



Facility Name & ID Number Montebello Healthcare Center

# 0047340 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 139

	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	139	Skilled (SNF)	139	50,874	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	139	TOTALS	139	50,874	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	1,375		
9	SNF/PED					9
10	ICF	13,275	2,794	718	16,787	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,650	2,794	2,163	19,607	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 38.54%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

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 06/01/1993

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 06/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 139 and days of care provided 1,445

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	95,254	11,184	6,757	113,195		113,195		113,195		1
2	Food Purchase		84,572		84,572		84,572		84,572		2
3	Housekeeping	53,154	9,540		62,694		62,694		62,694		3
4	Laundry	21,088	5,514	45	26,647		26,647		26,647		4
5	Heat and Other Utilities			100,410	100,410		100,410		100,410		5
6	Maintenance	16,877	32,438	804	50,119	(3,774)	46,345	64	46,409		6
7	Other (specify):*			11,294	11,294		11,294		11,294		7
8	<b>TOTAL General Services</b>	<b>186,373</b>	<b>143,248</b>	<b>119,310</b>	<b>448,931</b>	<b>(3,774)</b>	<b>445,157</b>	<b>64</b>	<b>445,221</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			7,950	7,950		7,950		7,950		9
10	Nursing and Medical Records	765,709	54,630	5,890	826,229		826,229		826,229		10
10a	Therapy	(288)	2,866	147,533	150,111		150,111		150,111		10a
11	Activities	29,221	2,130	2,230	33,581	6,453	40,034		40,034		11
12	Social Services	27,063	2,085		29,148		29,148		29,148		12
13	CNA Training	288			288		288		288		13
14	Program Transportation	21,511			21,511	(21,511)					14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>843,504</b>	<b>61,711</b>	<b>163,603</b>	<b>1,068,818</b>	<b>(15,058)</b>	<b>1,053,760</b>		<b>1,053,760</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	72,695			72,695		72,695		72,695		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			15,657	15,657		15,657	399	16,056		20
21	Clerical & General Office Expenses	75,707	7,773	138,246	221,726		221,726	(9,760)	211,966		21
22	Employee Benefits & Payroll Taxes			176,069	176,069		176,069		176,069		22
23	Inservice Training & Education										23
24	Travel and Seminar			20,732	20,732		20,732	7,656	28,388		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			134,189	134,189		134,189	(22,513)	111,676		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>148,402</b>	<b>7,773</b>	<b>484,893</b>	<b>641,068</b>		<b>641,068</b>	<b>(24,218)</b>	<b>616,850</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,178,279</b>	<b>212,732</b>	<b>767,806</b>	<b>2,158,817</b>	<b>(18,832)</b>	<b>2,139,985</b>	<b>(24,154)</b>	<b>2,115,831</b>		<b>29</b>

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

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006  
Ending: 12/31/2006

Facility Name & ID Number Montebello HealthCare Center # 0031468

**SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES**

**Operating Expense - Line 7**

**Amount**

Infectious Waste Disposal <> Default <> Nursing Admin/Supv 4,148  
Infectious Waste Disposal <> Default <> Physical Plant  
Garbage Service<>Default<>Prod<>Physical Plant 7,145  
Garbage Service <> Default <> Physical Plant

11,293

**Health Care Program - Line 15**

**Amount**

N/A

0

**General & Administrative - Line 27**

**Amount**

N/A

0

**Inservice Education - Line 23 Column 3 (over \$2,000)**

**Amount**

N/A

0

STATE OF ILLINOIS

Report Period:

Beginning: 1/1/2006

Page -3.2

Facility Name & ID Number Montebello HealthCare Center # 0031468

Ending: 12/31/2006

Meals - adjustment

Sales Tax - adjustment

19,607 Days ( Total Patient days)  
 3 Mult (3 meals a day)  


---

 58,821 Sub total  
 0 meals to employess (reported by facility)  


---

 58,821 Add Sub  
 84,572 Divide -Pg 3, line 2, column 2  


---

 1.44 Cost per day

84,572 Total Food Cost (page 3,Line 2, col 2)  
 0.01 Mult  


---

 845.72 Sub total  
 14.20% Mult (Pvt pay div by total census)  
 120 = adjust for nonallowable sale tax  
 for page 5A,

1.44 Cost per day  
 0 mult - meal to employees  
 0 = adjust for pg 2, line 2, column2

Reclassification V

Page 3 Line 6  
 Repair & Maint <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 83001000003850 (3,774) Reclass From  
 (5,392 x 70% = 3,774)  
 Page 4 line 38 3,744.00 Reclass to

Page 3 Line 14  
 Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 (19,388) Reclass From  
 Salaries Overtime/Dbt Time<>Driver<>Transport Non<>Emergency 700500750403850 (1,530) Reclass From  
 Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport Non<>Emergen 730012000003850 (593) Reclass From  
 (21998 x 70% = 15399 ) 70% is Medical 30% is activities (21,511) total

Page 3 line 11 6,453 Reclass to  
 Page 4 line 38 15,058 Reclass to

Page 4 Line 35 Rent  
 Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 841005000003850 102 Reclass From  
 (146 x 70% = 102 lease for Medical)  
 Page 4 line 38 (102) Reclass to

Facility Name &amp; ID Number

Montebello Healthcare Center

#0047340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	
	<b>D. Ownership</b>											
30	Depreciation			20,299	20,299		20,299	12,457	32,756			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(199)	(199)		(199)	(199)	(398)			32
33	Real Estate Taxes			2,410	2,410		2,410	476	2,886			33
34	Rent-Facility & Grounds			62,161	62,161		62,161	18	62,179			34
35	Rent-Equipment & Vehicles			146	146	102	248	6,181	6,429			35
36	Other (specify):*							8,550	8,550			36
37	<b>TOTAL Ownership</b>			84,817	84,817	102	84,919	27,483	112,402			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					18,730	18,730		18,730			38
39	Ancillary Service Centers		31,060	7,941	39,001		39,001	8,746	47,747			39
40	Barber and Beauty Shops			997	997		997	(997)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		31,060	85,041	116,101	18,730	134,831	7,749	142,580			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,178,279	243,792	937,664	2,359,735		2,359,735	11,078	2,370,813			45

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

STATE OF ILLINOIS

Report Period: Beginning: 1012006  
Ending: 12/31/2006

Facility Name & ID Number Montebello HealthCare Center # 0031468

**SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES**

**Ownership - Line 36**

**Amount**

Fresh Start Acctg Adj <> Bankruptcy Exp Acq <> Cost Non Overhead	0
	<u>-</u>

**Ancillary Expenses - Line 43 -Column 2**

**Amount**

Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	<u>0</u>

**Ancillary Expenses - Line 43 -Column 3**

**Amount**

Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
	<u>-</u>

**Rent-Facility & Grounds - Expenses- Line 34 Column 3**

Lease Expense Facility-Realty-Default-Prod	17,469
Lease Expense Facility <> Default <> Realty	44,692
	0
	<u>62,161</u>

**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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,399)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(123,044)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (128,443)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	139,521		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 139,521		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 11,078		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.			\$	14	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

## Montebello Healthcare Center

ID# 0047340

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Sales Taxes	\$ (120)	21	1
2	Small Balance Adjustment	(7)	21	2
3	Memorium/ Benevolence	(104)	21	3
4	Depreciation Reconciliation	12,457	30	4
5	Activities Program Receipts	0	11	5
6	Property Taxes Adjust to actual	0	33	6
7	Professional liability Insurance	(22,513)	26	7
8	Barber & beauty	(997)	40	8
9	Public Relations Expenses	0	20	9
10	Non Allowable Advertising	0	20	10
11	Entertainment	(7)	24	11
12	Fresh Start	0	36	12
13	Civic Dues	0	20	13
14	Penalties	0	21	14
15	Vending receipts	(660)	21	15
16	Misc Receipts	0	21	16
17	Marketing Wages	(494)	21	17
18	Marketing Bonus	0	21	18
19	Marketing Holiday	0	21	19
20	Marketing Sick	0	21	20
21	Marketing Vacation	0	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	0	21	23
24	Donations/ Contributions	(1,436)	21	24
25	Legal Fees - Bankruptcy	0	21	25
26	Legal Structure Management Fees	(108,964)	21	26
27	Undocumented Travel		24	27
28	Interest Income	(199)	32	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(123,044)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello Healthcare Center# 0047340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	64	0	0	0	0	0	0	0	0	0	64	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	64	0	0	0	0	0	0	0	0	0	64	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	399	0	0	0	0	0	0	0	0	0	399	20
21	Clerical & General Office Expenses	(117,184)	107,424	0	0	0	0	0	0	0	0	0	(9,760)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7)	7,663	0	0	0	0	0	0	0	0	0	7,656	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(22,513)	0	0	0	0	0	0	0	0	0	0	(22,513)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(139,704)	115,486	0	0	0	0	0	0	0	0	0	(24,218)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(139,704)	115,550	0	0	0	0	0	0	0	0	0	(24,154)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montebello Healthcare Center# 0047340

Report Period Beginning:

01/01/2006 Ending:12/31/2006

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	12,457	0	0	0	0	0	0	0	0	0	0	12,457	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(199)	0	0	0	0	0	0	0	0	0	0	(199)	32
33	Real Estate Taxes	0	476	0	0	0	0	0	0	0	0	0	476	33
34	Rent-Facility & Grounds	0	18	0	0	0	0	0	0	0	0	0	18	34
35	Rent-Equipment & Vehicles	0	6,181	0	0	0	0	0	0	0	0	0	6,181	35
36	Other (specify):*	0	8,550	0	0	0	0	0	0	0	0	0	8,550	36
37	<b>TOTAL Ownership</b>	<b>12,258</b>	<b>15,225</b>	<b>0</b>	<b>27,483</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	8,746	0	0	0	0	0	0	0	0	0	8,746	39
40	Barber and Beauty Shops	(997)	0	0	0	0	0	0	0	0	0	0	(997)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>(997)</b>	<b>8,746</b>	<b>0</b>	<b>7,749</b>	<b>44</b>								
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(128,443)</b>	<b>139,521</b>	<b>0</b>	<b>11,078</b>	<b>45</b>								

Facility Name & ID Number Montebello Healthcare Center

# 0047340

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**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
SSC Equity Holdings LLC	100	See Attachment Page 6.1		SSC Equity Holdings,	Atlanta, GA	Management

**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	5 Utilities	\$	SSC Equity Holdings, LLC	100.00%	\$	\$	1	
2	V	6 Repair & Maintenance		SSC Equity Holdings, LLC	100.00%	64	64	2	
3	V	39 Professional Services		SSC Equity Holdings, LLC	100.00%	8,746	8,746	3	
4	V	20 Fees, Subscriptions, Promotions		SSC Equity Holdings, LLC	100.00%	399	399	4	
5	V	10 Nursing & Medical Records		SSC Equity Holdings, LLC	100.00%			5	
6	V	21 Clerical & General Office Exp		SSC Equity Holdings, LLC	100.00%	107,424	107,424	6	
7	V	24 Travel & Seminar		SSC Equity Holdings, LLC	100.00%	7,663	7,663	7	
8	V	26 Insurance Premium		SSC Equity Holdings, LLC	100.00%			8	
9	V	36 Depreciation		SSC Equity Holdings, LLC	100.00%	8,550	8,550	9	
10	V	33 Taxes - Property		SSC Equity Holdings, LLC	100.00%	476	476	10	
11	V	35 Rental & Leasing		SSC Equity Holdings, LLC	100.00%	6,181	6,181	11	
12	V	34 Lease Expense		SSC Equity Holdings, LLC	100.00%	18	18	12	
13	V	26 Property Insurance		SSC Equity Holdings, LLC	100.00%			13	
14	Total		\$			\$ 139,521	\$ *	139,521	14

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006  
Ending: 12/31/2006

Facility Name & ID Number: Montebello HealthCare Center # 0031468

Related Illinois Nursing Homes  
as of  
12/31/2006

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
------------	--------------------------------	--------------------------

SSC Equity Holdings, LLC

Montebello Healthcare Center	0031468
Nature Trail HealthCare Center	0039586
Odin HealthCare Center	0039503
Mariner Health of Westchester	0042374

Facility Name & ID Number      Montebello Healthcare Center      #      0047340      Report Period Beginning:      01/01/2006      Ending:      12/31/2006

## 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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Montebello Healthcare Center

# 0047340 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 SSC Equity Holdings, LLC  
 Street Address One Ravinia Dr. Suite 1400  
 City / State / Zip Code Atlanta, GA 30346  
 Phone Number ( 770) 829-5100  
 Fax Number ( 770) 393-8054

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	5	Utilities			\$	\$			1
2	6	Repair & Maintenance	1		64		1	64	2
3	39	Professional Services	1		8,746		1	8,746	3
4	20	Fees, Subscriptions, Promotions	1		399		1	399	4
5	10	Nursing & Medical Records							5
6	21	Clerical & General Office Exp	1		107,424		1	107,424	6
7	24	Travel & Seminar	1		7,663		1	7,663	7
8	26	Insurance Premium							8
9	36	Depreciation	1		8,550		1	8,550	9
10	33	Taxes - Property	1		476		1	476	10
11	35	Rental & Leasing	1		6,181		1	6,181	11
12	34	Leasse Expense	1		18		1	18	12
13	26	Property Insurance							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				\$ 139,521	\$		\$ 139,521	25

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	15

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

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

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

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

**B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2005 report.		\$ 53,916	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 53,913	2
3.	Under or (over) accrual (line 2 minus line 1).		\$ (3)	3
4.	Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 2,413	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 2,410	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2001	47,957	8	
	2002	52,531	9	
	2003	53,913	10	
	2004	54,772	11	
	2005	28,605	12	
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 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,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Montebello Healthcare Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0047340

CONTACT PERSON REGARDING THIS REPORT Lee Grigsby

TELEPHONE (832)467-6244 FAX #: (832)467-6246

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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>11-29-999-119</u>	<u>Lot B Sub (EX 2A SE Cor &amp; 377)</u>	<u>\$ 28,604.82</u>	<u>\$ 28,604.82</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ <u>28,604.82</u></b>	<b>\$ <u>28,604.82</u></b>

**B. Real Estate Tax Cost Allocation:**

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

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

**C. Tax Bills**

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,581 B. General Construction Type: Exterior Brick Frame Steel 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	305,550	1993	\$ 43,747	1
2					2
3	TOTALS	305,550		\$ 43,747	3

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	139	1993	1974	\$ 2,576,687	\$ 122,699	21	\$ 122,699		\$ 1,030,042	4
5				46,664	2,333	20	2,333		6,999	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Interior Building Improvements		1995	8,889	444	20	444		6,104	9
10	A/C Units		1996	2,775	139	20	139		5,494	10
11	Sprinkle Guard System		1996	887	44	20	44		1,396	11
12	Sprinkler Repair		1997	2,239	112	20	112		640	12
13	Sprinkler Repair		1997	2,317	116	20	116		1,221	13
14	Carpet in Lobby		1997	1,890	95	20	95		1,101	14
15	Nurses Station		1997	2,363	118	20	118		926	15
16	A/C Systems		1997	8,325	416	20	416		1,854	16
17	Nurses Station		1997	2,613	131	20	131		3,779	17
18	A/C Systems		1997	2,969	148	20	148		1,393	18
19	Light Fixtures		1997	1,002	50	20	50		1,234	19
20	Sprinkler Repair		1997	797	40	20	40		463	20
21	2: Exterior Signs #73		1998	663	5	12	5		366	21
22	Heating, Ventilation & A/C		1998	2,643	264	10	264		841	22
23	Rplc 6: 18K BTU Heating, Ventilation & A/C #77		1998	4,070	407	10	407		2,532	23
24	2: 60 K BTU Kitchen Heating, Ventilation & A/C #78		1998	6,800	407	10	407		3,394	24
25	Phone System #72		1998	1,338	134	10	134		4,302	25
26	Nurses Station #71		1998	1,925	128	20	128		1,193	26
27	Adjustment 1998		1998		(35)			35		27
28	Water Heater #80 & 81 & 82		1999	3,092	309	10	309		2,266	28
29	Water Pipe Hook-up #83 & 84		1999	256	26	10	26		1,700	29
30	Generator 100 AMP XFER Switch #93		2001	5,137	257	20	257		650	30
31	3: Door Relay Instl #94		2001	912	91	10	91		1,210	31
32	2: W/G Monitor Digat Reset #95		2001	1,892	189	10	189		727	32
33	Use Tax 2: W/G Montor Digat #96		2001	8,191	819	10	819		2,364	33
34	Kohler Sink W/ Sink Rims #97		2001	592	30	20	30		3,200	34
35	Use Tax: Kohler Sink W/ Sink Rims #98		2001	34	2	20	2		118	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

STATE OF ILLINOIS

Facility Name & ID Number Montebello Healthcare Center

# 0047340

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Royal 3.5 Gal Water Sver #99	2001	\$ 325	\$ 17	20	\$ 17		\$ 80		37
38	Use Tax: Royal 3.5 Gal Water Sver #100	2001	20	1	20	1		5		38
39	Wanderguard & Lock System Instl #102	2001	8,360	836	10	836		4,041		39
40	Air Handler & Coil Instl, Kitchen #105	2001	915	46	20	46		214		40
41	2:Push-Button & Digital reset #106	2001	822	82	10	82		383		41
42	Instl 5Ton A./C Unit Kitchen #107	2001	1,475	148	10	148		665		42
43	Instl Charge W/G System #110	2001	325	33	10	33		142		43
44	E Elec Water Heater Instl #111	2001	3,275	327	10	327		1,418		44
45										45
46	DuKane Nurse Call system #5010	2002	17,665	1,767	10	1,767		8,098		46
47	DuKane Nurse Call system # 5011	2002	6,837	684	10	684		3,077		47
48	Service Call - Old Nurse Call System # 5022	2002	863	86	10	86		1,306		48
49	Nurse Call System # 5026	2002	17,748	1,775	10	1,775		7,691		49
50	Nurse Call System -Bal Due # 5026	2002	17,748	1,775	10	1,775		7,543		50
51	Instl Nurse Call System #5027	2002	2,532	253	10	253		1,076		51
52										52
53	New Nurse Call Station #5030	2003	4,720	472	10	472		1,927		53
54	Breaker Instl Range Hood #5032	2003	2,135	214	10	214		891		54
55	155: Brass Dry Pendants Instl #5035	2003	1,086	43	25	43		155		55
56	Carrier -RTU NW Wing #5042	2003	7,548	755	10	755		2,642		56
57	Add sprinkler Head Stairs # 5047	2003	760	30	25	30		101		57
58	Rplc Roof UltraPlus (29% Dwn) # 5048	2003	43,215	4,322	10	4,322		14,756		58
59	CREDIT Maglock Sngl Door (#15580) #5049	2003	(691)	(69)	10	(69)		(391)		59
60	Wanderguard Instl #5050	2003	338	34	10	34		192		60
61	7: Verticle Blinds #5052	2003	840	168	5	168		574		61
62	7: Rodpocket Draps, 7 Rods # 5053	2003	869	174	5	174		580		62
63	Replc Roof #5054	2003	86,443	8,644	10	8,644		28,093		63
64	Blinds 30 Resident Rooms # 5055	2003	1,371	274	5	274		896		64
65										65
66	2:120 Gallon Water Heater	2004	7,770	583	120	583		1,749		66
67										67
68										68
69										69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,933,275	\$ 153,390		\$ 153,425	\$ 35	\$ 1,175,413		70

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

## STATE OF ILLINOIS

Page 12B

Facility Name &amp; ID Number Montebello Healthcare Center

# 0047340

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## 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	\$ 2,933,275	\$ 153,390		\$ 153,425	\$ 35	\$ 1,175,413		1
2	Watermain Repair	2005 8,950	209	25	209		418		2
3	Retaining Wall - Partial Pmt	2005 6,550	136	20	136	0	272		3
4	Fire Alarm Control Panel	2005 2,531	84	10	84		168		4
5	Construct Walkway Cover	2005 5,225	145	15	145		290		5
6	Leveled Ground Around Stairway	2005 546	15	15	15		30		6
7	Fire Alarm System	2005 1,920	64	10	64		128		7
8	Instl New handrails	2005 429	10	15	10		20		8
9	Fire Alarm Control Panel	2005 926	39	10	39		78		9
10	Drywall Repairs-Water Break	2005 4,065	45	15	45		90		10
11	6 Ton 230V, RTU	2005 27,558	919	10	919		1,838		11
12	Four heat Run-Duct System	2005 1,500	25	10	25		50		12
13	Rpr-Damaged Phone System	2005 1,576	53	10	53		106		13
14	Watermain Repair	2005 8,682	87	25	87		174		14
15	Retaining Wall - Partial Pmt	2005 6,359	79	20	79		158		15
16	Fire Alarm Control Panel	2005 2,404	60	10	60		120		16
17	Construct Walkway Cover	2005 5,022	84	15	84		168		17
18	Leveled Ground Around Stairway	2005 525	9	15	9		18		18
19	Fire Alarm System	2005 1,824	46	10	46		92		19
20	Instl New handrails	2005 415	7	15	7		14		20
21	Fire Alarm Control Panel	2005 872	22	10	22		44		21
22	Drywall Repairs-Water Break	2005 3,975	66	15	66		132		22
23									23
24	119 Gal Electric W/H	2006 4,362	400	10	400		400		24
25	Use Tax - 119 Gal Electric W/H	2006 268	25	10	25		25		25
26	Instl Water Heater	2006 659	60	10	60		60		26
27	Instl Electric - Water Heater	2006 384	35	10	35		35		27
28	42' Sidewalk / Outside Patio	2006 1,820	60	10	60		60		28
29	Sprinkler	2006 2,296	75	10	75		75		29
30	Rpr Sprinkler System	2006 6,893	46	25	46		46		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,041,809	\$ 156,293		\$ 156,329	\$ 35	\$ 1,180,522		34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,025,128	\$ 155,593	\$ 155,593	\$		\$ 1,179,821	71
72	Current Year Purchases	16,682	701	701			701	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,041,810	\$ 156,294	\$ 156,294	\$		\$ 1,180,522	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,127,366	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 312,587	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 312,623	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 35	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,361,044	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	O/H Allocation 06/01/1996	\$ 636	\$ 32	\$ 338	86
87	O/H Allocation 12/01/1996	1,136	57	574	87
88	O/H Allocation 08/01/1997	2,127	106	998	88
89	O/H Allocation 10/01/1997	360	18	166	89
90					90
91	TOTALS	\$ 4,259	\$ 213	\$ 2,076	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: SSC Submaster Holdings LLC

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:	139	01/01/2005	\$ 44,692	20		3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	139		\$ 44,692			7

10. Effective dates of current rental agreement:  
 Beginning 01/01/2005  
 Ending 12/06/2024

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ <u>                    </u>
13.	<u>/2008</u>	\$ <u>                    </u>
14.	<u>/2009</u>	\$ <u>                    </u>

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: \$ 7,505 Description: See Schedule 14.1  
 (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	<b>TOTAL</b>		\$	\$	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.

STATE OF ILLINOIS

Report Period: Beginning: 1012006

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Facility Name & ID Number

Montebello HealthCare Center

# 0031468

Ending: 12/31/2006

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Page/Line/Col  
Ref From

Name of G/L	G/L #	EQUIPMENT	Amount	Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Matress/ Beds		03/10/03
Lease Exp - Eqpt - <> Default <> Prod Oxygen	841000000002022	Concentrators	612.00	
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000			03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Diswasher	974.00	03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeeping	841000000007040			03/03/03
Lease Exp <> Eqpt<>Default<>Prod<>SNF Non Certified	841000000001011	Oxygen	262.00	
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050			03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admi	841000000008000	Mattress		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	841000000008100	Copies, Stamp machine Cable	4,853.00	03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plan	841000000008210	SNF Supplies	804.00	03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220			04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100			03/21/03

7,505.00 Grand Total

**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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a-03	8004	hrs	\$ 20,068					8,004	\$ 20,068	1
2	Licensed Speech and Language Development Therapist	10a-03	4697	hrs	16,668					4,697	16,668	2
3	Licensed Recreational Therapist	10a-03		hrs								3
4	Licensed Physical Therapist	10a-03	12753	hrs	45,929					12,753	45,929	4
5	Physician Care	39		visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	39		# of prescripts				31,060			31,060	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Exceptional Care Program											12
13	Other (specify):											13
14	<b>TOTAL</b>				\$ 82,665			\$ 31,060		25,454	\$ 113,725	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Montebello Healthcare Center

# 0047340

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	33,290		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	186,456		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	72		6
7	Other Prepaid Expenses	94,109		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 314,477	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	98,896		15
16	Equipment, at Historical Cost	31,096		16
17	Accumulated Depreciation (book methods)	(14,967)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	62,277		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	35,918		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 213,220	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 527,697	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 117,293	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,898		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,128		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attachment Sch 17.1	65,051		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 303,370	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	See Attachment Sch 17.1	(259,843)		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (259,843)	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 43,527	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 484,170	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 527,697	\$	48

\*(See instructions.)

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006 Page -17.1  
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Facility Name & ID Number Montebello HealthCare Center # 0031468

SUPPLEMENTAL SCHEDULE OF ASSETS & LIABILITIES

<u>OTHER CURRENT ASSETS:</u>	<u>AMOUNT</u>	
	0	Difference
Total	0	
Reconcile with schedule XV, line 9:	0	0

<u>OTHER NON-CURRENT ASSETS:</u>		
17 23-1 Excess Reorganized Value <> Excess Reorg Value <> Default		
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	35,918	
Total	35,918	Difference
Reconcile with schedule XV, line 23:	35,918	-

<u>OTHER CURRENT LIABILITIES:</u>	<u>AMOUNT</u>	
Misc Dedctns - Employee <> Other Deductions <> Default		17 36-1
Misc Dedctns - Employee <> Miscellaneous<> Default	(96)	
Accrued InsurancePLGL Post-Petition ClaimsDefault-Dept	(18,301)	
Accruals - Insurance <> Accrue HMO Ins <> Default	(11)	
Accruals - Insurance <> Self Funded Ins Acr <> Default	(12,581)	
Accruals - Insurance <> Basic Life <> Default	(113)	
Accruals - Insurance <> Lt Dsbly <> Default	3	
Accruals - Insurance <> Dental Ins <> Default		
Accruals - Insurance <> Executive Supp Life <> Default	(72)	
Accruals - Insurance <> Short Term Disability <> Default		
Accruals - Insurance <> Dependent Life <> Default-Dept	(24)	
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	(9)	
Accruals - Insurance <> NES Insurance <> Default-Dept	(953)	
Accruals -other Default -Dept-Suspense Allocation	(14,366)	
Accrued Other-Default-Dept-Accrued Legal Fees	(131)	
Accrued Other <> Default	(18,397)	
Total	(65,051)	Difference
Reconcile with schedule XV, line 36:	(65,051)	-

<u>OTHER NON-CURRENT LIABILITIES::</u>		
I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	(356,214)	17 43-1
Intercompany - Revolver <> Default <> Default	758,882	
Intercompany Revolver - SSC-Default-Dept-Default-Prod	(77,347)	
L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claims	(4,018)	
Other Non-Current Lby <> Rent Accrual <> Default	(61,459)	
Total	259,844	Difference
Reconcile with schedule XV, line 43:	259,844	0

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>704,056</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>704,056</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(3,090,729)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (3,090,729)	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>	Move RE	2,870,843	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 2,870,843	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 484,170	<b>24</b> *

\* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Montebello Healthcare Center

# 0047340

Report Period Beginning: 01/01/2006

Ending:

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**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$	1
2	Discounts and Allowances for all Levels	(1,052,337)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ (1,052,337)</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	197,821	6
7	Oxygen	1,995	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 199,816</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	(6)	13
14	Non-Patient Meals	580	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	53,312	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,220	19
20	Radiology and X-Ray	518	20
21	Other Medical Services	55,177	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 120,801</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc &amp; General Revenue (see Sch pg 19.1)</b>	<b>726</b>	<b>28</b>
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 726</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ (730,994)</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	448,931	31
32	Health Care	1,068,818	32
33	General Administration	641,068	33
<b>B. Capital Expense</b>			
34	Ownership	84,817	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	39,998	35
36	Provider Participation Fee	76,103	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,359,735</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(3,090,729)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (3,090,729)</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006 Page -19.1  
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Facility Name & ID Number Montebello Health Care Center # 0031468

**SUPPLEMENATAL INCOME SCHEDULE**

<u>DESCRIPTION Line 19 26a 1 &amp; 19 28 1</u>	<u>AMOUNT</u>	
Personal Purchase Receipts <> Default <> Vending	0	
Miscellaneous Receipts<>Default<>Prod<>Vending	(660.00)	
Miscellaneous Receipts<>Default<>Prod<>Administrative	(66)	
Total	(726.00)	Difference
Reconcile with schedule XVII, line 28:	(726)	0

<u>DESCRIPTIONS Line 19 28a 1</u>		
Personal Purchase Receipts <> Default <> Patient Personal Pu	-	
Personal Purchase Receipts <> Default <> Miscellaneous Rece	-	
Personal Purchase Expense <> Default <> Patient Personal Pu	-	
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-	
Activity Programs Receipts <> Default <> Other Misc Rev	-	
Miscellaneous Receipts<>Default<>Prod<>Activities		
Total	-	Difference
Reconcile with schedule XVII, line 28a:	0	-

Facility Name & ID Number **Montebello Healthcare Center**

# **0047340**

Report Period Beginning: **01/01/2006**

Ending: **12/31/2006**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rebecca Bliss	Administrator	100	\$ 72,695	Workers' Compensation Insurance	\$ 41,260	IDPH License Fee	\$	
				Unemployment Compensation Insurance	30,031	Advertising: Employee Recruitment	1,024	
				FICA Taxes	82,423	Health Care Worker Background Check	2,175	
				Employee Health Insurance	18,224	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues	7,050	
				Pension / Retirement	(91)	Home Office	399	
				Insurance Life	1,388	Total Advertising	6,119	
				Other Benefits	2,835	Less: Public Relations Expense (		
						Non-allowable advertising (		
						Yellow page advertising	(711)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 72,695			TOTAL (agree to Sch. V,	\$ 16,056	
(List each licensed administrator separately.)				TOTAL (agree to Schedule V,	\$ 176,070	line 20, col. 8)		
				line 22, col.8)				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$ 3,060
							In-State Travel	13,722
							Home Office	7,670
							Seminar Expense	3,943
							Entertainment Expense	(7)
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	line 24, col. 8)	\$ 28,388
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
TOTAL (agree to Schedule V, line 19, column 3)			\$					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number **Montebello Healthcare Center**

# **0047340**

Report Period Beginning: **01/01/2006**

Ending:

**12/31/2006**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,206	2,206	\$ 0.00	1
2	Assistant Director of Nursing		54,184		2
3	Registered Nurses	3,119	61,971	19.87	3
4	Licensed Practical Nurses	14,642	202,209	13.81	4
5	CNAs & Orderlies	40,127	367,295	9.15	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,941	20,381	10.50	9
10	Activity Assistants	1,317	8,840	6.71	10
11	Social Service Workers	1,955	27,063	13.84	11
12	Dietician				12
13	Food Service Supervisor	1,946	21,227	10.91	13
14	Head Cook	4,086	31,553	7.72	14
15	Cook Helpers/Assistants	6,467	45,224	6.99	15
16	Dishwashers				16
17	Maintenance Workers	1,599	13,158	8.23	17
18	Housekeepers	6,482	53,154	8.20	18
19	Laundry	3,132	21,124	6.74	19
20	Administrator	2,080	80,549	38.73	20
21	Assistant Administrator				21
22	Other Administrative	1,887	32,379	17.16	22
23	Office Manager				23
24	Clerical	3,061	35,436	11.58	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				31
32	Other Health Care Medicare Coord.-C	1,612	38,603	23.95	32
33	Other(specify) Marketing & Tran	1,836	22,667	12.35	33
34	TOTAL (lines 1 - 33)	99,495	\$ 1,137,017 *	\$ 11.43	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	145	\$ 5,300	1-3	35
36	Medical Director	95	7,950	9-3	36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant	32	1,783	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,230	11-3	44
45	Social Service Consultant	37	2,085	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	349	\$ 19,348		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53



Facility Name & ID Number Montebello Healthcare Center# 0047340Report Period Beginning: 01/01/2006 Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association - \$6,839.00
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,021 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 76,103  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ None
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.