Plumbing Work	2004	23,625		20	2,363	2,363	4,528	12
13	Replace Valves	2004	1,948		20	195	195	373	13
14	Pressure Balanced Shower Valves	2004	1,564		20	156	156	300	14
15	Mechanical Burner	2004	21,947		20	2,195	2,195	4,024	15
16	Drywall, Metal Studs, Fan Lights	2004	1,022		20	102	102	187	16
17	Emergency Fixture	2004	1,298		20	130	130	238	17
18	New Compressor	2004	1,070		20	107	107	187	18
19	Lamp Parts	2004	526		20	53	53	88	19
20	Replace Plate Glass	2004	750		20	75	75	119	20
21	Remove Bricks	2004	2,400		20	240	240	380	21
22	Replace Grease Traps	2004	1,593		20	159	159	252	22
23	Rewire Emergency Circuits	2004	4,945		20	495	495	783	23
24	Doors	2004	1,300		20	130	130	206	24
25	Condenser Fan Motor	2004	972		20	97	97	154	25
26	Elevator Repair	2004	2,308		20	115	115	183	26
27	12 Light Covers	2004	734		20	73	73	110	27
28	Install 4 Glass Block Windows	2004	1,700		20	170	170	241	28
29	New Fire Hoses & Reels	2004	2,823		20	282	282	400	29
30	35 Cases Of Tiles	2004	837		20	84	84	119	30
31	Various Hardware Supplies	2004	718		20	72	72	102	31
32	Tiles	2004	1,075		20	107	107	143	32
33	Locks	2004	668		20	67	67	89	33
34	TOTAL (lines 1 thru 33)		\$ 16,685,569	\$ 771,943		\$ 370,458	\$ (401,485)	\$ 2,282,223	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 16,685,569	\$ 771,943		\$ 370,458	\$ (401,485)	\$ 2,282,223	1
2	Various Hardware Supplies	2004	939		20	94	94	125	2
3	Various Hardware Supplies	2004	702		20	70	70	94	3
4	Repair Fire Hose Racks	2004	524		20	52	52	70	4
5	Repair Leak	2004	783		20	78	78	98	5
6	Ceiling Fans, Plumbing Parts	2004	784		20	78	78	98	6
7	Ballasts & Light Bulbs	2004	901		20	90	90	105	7
8	Light Fixtures, Plates Etc.	2004	530		20	53	53	62	8
9	Clark Devon Hardware	2004	511		20	51	51	60	9
10	8 Insulated Glass Units	2004	1,353		20	135	135	147	10
11	Door Locks/ Hardware	2004	2,283		20	228	228	247	11
12	Plumbing / Sink	2004	591		20	30	30	49	12
13	Room Improvements	2004	813		20	41	41	78	13
14	Paint	2004	965		20	48	48	52	14
15	Tile	2004	570		20	29	29	55	15
16	Toilets	2004	579		20	29	29	56	16
17	Tile	2004	1,061		20	53	53	97	17
18	Elevator Repair	2004	884		20	44	44	77	18
19	Elevator Repair	2004	552		20	28	28	35	19
20	Inspection Of Outside Walls	2005	20,000		20	2,000	2,000	2,000	20
21	New Governor	2005	3,800		20	380	380	380	21
22	Various Hardware Parts	2005	558		20	56	56	56	22
23	Paints	2005	1,064		20	35	35	35	23
24	Architect Tuckpointing	2005	22,500		20	2,063	2,063	2,063	24
25	Scaffold	2005			20	144	144	144	25
26	Toilet Parts	2005	799		20	73	73	73	26
27	Various Supplies	2005	590		20	49	49	49	27
28	Paints	2005	1,763		20	147	147	147	28
29	Paints	2005	2,112		20	70	70	70	29
30	Tiles & Adhesive	2005	576		20	38	38	38	30
31	Microprocessor Control System	2005	165,000		20	6,875	6,875	6,875	31
32	South Fire Escape	2005	2,628		20	110	110	110	32
33	Air Conditioners	2005	1,991		20	41	41	41	33
34	TOTAL (lines 1 thru 33)		\$ 16,924,275	\$ 771,943		\$ 383,770	\$ (388,173)	\$ 2,295,909	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 16,924,275	\$ 771,943		\$ 383,770	\$ (388,173)	\$ 2,295,909	1
2	Kitchen Door	2005	1,783		20	52	52	52	2
3	Laundry Panel - Electrical	2005	1,842		20	38	38	38	3
4	Emergency Lights	2005	3,321		20	42	42	42	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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 12F, Carried Forward	\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
1		\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041	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
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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 12H, Carried Forward	\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041		1
2									2
3									3
4									4
5									5
6									6
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10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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 12I, Carried Forward		\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041	1
2									2
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4									4
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6									6
7									7
8									8
9									9
10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
1		\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
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24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 16,931,221	\$ 771,943		\$ 383,902	\$ (388,041)	\$ 2,296,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	450		1999	1975	\$ 14,605,934	\$	39	\$ 253,846	\$ 253,846	\$ 1,745,192	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Somerset Realty, LLC		1999		586,916		20	29,346	29,346	176,752	9
10	Somerset Realty, LLC		2000		13,789		20	690	690	6,951	10
11	Somerset Realty, LLC (see attached)		2003		52,110		20	2,606	2,606	7,318	11
12	Somerset Realty, LLC (see attached)		2004		83,025		20	4,151	4,151	8,149	12
13	Somerset Realty, LLC (see attached)		2005		92,649		20	4,632	4,632	4,632	13
14											14
15	Somerset Realty, LLC (Book Depreciation)					691,638			(691,638)		15
16											16
17											17
18											18
19											19
20											20
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30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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)	\$ 15,434,423	\$ 691,638		\$ 295,271	\$ (396,367)	\$ 1,948,994	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	2201 Main LLC allocation		2002	2002	\$ 48,134	\$ 1,234	39	\$ 1,234	\$	\$ 4,063	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Allocation from 2201 Main LLC			2002	39,762	1,988	20	1,988		6,958	9
10	Allocation from 2201 Main LLC			2003	46,859	2,343	20	2,343		5,857	10
11	Allocation from 2201 Main LLC			2005	2,328	52	20	52		52	11
12											12
13											13
14											14
15											15
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning:

01/01/05

Ending:

12/31/05

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)	\$	137,083	\$	5,617	\$	5,617	\$	16,930	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place # 0044289 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 2,764,961	\$ 49,733	\$ 81,340	\$ 31,607	10	\$ 299,891	71
72	Current Year Purchases	39,267	973	(18,785)	(19,758)	10	(18,785)	72
73	Fully Depreciated Assets	22,547				10	22,547	73
74								74
75	TOTALS	\$ 2,826,775	\$ 50,706	\$ 62,555	\$ 11,849		\$ 303,653	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		VAN	1999	\$ 5,000	\$	\$	\$	5	\$ 5,000	76
77		INSTALL SEATBELTS	2000	780		78	78	5	436	77
78		1995 CADILLAC SEDAN	2004	5,500		1,588	1,588	5	1,794	78
79		Care Centers Allocation		67,065	4,912	4,912		5	50,785	79
80	TOTALS			\$ 78,345	\$ 4,912	\$ 6,578	\$ 1,666		\$ 58,015	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)		\$ 20,971,270	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 827,561	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 453,035	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (374,526)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,657,709	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	Allocated from Care Centers				22,891			6
7	TOTAL				\$ 22,891			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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 14,931 Description: See Attached Schedule

(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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(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	\$ 2,000	\$ 9,756	1
2	Cash-Patient Deposits	75,280	75,280	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,561,787	2,561,787	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	302,842	477,444	6
7	Other Prepaid Expenses	30,055	30,055	7
8	Accounts Receivable (owners or related parties)	279,896	789,896	8
9	Other(specify): <u>See Attached Schedule</u>	11,022	2,094,180	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,262,882	\$ 6,038,398	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,100,000	13
14	Buildings, at Historical Cost		9,900,000	14
15	Leasehold Improvements, at Historical Cost	1,325,258	3,925,732	15
16	Equipment, at Historical Cost	293,858	1,115,055	16
17	Accumulated Depreciation (book methods)	(469,522)	(4,719,772)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		194,679	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,369)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		10,907,768	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,149,594	\$ 22,409,093	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,412,476	\$ 28,447,491	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,479,862	\$ 1,573,084	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	70,141	70,141	28
29	Short-Term Notes Payable	676,549	676,549	29
30	Accrued Salaries Payable	273,356	273,356	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,779	8,779	31
32	Accrued Real Estate Taxes(Sch.IX-B)		566,300	32
33	Accrued Interest Payable		132,394	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,508,687	\$ 3,300,603	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		28,118,995	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 28,118,995	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,508,687	\$ 31,419,598	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,903,789	\$ (2,972,107)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,412,476	\$ 28,447,491	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,378,875	1
2	Restatements (describe):		2
3	<u>See Attached</u>	(6,535,670)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 843,205	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,235,584	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	(1,175,000)	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)	\$ 1,060,584	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)	\$ 1,903,789	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	\$ 14,994,386	1
2	Discounts and Allowances for all Levels	(142)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,994,244	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	142	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	45	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 187	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	47,974	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 47,974	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,042,405	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,649,364	31
32	Health Care	3,861,714	32
33	General Administration	2,988,737	33
B. Capital Expense			
34	Ownership	3,060,631	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	246,375	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,806,821	40
41	Income before Income Taxes (line 30 minus line 40)**	2,235,584	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,235,584	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/05

Ending:

12/31/05

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	1,157	1,318	\$ 45,656	\$ 34.64	1
2	Assistant Director of Nursing	3,499	3,818	110,931	29.05	2
3	Registered Nurses	7,437	8,396	179,491	21.38	3
4	Licensed Practical Nurses	38,495	41,624	911,804	21.91	4
5	CNAs & Orderlies	124,710	136,876	1,364,062	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,892	2,230	24,073	10.80	8
9	Activity Director	3,699	4,190	69,268	16.53	9
10	Activity Assistants	26,350	28,611	238,106	8.32	10
11	Social Service Workers	43,337	47,723	687,408	14.40	11
12	Dietician	3,510	4,024	43,332	10.77	12
13	Food Service Supervisor	3,871	4,377	53,629	12.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,442	6,078	58,051	9.55	15
16	Dishwashers	35,862	38,906	300,126	7.71	16
17	Maintenance Workers	28,784	31,593	368,642	11.67	17
18	Housekeepers	43,438	47,720	382,621	8.02	18
19	Laundry	1,713	1,847	13,457	7.29	19
20	Administrator	1,889	2,638	100,706	38.18	20
21	Assistant Administrator	1,869	2,146	56,164	26.17	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,684	18,348	235,500	12.84	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	3,902	4,536	62,742	13.83	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,009	1,129	11,246	9.96	33
34	TOTAL (lines 1 - 33)	398,549	438,128	\$ 5,317,015 *	\$ 12.14	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	382	\$ 21,881	01-03	35
36	Medical Director	monthly	12,000	09-03	36
37	Medical Records Consultant	monthly	1,752	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	6,188	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	8	299	11-03	44
45	Social Service Consultant	monthly	7,200	12-03	45
46	Other(specify)				46
47					47
48	<u>CCI - See Attached</u>		17,912	various	48
49	TOTAL (lines 35 - 48)	390	\$ 67,232		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	477	17,289	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	477	\$ 17,289		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

0044289

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	
Karen James	Administrator	0	\$ 63,819	Workers' Compensation Insurance	\$ 90,766	IDPH License Fee	\$ 5,500	
Jeremy Boshes	Administrator	0	36,888	Unemployment Compensation Insurance	78,519	Advertising: Employee Recruitment	19,670	
Blake Willey	Asst Admin	0	56,164	FICA Taxes	397,568	Health Care Worker Background Check	1,912	
				Employee Health Insurance	217,223	(Indicate # of checks performed 104)		
				Employee Meals		Dues & Subscriptions	24,431	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	3,637	
				Chicago Employee Taxes	10,518	Advertising & Promotion	58,012	
				Employee Physicals	674	Telephone Directory Advertising	1,701	
				Pension Expense	34,295	Allocated from Care Centers	12,635	
				Other Employee Welfare	15,789			
				Holiday Expense	5,237	Less: Public Relations Expense	()	
						Non-allowable advertising	(58,012)	
						Yellow page advertising	(1,701)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 156,871	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 850,589		\$ 67,785		
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
Management Fees - Nathan Langsner			12,000				Out-of-State Travel	\$
Management Fees - Care Centers Inc.			310,000					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 322,000					
(Attach a copy of any management service agreement)							Seminar Expense	1,480
							Allocated from Care Centers	12,267
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount	\$			()	
ADP, Inc.	Payroll		20,322				(agree to Sch. V, line 24, col. 8)	
Care Centers Inc.	Data Processing		16,200				\$ 13,747	
Personnel Planners	Unemployment Consult		3,330					
Frost, Ruttenberg & Rothblatt	Accounting		18,000					
Care Centers Inc.	Accounting		15,000					
Care Centers Inc.	Bookkeeping		91,800					
Care Centers Inc.	Home Office Expense		378,000					
Care Centers Inc.	Ancillary Admin. Services		54,000					
BDO Seidman	Line of Credit - Audit		4,213					
Legat Architects	Architects		870					
Care Centers Inc.	Legal		41,063					
See Supplemental Schedule			1,873					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 644,671					
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Somerset Place

Report Period Beginning: 01/01/05 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$22,112
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 107 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ 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. \$ 246,375
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT