

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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: 0026914

Facility Name: Concord Extended Care

Address: 9401 South Ridgeland Avenue Oak Lawn 60453
 Number City Zip Code

County: Cook

Telephone Number: (708) 449-9090 **Fax #** (708) 449-7070

HFS ID Number: 362833027001

Date of Initial License for Current Owners: 00/00/67

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/06 to 12/31/06 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 Concord Extended Care

0026914 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>134</u>	Skilled (SNF)	<u>134</u>	<u>48,910</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>134</u>	TOTALS	<u>134</u>	<u>48,910</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>27,268</u>	<u>6,931</u>	<u>4,565</u>	<u>38,764</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,268</u>	<u>6,931</u>	<u>4,565</u>	<u>38,764</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.26%

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

62 (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 1962

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

YES Date 1962 NO

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

YES NO If YES, enter number of beds certified 50 and days of care provided 4,099

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	207,183	50,015	11,379	268,577		268,577	3,376	271,953			1
2	Food Purchase		166,643		166,643	(24,090)	142,553	(588)	141,965			2
3	Housekeeping	152,592	34,063		186,655		186,655	(2,779)	183,876			3
4	Laundry	92,183	19,558		111,741		111,741	(8)	111,733			4
5	Heat and Other Utilities			116,200	116,200		116,200	1,605	117,805			5
6	Maintenance	74,215		87,746	161,961		161,961	31,428	193,389			6
7	Other (specify):*							4,398	4,398			7
8	TOTAL General Services	526,173	270,279	215,325	1,011,777	(24,090)	987,687	37,431	1,025,118			8
	B. Health Care and Programs											
9	Medical Director			17,000	17,000		17,000		17,000			9
10	Nursing and Medical Records	1,958,061	50,504	39,283	2,047,848		2,047,848	6,302	2,054,150			10
10a	Therapy	110,821		4,956	115,777		115,777	1,781	117,558			10a
11	Activities	79,945	8,096	2,315	90,356		90,356		90,356			11
12	Social Services	110,473		2,997	113,470		113,470	8,715	122,185			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,482	3,482			15
16	TOTAL Health Care and Programs	2,259,300	58,600	66,551	2,384,451		2,384,451	20,280	2,404,731			16
	C. General Administration											
17	Administrative	79,742		47,000	126,742		126,742	29,783	156,525			17
18	Directors Fees											18
19	Professional Services			284,874	284,874	(15,000)	269,874	(224,939)	44,935			19
20	Dues, Fees, Subscriptions & Promotions			46,790	46,790		46,790	(7,440)	39,350			20
21	Clerical & General Office Expenses	113,237	22,289	288,785	424,311		424,311	(158,093)	266,218			21
22	Employee Benefits & Payroll Taxes			447,787	447,787	24,090	471,877	(3,986)	467,891			22
23	Inservice Training & Education			180	180		180		180			23
24	Travel and Seminar			1,998	1,998		1,998	2,555	4,553			24
25	Other Admin. Staff Transportation			4,714	4,714		4,714	43	4,757			25
26	Insurance-Prop.Liab.Malpractice			131,278	131,278		131,278	(281)	130,997			26
27	Other (specify):*							18,701	18,701			27
28	TOTAL General Administration	192,979	22,289	1,253,406	1,468,674	9,090	1,477,764	(343,658)	1,134,106			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,978,452	351,168	1,535,282	4,864,902	(15,000)	4,849,902	(285,946)	4,563,956			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.

Facility Name & ID Number Concord Extended Care #0026914 Report Period Beginning: 01/01/06 Ending: 12/31/06

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			73,042	73,042		73,042	96,759	169,801			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,238	20,238		20,238	274,686	294,924			32
33	Real Estate Taxes					15,000	15,000	139,985	154,985			33
34	Rent-Facility & Grounds			516,203	516,203		516,203	(513,471)	2,732			34
35	Rent-Equipment & Vehicles			2,527	2,527		2,527	758	3,285			35
36	Other (specify):*							19,881	19,881			36
37	TOTAL Ownership			612,010	612,010	15,000	627,010	18,598	645,608			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		205,915	389,558	595,473		595,473	(9,530)	585,943			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,365	73,365		73,365		73,365			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		205,915	462,923	668,838		668,838	(9,530)	659,308			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,978,452	557,083	2,610,215	6,145,750		6,145,750	(276,878)	5,868,872			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 Concord Extended Care

0026914

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	11,263	30		9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(294)	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	(31,916)	21		18
19	Entertainment				19
20	Contributions	(670)	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	(124,803)	21		24
25	Fund Raising, Advertising and Promotional	(7,700)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,237)	20		28
29	Other-Attach Schedule	(150,469)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (305,833)		\$	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)	28,954		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 28,954		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (276,878)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Sch. V Line
1	Miscellaneous Income	21
2	Buy-Down	19
3	Theft Loss	21
4	Collection Expense	21
5	VA Pharmacy	10
6	VA Oxygen	10
7	K/OPJ Dues	20
8	Non-Allowable Expense	21
9	Non-Allowable Legal Fees	19
10	Building Company	10
11	Professional Fees	19
12	Amortization	36
13	Licenses & Fees	20
14	Non-Allowable Billing Service	19
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100		100
101	Total	101

(150,469)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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			328				2,680	374		(6)		3,376	1
2	Food Purchase	(294)							(294)				(588)	2
3	Housekeeping										(2,779)		(2,779)	3
4	Laundry										(8)		(8)	4
5	Heat and Other Utilities			1,496			67		42				1,605	5
6	Maintenance		25,022	2,269	3,878	608	44		67		(460)		31,428	6
7	Other (specify):*				561	3,379		458					4,398	7
8	TOTAL General Services	(294)	25,022	4,093	4,439	3,987	111	3,138	189		(3,254)		37,431	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,609)						14,351			(2,440)		6,302	10
10a	Therapy							1,781					1,781	10a
11	Activities													11
12	Social Services				2,140			6,575					8,715	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				287			3,195					3,482	15
16	TOTAL Health Care and Programs	(5,609)			2,427			25,902			(2,440)		20,280	16
	C. General Administration													
17	Administrative			1,460	3,240			24,434	649				29,783	17
18	Directors Fees													18
19	Professional Services	(30,796)	8,700	(179,750)			(23,112)		19				(224,939)	19
20	Fees, Subscriptions & Promotions	(11,766)	250	4,020			27		29				(7,440)	20
21	Clerical & General Office Expenses	(266,379)		8,399	92,097		21	6,887	882				(158,093)	21
22	Employee Benefits & Payroll Taxes					(1,536)				(2,193)	(258)		(3,986)	22
23	Inservice Training & Education													23
24	Travel and Seminar			2,537			29				(11)		2,555	24
25	Other Admin. Staff Transportation								43				43	25
26	Insurance-Prop.Liab.Malpractice			(361)			15		65				(281)	26
27	Other (specify):*				14,219			4,266	216				18,701	27
28	TOTAL General Administration	(308,941)	8,950	(163,695)	109,556	(1,536)	(23,020)	35,587	1,903	(2,193)	(269)		(343,658)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(314,844)	33,972	(159,602)	116,422	2,451	(22,909)	64,627	2,092	(2,193)	(5,963)		(285,946)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06 Ending:

12/31/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	11,263	78,063	7,219			199		15				96,759	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7)	257,193	16,930			568		2				274,686	32
33	Real Estate Taxes		138,604	1,236			130		15				139,985	33
34	Rent-Facility & Grounds		(516,203)	2,732									(513,471)	34
35	Rent-Equipment & Vehicles			732					26				758	35
36	Other (specify):*	(2,245)	22,126										19,881	36
37	TOTAL Ownership	9,011	(20,217)	28,849			897		58				18,598	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(5,277)		(4,253)		(9,530)	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								(5,277)		(4,253)		(9,530)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(305,833)	13,755	(130,753)	116,422	2,451	(22,012)	64,627	(3,127)	(2,193)	(10,216)		(276,878)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Concord Health Care Properties		

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	\$ 516,203	Concord Health Care Properties	100.00%	\$	\$ (516,203)	1
2	V	32 Interest	496	Concord Health Care Properties	100.00%		(496)	2
3	V	19 Professional Fees		Concord Health Care Properties	100.00%	8,700	8,700	3
4	V	06 Repairs & Maintenance		Concord Health Care Properties	100.00%	25,022	25,022	4
5	V	36 Amortization		Concord Health Care Properties	100.00%	2,245	2,245	5
6	V	33 Real Estate Taxes		Concord Health Care Properties	100.00%	138,604	138,604	6
7	V	20 Licenses & Fees		Concord Health Care Properties	100.00%	250	250	7
8	V	32 Interest Expense		Concord Health Care Properties	100.00%	257,689	257,689	8
9	V	36 MIP Expense		Concord Health Care Properties	100.00%	19,881	19,881	9
10	V	30 Depreciation		Concord Health Care Properties	100.00%	78,063	78,063	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 516,699			\$ 530,454	\$ * 13,755	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care# 0026914Report Period Beginning: 01/01/06Ending: 12/31/06

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%	\$ 328	328	15
16	V	05 Utilities		Care Centers, Inc.	100.00%	1,496	1,496	16
17	V	06 Maintenance		Care Centers, Inc.	100.00%	2,269	2,269	17
18	V							18
19	V	17 Administration		Care Centers, Inc.	100.00%	1,460	1,460	19
20	V	19 Professional Fees	190,829	Care Centers, Inc.	100.00%	11,079	(179,750)	20
21	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	4,020	4,020	21
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	8,399	8,399	22
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	2,537	2,537	23
24	V	26 Insurance		Care Centers, Inc.	100.00%	(361)	(361)	24
25	V	30 Depreciation		Care Centers, Inc.	100.00%	7,219	7,219	25
26	V	32 Interest		Care Centers, Inc.	100.00%	16,930	16,930	26
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,236	1,236	27
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	2,732	2,732	28
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	732	732	29
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%			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		\$ 190,829			\$ 60,076	\$ * (130,753)	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	06	Maintenance Salary		Care Centers, Inc.	100.00%	3,878	3,878	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	561	561	16
17	V	10	Nursing Salary		Care Centers, Inc.	100.00%			17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	2,140	2,140	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	287	287	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	3,240	3,240	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	92,097	92,097	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	14,219	14,219	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			\$			\$ 116,422	\$ * 116,422	39

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

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	10,032	Care Centers, Inc.	100.00%	10,640	608	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	3,379	3,379	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V	17 Administration Salary		Care Centers, Inc.	100.00%			21
22	V	21 Office Salary		Care Centers, Inc.	100.00%			22
23	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			23
24	V							24
25	V	22 Employee Benefits	1,536				(1,536)	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		\$ 11,568			\$ 14,019	\$ * 2,451	39

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

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	19	Professional Fees	\$ 23,400	Care Centers Clinical, Inc.	100.00%	\$ 288	\$ (23,112)	15
16	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	27	27	16
17	V	21	Office and Clerical		Care Centers Clinical, Inc.	100.00%	21	21	17
18	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	29	29	18
19	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	199	199	19
20	V	32	Interest		Care Centers Clinical, Inc.	100.00%	568	568	20
21	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	67	67	21
22	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	44	44	22
23	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	15	15	23
24	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	130	130	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		\$ 23,400				\$ 1,388	\$ * (22,012)	39

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

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	\$	Care Centers Clinical, Inc.	100.00%	\$ 2,680	\$ 2,680	15	
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	458	458	16	
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	14,351	14,351	17	
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,781	1,781	18	
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	6,575	6,575	19	
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	3,195	3,195	20	
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	24,434	24,434	21	
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	6,887	6,887	22	
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	4,266	4,266	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		\$				\$ 64,627	\$ *	64,627	39

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

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$		Care Centers Health Systems	100.00%	\$ 374	\$ 374	15
16	V	02	Food		719	Care Centers Health Systems	100.00%	425	(294)	16
17	V	05	Utilities			Care Centers Health Systems	100.00%	42	42	17
18	V	06	Maintenance			Care Centers Health Systems	100.00%	67	67	18
19	V	17	Administration			Care Centers Health Systems	100.00%	98	98	19
20	V	19	Professional Fees			Care Centers Health Systems	100.00%	19	19	20
21	V	20	Dues & Subscriptions			Care Centers Health Systems	100.00%	29	29	21
22	V	21	Office & Clerical			Care Centers Health Systems	100.00%	62	62	22
23	V	25	Auto Expenses			Care Centers Health Systems	100.00%	43	43	23
24	V	26	Insurance			Care Centers Health Systems	100.00%	65	65	24
25	V	30	Depreciation			Care Centers Health Systems	100.00%	15	15	25
26	V	32	Interest Expense			Care Centers Health Systems	100.00%	2	2	26
27	V	33	Real Estate Taxes			Care Centers Health Systems	100.00%	15	15	27
28	V	35	Rent - Equipment & Auto			Care Centers Health Systems	100.00%	26	26	28
29	V	39	Ancillary Enteral Supplies		9,309	Care Centers Health Systems	100.00%	4,032	(5,277)	29
30	V	17	Administrative-Salary			Care Centers Health Systems	100.00%	551	551	30
31	V	21	Office & Clerical-Salary			Care Centers Health Systems	100.00%	820	820	31
32	V	27	Emp. Ben. - Gen. Admin.			Care Centers Health Systems	100.00%	216	216	32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$	10,028			\$ 6,901	\$ * (3,127)	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	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 108,299	\$ 108,299	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	110,492	CCS EMPLOYEE BENEFIT GROUP	100.00%		(110,492)	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			\$ 110,492			\$ 108,299	\$ * (2,193)	39

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

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	\$ 79	Xcel Supply, LLC	100.00%	\$ 73	\$ (6)	15
16	V	03 Housekeeping	34,271	Xcel Supply, LLC	100.00%	31,491	(2,779)	16
17	V	04 Laundry	100	Xcel Supply, LLC	100.00%	92	(8)	17
18	V	06 Repairs & Maintenance	5,677	Xcel Supply, LLC	100.00%	5,217	(460)	18
19	V	10 Nursing	30,085	Xcel Supply, LLC	100.00%	27,645	(2,440)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	3,176	Xcel Supply, LLC	100.00%	2,919	(258)	24
25	V	24 Seminars & Education	137	Xcel Supply, LLC	100.00%	126	(11)	25
26	V	39 Ancillary	52,444	Xcel Supply, LLC	100.00%	48,191	(4,253)	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		\$ 125,969			\$ 115,753	\$ * (10,216)	39

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

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.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Eric Rothner	Owner	Administrative	33.33%	See Attached	0.81	1.75%	Alloc Salary	\$ 1,329	17-7	1
2	Gale Rothner	Relative	Administrative	N/A	See Attached	0.85	2.42%	Alloc Salary	1,898	17-7	2
3	Mark Steinberg	Relative	Administrative	N/A	See Attached	1.34	2.43%	Alloc Salary	3,251	17-7	3
4	Noah Wolff	Owner	Administrative	16.67%	See Attached	10.00	25.65%	Mgmt Fees	47,000	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 53,478		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 Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	1,592,658	31	\$ 13,468	\$ 38,764	\$ 328	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	38,764	1,496	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	38,764	2,269	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	38,764	1,460	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	38,764	11,079	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	38,764	4,020	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	38,764	8,399	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	38,764	2,537	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	38,764	(361)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	38,764	7,219	11
12	32	Interest	Patient Days	1,592,658	31	695,586	38,764	16,930	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	38,764	1,236	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	38,764	2,732	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	38,764	732	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 60,076	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	Patient Days	1,592,658	31	159,318	159,318	38,764	3,878	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	31	23,038		38,764	561	2
3	10	Nursing Salary	Patient Days	1,592,658	31			38,764		3
4	10a	Rehab Salary	Patient Days	1,592,658	31			38,764		4
5	12	Social Service Salary	Patient Days	1,592,658	31	87,938	87,938	38,764	2,140	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	31	11,794		38,764	287	6
7	17	Administration Salary	Patient Days	1,592,658	31	133,122	133,122	38,764	3,240	7
8	21	Office Salary	Patient Days	1,592,658	31	3,783,895	3,783,895	38,764	92,097	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	31	584,195		38,764	14,219	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					\$ 4,783,299	\$ 4,164,272		\$ 116,422	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Allocation	26	366,540	366,540		10,640	1
2	07	Emp. Ben. - Gen. Serv.	Direct Allocation	26	60,795			3,379	2
3									3
4									4
5									5
6									6
7									7
8	21	Office Salary	Direct Allocation	23	418,249	418,249			8
9	27	Emp. Ben. - Gen. Admin.	Direct Allocation	23	70,744				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				\$ 916,329	\$ 784,790		\$ 14,019	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Clinical, 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	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 38,764	\$ 288	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	38,764	27	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	38,764	21	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	38,764	29	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	38,764	199	5
6	32	Interest	Patient Days	1,592,658	30	23,321	38,764	568	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	38,764	67	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	38,764	44	8
9	26	Insurance	Patient Days	1,592,658	30	623	38,764	15	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	38,764	130	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					\$ 57,020	\$	\$ 1,388	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Clinical, 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	1,592,658	30	110,093	110,093	38,764	2,680	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	38,764	458	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		38,764	14,351	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	38,764	1,781	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	38,764	6,575	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		38,764	3,195	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		38,764	24,434	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	38,764	6,887	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		38,764	4,266	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					\$ 2,655,265	\$ 755,172		\$ 64,627	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Health Systems
 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	Billable Income	2,455,454	33	91,698	10,028	374	1
2	02	Food	Billable Income	2,455,454	33	104,128	10,028	425	2
3	05	Utilities	Billable Income	2,455,454	33	10,245	10,028	42	3
4	06	Maintenance	Billable Income	2,455,454	33	16,367	10,028	67	4
5	17	Administration	Billable Income	2,455,454	33	24,000	10,028	98	5
6	19	Professional Fees	Billable Income	2,455,454	33	4,618	10,028	19	6
7	20	Dues & Subscriptions	Billable Income	2,455,454	33	7,167	10,028	29	7
8	21	Office & Clerical	Billable Income	2,455,454	33	15,126	10,028	62	8
9	25	Auto Expenses	Billable Income	2,455,454	33	10,605	10,028	43	9
10	26	Insurance	Billable Income	2,455,454	33	15,802	10,028	65	10
11	30	Depreciation	Billable Income	2,455,454	33	3,557	10,028	15	11
12	32	Interest Expense	Billable Income	2,455,454	33	392	10,028	2	12
13	33	Real Estate Taxes	Billable Income	2,455,454	33	3,660	10,028	15	13
14	35	Rent - Equipment & Auto	Billable Income	2,455,454	33	6,478	10,028	26	14
15	39	Ancillary Enteral Supplies	Billable Income	2,455,454	33	987,356	10,028	4,032	15
16	17	Administrative-Salary	Billable Income	2,455,454	33	134,802	10,028	551	16
17	21	Office & Clerical-Salary	Billable Income	2,455,454	33	200,852	200,852	820	17
18	27	Emp. Ben. - Gen. Admin.	Billable Income	2,455,454	33	52,885	52,885	216	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,689,738	\$ 253,738	\$ 6,901	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 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>108,299</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				\$	\$		\$ <u>108,299</u>	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Supply, LLC
 Street Address 2201 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		\$	\$		73	1
2	03	Housekeeping	Direct Allocation					31,491	2
3	04	Laundry	Direct Allocation					92	3
4	06	Repairs & Maintenance	Direct Allocation					5,217	4
5	10	Nursing	Direct Allocation					27,645	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees, Subscriptions & Prom	Direct Allocation						8
9	21	Clerical & General Office	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					2,919	10
11	24	Seminars & Education	Direct Allocation					126	11
12	39	Ancillary	Direct Allocation					48,191	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				\$	\$		115,753	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	Name of Lender	2		3	4	5	6		8	9	10						
		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 Mortgage		X	Mortgage			\$	\$ 3,949,545			\$ 257,689	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
Working Capital																	
6	Dawia Loan		X	Working Capital				641,702			20,238	6					
7												7					
8	See Supplemental Schedule											8					
9	TOTAL Facility Related						\$	\$ 4,591,247			\$ 277,927	9					
B. Non-Facility Related*																	
10	Interest Income		X								(7)	10					
11	Interest Income - Bldg. Co.		X								(496)	11					
12	Care Centers Allocation		X								17,500	12					
13	See Supplemental Schedule											13					
14	TOTAL Non-Facility Related						\$	\$			\$ 16,997	14					
15	TOTALS (line 9+line14)						\$	\$ 4,591,247			\$ 294,924	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,881 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

Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

* 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Extended Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026914

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 2005 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 2005.

(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>24-05-302-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>145,903.84</u>	\$ <u>145,903.84</u>
2. <u>Home Office Allocation</u>	<u>See Attached</u>	\$ <u>53,052.60</u>	\$ <u>1,225.51</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>198,956.44</u>	\$ <u>147,129.35</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Extended Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026914

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 2000 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 2000.

(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Concord Extended Care

0026914 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,133 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

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>56,110</u>	<u>1962</u>	<u>\$ 27,417</u>	1
2	<u>Care Centers Allocation</u>			<u>8,634</u>	2
3	TOTALS	56,110		\$ 36,051	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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			1974	1,435		20			1,435	9
10	Various			1976	4,663		20			4,663	10
11	Various			1977	2,336		20			2,336	11
12	Various			1978	765		20			765	12
13	Various			1980	33,145		20			33,145	13
14	Various			1982	2,378		20			2,292	14
15	Various			1983	45,375		20	1,815	1,815	41,786	15
16	Various			1985	21,344		20			34,699	16
17	Various			1986	31,133		20	747	747	31,065	17
18	Various			1988	41,219		20	1,662	1,662	31,093	18
19	Various			1989	3,324		20	166	166	2,876	19
20	Various			1990	8,400		20	420	420	6,755	20
21	Various			1991	34,006		20	1,702	1,702	26,864	21
22	Various			1992	8,695		20	435	435	6,243	22
23	Various			1993	11,679		20	585	585	8,001	23
24	Various			1994	29,410		20	1,472	1,472	18,468	24
25	Various			1995	118,494		20	5,927	5,927	67,031	25
26	Various			1996	68,945		20	3,449	3,449	35,284	26
27	Various			1997	54,013		20	2,701	2,701	25,525	27
28	Various			1998	158,651		20	7,933	7,933	67,307	28
29	Various			1999	40,891		20	2,045	2,045	16,099	29
30	Various			2000	123,534		20	6,179	6,179	39,485	30
31	Various			2001	17,052		20	777	777	3,782	31
32	Various			2002	17,598		20	2,089	2,089	9,760	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 Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		2,034,842	78,063		61,502	(16,561)	1,307,782	67
68		33,886	959		1,404	445	5,622	68
69			73,042			(73,042)		69
70		\$ 2,947,213	\$ 152,064		\$ 103,010	\$ (49,054)	\$ 1,830,163	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 2,947,213	\$ 152,064		\$ 103,010	\$ (49,054)	\$ 1,830,163	1
2	Huac	2003	2,838		20	142	142	473	2
3	Fix Bathroom Plumbing	2003	2,515		20	126	126	398	3
4	Locks	2003	3,798		20	380	380	1,488	4
5	Repair Hot Water Heater	2003	813		20	81	81	305	5
6	Door Key Pads	2003	875		20	88	88	328	6
7	Front Door	2003	4,800		20	480	480	1,680	7
8	Plumbing	2003	2,515		20	252	252	859	8
9	Steel Door	2003	950		20	95	95	325	9
10	Glass Door	2003	2,200		20	220	220	733	10
11	Exhaust System	2003	2,600		20	260	260	845	11
12	Code Alert - Alarm	2003	608		20	61	61	218	12
13	Install Panic Device	2004	2,521		20	252	252	756	13
14	Repair Concrete Ramp	2004	4,250		20	425	425	1,098	14
15	Office Equipment	2004	572		20	57	57	138	15
16	Replace Door Holder	2004	1,657		20	331	331	939	16
17	Fire Rated Device	2004	961		20	137	137	389	17
18	A/C Startup	2004	1,301		20	260	260	694	18
19	Keypad For Elevator	2004	955		20	96	96	279	19
20	Static Pressure Test	2004	2,850		20	285	285	808	20
21	Repair Walls	2004	4,475		20	448	448	1,193	21
22	Carpeting	2004	2,578		20	368	368	951	22
23	Electrical Work	2004	582		20	58	58	165	23
24	Plumbing Repairs	2004	2,100		20	58	58	165	24
25	Repair Valve In Boiler Room	2004	2,219		20	111	111	333	25
26	Repair Water Lines	2004	1,253		20	63	63	183	26
27	Landscaping	2004	471		20	47	47	122	27
28	Locks And Key Pads	2004	1,804		20	180	180	466	28
29	Keypad For Elevator	2004	573		20	57	57	148	29
30	Painting	2004	19,700		20	1,970	1,970	5,089	30
31	Hvac	2004	18,705		20	1,871	1,871	4,832	31
32	Parking Lot	2004	4,750		20	475	475	1,227	32
33	Concrete West Side Entrance	2004	4,750		20	475	475	1,227	33
34	TOTAL (lines 1 thru 33)		\$ 3,050,752	\$ 152,064		\$ 113,219	\$ (38,845)	\$ 1,859,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 3,050,752	\$ 152,064		\$ 113,219	\$ (38,845)	\$ 1,859,017	1
2	Concrete West Side Entrance	2004	275		20	28	28	71	2
3	Northside Ramp	2004	2,300		20	230	230	594	3
4	5/04 Payment	2005	(4,475)		20	(448)	(448)	(820)	4
5	Electrical	2005	2,125		20	106	106	151	5
6	Door Frames	2005	2,178		20	109	109	118	6
7	Duct Work	2005	1,995		20	100	100	125	7
8	Guardian Air Units	2006	6,750		20	675	675	675	8
9	Underground Grease Trap Line Relocation	2006	675		20	56	56	56	9
10	Concrete Ramp	2006	3,133		20	104	104	104	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		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
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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)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		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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19									19
20									20
21									21
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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)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		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
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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	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 12G, Carried Forward		\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

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Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 12K, Carried Forward	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 12L, Carried Forward	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		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
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18									18
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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	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 12P, Carried Forward	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,065,708	\$ 152,064		\$ 114,179	\$ (37,885)	\$ 1,860,091		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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			1962	1962	\$ 339,532	\$		\$	\$	\$	4
5			1987	1987	1,493,264			57,012	57,012	1,293,863	5
6			1962	1962	112,250						6
7											7
8											8
Improvement Type**											
9		Concord Health Care Properties		2004	65,852		20	3,293	3,293	11,525	9
10		Concord Health Care Properties		2005	23,944		20	1,197	1,197	2,394	10
11											11
12		Concord Health Care Properties Book Depreciation				78,063			(78,063)		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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)	\$ 2,034,842	\$ 78,063		\$ 61,502	\$ (16,561)	\$ 1,307,782	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

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	\$ 10,647	\$ 273		\$ 273	\$	\$ 1,172	4
5		Care Centers Clinical Allocation	2002	2002	1,123	29		29		154	5
6		Care Centers Health Systems Allocation	2002	2002	129	3		3		14	6
7											7
8											8
Improvement Type**											
9		2201 Main LLC Allocation		2002	8,795	366	20	440	74	1,979	9
10		2201 Main LLC Allocation		2003	10,365	197	20	518	321	1,814	10
11		2201 Main LLC Allocation		2005	515	23	20	26	3	39	11
12											12
13		Care Centers Clinical Allocation		2002	928	39	20	46	7	209	13
14		Care Centers Clinical Allocation		2003	1,093	21	20	55	34	191	14
15		Care Centers Clinical Allocation		2005	54	2	20	3	1	4	15
16											16
17		Care Centers Health Systems Allocation		2002	106	4	20	5	1	24	17
18		Care Centers Health Systems Allocation		2003	125	2	20	6	4	22	18
19		Care Centers Health Systems Allocation		2005	6	-	20	-		-	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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)	\$	\$ 33,886		\$ 1,404	\$ 445	\$ 5,622	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 523,364	\$ 6,152	\$ 53,858	\$ 47,706	10	\$ 351,764	71
72	Current Year Purchases	21,543	36	254	218	10	254	72
73	Fully Depreciated Assets	429,443				10	429,443	73
74								74
75	TOTALS	\$ 974,349	\$ 6,188	\$ 54,112	\$ 47,924		\$ 781,461	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	Care Centers	Allocation	2006	\$ 17,502	\$ 212	\$ 1,436	\$ 1,224	5	\$ 12,521	76
77	Care Centers Clinical	Allocation	2006	1,065	72	72		5	72	77
78										78
79										79
80	TOTALS			\$ 18,567	\$ 284	\$ 1,508	\$ 1,224		\$ 12,593	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)	\$ 4,094,675	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 158,536	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,799	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,263	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,654,145	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

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	Care Centers Allocation				2,732			5
6								6
7	TOTAL				\$ 2,732			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 3,285 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.

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	39 - 03	hrs	\$		\$ 167,947	\$		\$ 167,947	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			52,420	107		52,527	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			169,243			169,243	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				112,506		112,506	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					(52)	93,302		93,250	13
14	TOTAL			\$		\$ 389,558	\$ 205,915		\$ 595,473	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 Concord Extended Care# 0026914Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 1,000	\$ 18,679	1
2	Cash-Patient Deposits	51,904	51,904	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,140,989	1,140,989	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	168,696	200,318	6
7	Other Prepaid Expenses	12,253	12,253	7
8	Accounts Receivable (owners or related parties)	62,755	62,755	8
9	Other(specify): <u>See Attached Schedule</u>	38,696	207,894	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,476,293	\$ 1,694,792	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		27,417	13
14	Buildings, at Historical Cost		2,139,849	14
15	Leasehold Improvements, at Historical Cost	887,003	887,003	15
16	Equipment, at Historical Cost	926,740	1,051,179	16
17	Accumulated Depreciation (book methods)	(1,556,983)	(2,897,559)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		68,484	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 256,760	\$ 1,276,373	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,733,053	\$ 2,971,165	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,372,812	\$ 1,443,966	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,851	43,851	28
29	Short-Term Notes Payable	641,702	641,702	29
30	Accrued Salaries Payable	104,853	104,853	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,151	7,151	31
32	Accrued Real Estate Taxes(Sch.IX-B)		153,200	32
33	Accrued Interest Payable		21,328	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)	\$ 2,170,369	\$ 2,416,051	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,949,546	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)	\$	\$ 3,949,546	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,170,369	\$ 6,365,597	46
47	TOTAL EQUITY (page 18, line 24)	\$ (437,316)	\$ (3,394,432)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,733,053	\$ 2,971,165	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 427,240	1
2	Restatements (describe):		2
3	<u>See Attached</u>	(205,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 222,240	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(659,556)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (659,556)	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)	\$ (437,316)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 5,285,208	1
2	Discounts and Allowances for all Levels	(1,340,760)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,944,448	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,350,195	6
7	Oxygen	2,863	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,353,058	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	105,895	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,555	19
20	Radiology and X-Ray	5,620	20
21	Other Medical Services	26,179	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 180,249	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,432	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,432	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,486,194	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,011,777	31
32	Health Care	2,384,451	32
33	General Administration	1,468,674	33
B. Capital Expense			
34	Ownership	612,010	34
C. Ancillary Expense			
35	Special Cost Centers	595,473	35
36	Provider Participation Fee	73,365	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,145,750	40
41	Income before Income Taxes (line 30 minus line 40)**	(659,556)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (659,556)	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 Concord Extended Care

0026914

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,635	1,900	\$ 66,894	\$ 35.21	1
2	Assistant Director of Nursing	1,328	1,535	47,926	31.22	2
3	Registered Nurses	7,789	8,659	207,366	23.95	3
4	Licensed Practical Nurses	30,485	32,786	815,545	24.87	4
5	CNAs & Orderlies	71,404	76,495	756,360	9.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,477	8,021	110,821	13.82	8
9	Activity Director	1,848	2,133	24,611	11.54	9
10	Activity Assistants	6,567	7,166	55,334	7.72	10
11	Social Service Workers	6,912	7,585	110,473	14.56	11
12	Dietician					12
13	Food Service Supervisor	1,774	2,110	36,258	17.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,323	4,822	44,940	9.32	15
16	Dishwashers	13,215	14,449	125,985	8.72	16
17	Maintenance Workers	3,946	4,435	74,215	16.73	17
18	Housekeepers	16,153	17,215	152,592	8.86	18
19	Laundry	8,577	9,366	92,183	9.84	19
20	Administrator	2,070	2,306	79,742	34.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,698	8,454	113,237	13.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,017	2,320	27,348	11.79	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,052	2,239	36,622	16.36	33
34	TOTAL (lines 1 - 33)	197,270	213,996	\$ 2,978,452 *	\$ 13.92	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	265	\$ 11,379	01-03	35
36	Medical Director	Monthly	17,000	09-03	36
37	Medical Records Consultant	Monthly	1,125	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,602	10-03	39
40	Physical Therapy Consultant	9	360	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,315	11-03	44
45	Social Service Consultant	56	2,997	12-03	45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	115	4,596	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	492	\$ 41,374		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	85	\$ 4,299	10-03	50
51	Licensed Practical Nurses	912	32,257	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	997	\$ 36,556		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

Report Period Beginning: 01/01/06 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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

