

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0048520

Facility Name: Center Home Hispanic Elderly

Address: 1401 North California Chicago 60622
 Number City Zip Code

County: Cook

Telephone Number: (773)782-8700 **Fax #** (773)276-0465

HFS ID Number: 363527934001

Date of Initial License for Current Owners: 10/1/2006

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) _____
	(Type or Print Name) _____ (Date) _____
	(Title) _____
Paid Preparer	(Signed) _____ (Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>

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 Center Home Hispanic Elderly

0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

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>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,170</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>56,940</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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>24,699</u>	<u>467</u>	<u>5,343</u>	<u>30,509</u>	8
9	SNF/PED					9
10	ICF	<u>19,624</u>	<u>382</u>	<u>8</u>	<u>20,014</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,323</u>	<u>849</u>	<u>5,351</u>	<u>50,523</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.73%

D. How many bed-hold days during this year were paid by the Department? 1,627 (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 10/1/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2006 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 98 and days of care provided 5,343

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Center Home Hispanic Elderly # 0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	243,492	84,794	32,297	360,583		360,583	(6,296)	354,287			1
2	Food Purchase		261,586		261,586		261,586	215	261,801			2
3	Housekeeping	177,012	45,891		222,903		222,903	(118)	222,785			3
4	Laundry	103,521	23,255		126,776		126,776	(345)	126,431			4
5	Heat and Other Utilities			181,001	181,001		181,001	3,181	184,182			5
6	Maintenance	128,947		103,562	232,509		232,509	6,831	239,340			6
7	Other (specify):*							2,241	2,241			7
8	TOTAL General Services	652,972	415,526	316,860	1,385,358		1,385,358	5,709	1,391,067			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,380,933	153,884	86,836	2,621,653		2,621,653	9,613	2,631,266			10
10a	Therapy	169,589		4,814	174,403		174,403	2,257	176,660			10a
11	Activities	89,774	6,974	964	97,712		97,712		97,712			11
12	Social Services	170,467	12		170,479		170,479	6,481	176,960			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,137	4,137			15
16	TOTAL Health Care and Programs	2,810,763	160,870	92,614	3,064,247		3,064,247	22,488	3,086,735			16
	C. General Administration											
17	Administrative	179,071			179,071		179,071	59,755	238,826			17
18	Directors Fees											18
19	Professional Services			333,508	333,508		333,508	(295,849)	37,659			19
20	Dues, Fees, Subscriptions & Promotions			66,330	66,330		66,330	(5,775)	60,555			20
21	Clerical & General Office Expenses	105,789	20,592	250,464	376,845		376,845	(3,454)	373,391			21
22	Employee Benefits & Payroll Taxes			620,714	620,714		620,714	(5,996)	614,718			22
23	Inservice Training & Education			344	344		344		344			23
24	Travel and Seminar			1,124	1,124		1,124	1,417	2,541			24
25	Other Admin. Staff Transportation			1,211	1,211		1,211	1,750	2,961			25
26	Insurance-Prop.Liab.Malpractice			148,261	148,261		148,261	2,291	150,552			26
27	Other (specify):*							34,563	34,563			27
28	TOTAL General Administration	284,860	20,592	1,421,956	1,727,408		1,727,408	(211,298)	1,516,110			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,748,595	596,988	1,831,430	6,177,013		6,177,013	(183,101)	5,993,912			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 Center Home Hispanic Elderly #0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			11,341	11,341	11,341	277,866	289,207			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			117,123	117,123	117,123	532,928	650,051			32
33	Real Estate Taxes			206,348	206,348	206,348	2,575	208,923			33
34	Rent-Facility & Grounds			660,000	660,000	660,000	(656,461)	3,539			34
35	Rent-Equipment & Vehicles			5,373	5,373	5,373	594	5,967			35
36	Other (specify):*						15,196	15,196			36
37	TOTAL Ownership			1,000,185	1,000,185	1,000,185	172,698	1,172,883			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		295,140	396,217	691,357	691,357	(28,551)	662,806			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			85,410	85,410	85,410		85,410			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		295,140	481,627	776,767	776,767	(28,551)	748,216			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,748,595	892,128	3,313,242	7,953,965	7,953,965	(38,954)	7,915,011			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 Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(356,693)	30		9
10	Interest and Other Investment Income	(6)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(7,464)	21		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	(152,792)	21		24
25	Fund Raising, Advertising and Promotional	(9,772)	20		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	(16,087)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (542,857)		\$	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)	503,904		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 503,904		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (38,954)		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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Jury Duty Income	10
2	Collection Expense	21
3	CCPI Fees	20
4	Marketing Consultant	19
5	Brns Year Lease Fees	19
6	Capitalized Repair & Maintenance	06
7	Annual Report	20
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100		100
101	Total	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

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			212	3,006	(9,510)		(4)					(6,296)	1
2	Food Purchase	(44)		261		(2)							215	2
3	Housekeeping			398	40	41		(597)					(118)	3
4	Laundry							(345)					(345)	4
5	Heat and Other Utilities			1,897	103	1,181							3,181	5
6	Maintenance	(3,020)		9,051	13	481	314	(8)					6,831	6
7	Other (specify):*			1,956	285								2,241	7
8	TOTAL General Services	(3,064)		13,775	3,447	(7,809)	314	(955)					5,709	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)			23,350	(1,093)		(12,627)					9,613	10
10a	Therapy				2,257								2,257	10a
11	Activities													11
12	Social Services				6,481								6,481	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,137								4,137	15
16	TOTAL Health Care and Programs	(17)			36,225	(1,093)		(12,627)					22,488	16
	C. General Administration													
17	Administrative			9,057	41,016	9,682							59,755	17
18	Directors Fees													18
19	Professional Services	(10,680)		(202,417)	(82,880)	128							(295,849)	19
20	Fees, Subscriptions & Promotions	(12,001)		5,469	25	732							(5,775)	20
21	Clerical & General Office Expenses	(160,397)		132,537	10,617	16,225	(2,436)						(3,454)	21
22	Employee Benefits & Payroll Taxes			(5,910)				(86)					(5,996)	22
23	Inservice Training & Education													23
24	Travel and Seminar			925	492								1,417	24
25	Other Admin. Staff Transportation			1,197		553							1,750	25
26	Insurance-Prop.Liab.Malpractice			1,213	13	1,065							2,291	26
27	Other (specify):*			23,727	6,972	3,864							34,563	27
28	TOTAL General Administration	(183,078)		(34,202)	(23,745)	32,249	(2,436)	(86)					(211,298)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(186,159)		(20,427)	15,927	23,347	(2,122)	(13,668)					(183,101)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Center Home Hispanic Elderly # 0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(356,693)	614,521	15,472	650	833	3,083						277,866	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6)	498,506	29,193	2,798	1,388	1,049						532,928	32
33	Real Estate Taxes			2,265	153	157							2,575	33
34	Rent-Facility & Grounds		(660,000)	2,446		1,093							(656,461)	34
35	Rent-Equipment & Vehicles			322	5	267							594	35
36	Other (specify):*		15,196										15,196	36
37	TOTAL Ownership	(356,699)	468,223	49,698	3,606	3,738	4,132						172,698	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(19,516)	(7,875)	(1,160)					(28,551)	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					(19,516)	(7,875)	(1,160)					(28,551)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(542,857)	468,223	29,271	19,533	7,569	(5,865)	(14,828)					(38,954)	45

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		
				Center Home Property, LLC		Building Company

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 660,000	Center Home Property, LLC	100.00%	\$	\$ (660,000)	1
2	V	30 Depreciation				614,521	614,521	2
3	V	36 Amortization				15,196	15,196	3
4	V	32 Interest				498,506	498,506	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 660,000			\$ 1,128,223	\$ * 468,223	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly # 0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

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, Inc.	100.00%	\$ 212	\$ 212	15	
16	V	02	Food		Care Centers, Inc.	100.00%	261	261	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	398	398	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	1,897	1,897	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	3,129	3,129	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	1,896	1,896	20	
21	V	19	Professional Fees	212,423	Care Centers, Inc.	100.00%	10,006	(202,417)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	5,469	5,469	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	15,850	15,850	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	925	925	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,197	1,197	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	1,213	1,213	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	15,472	15,472	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	29,193	29,193	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,265	2,265	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,446	2,446	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	322	322	31	
32	V	06	Maintenance	3,563	Care Centers, Inc.	100.00%	9,485	5,922	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,956	1,956	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	7,161	7,161	34	
35	V	21	Office and Clerical	35,838	Care Centers, Inc.	100.00%	152,525	116,687	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	23,727	23,727	36	
37	V	22	Employee Benefits	5,910	Care Centers, Inc.	100.00%		(5,910)	37	
38	V								38	
39	Total			\$ 257,734			\$ 287,005	\$ * 29,271	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly# 0048520Report Period Beginning: 01/01/07Ending: 12/31/07

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	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 40	\$ 40	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	103	103	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	13	13	17	
18	V	19	Professional Fees	84,591	Care Centers Clinical, Inc.	100.00%	1,711	(82,880)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	25	25	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	100	100	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	492	492	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	13	13	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	650	650	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	2,798	2,798	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	153	153	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	5	5	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	3,006	3,006	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	285	285	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	23,350	23,350	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	2,257	2,257	30	
31	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	6,481	6,481	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	4,137	4,137	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	41,016	41,016	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	10,517	10,517	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	6,972	6,972	35	
36	V	22	Employee Benefits		Care Centers Clinical, Inc.	100.00%			36	
37	V								37	
38	V								38	
39	Total			\$ 84,591			\$ 104,124	\$ * 19,533	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly # 0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

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, Inc.	100.00%	\$ 5,893	\$ 5,893	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	41	41	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	1,181	1,181	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	481	481	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	128	128	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	732	732	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,530	2,530	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	553	553	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	1,065	1,065	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	833	833	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	1,388	1,388	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	157	157	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	1,093	1,093	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	267	267	28	
29	V	01	Dietary	22,932	Care Centers Health Systems, Inc.	100.00%	7,529	(15,403)	29	
30	V	02	Food	2	Care Centers Health Systems, Inc.	100.00%		(2)	30	
31	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%			31	
32	V	10	Nursing	1,628	Care Centers Health Systems, Inc.	100.00%	535	(1,093)	32	
33	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33	
34	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34	
35	V	39	Ancillary	29,055	Care Centers Health Systems, Inc.	100.00%	9,539	(19,516)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	9,682	9,682	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	13,695	13,695	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	3,864	3,864	38	
39	Total			\$ 53,617			\$ 61,186	\$ *	7,569	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly # 0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 314	\$ 314	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	2,471	2,471	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	207	207	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	612	612	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	842	842	20
21	V	21	Office and Clerical	2,436	Vent Lease, LLC.	100.00%		(2,436)	21
22	V	39	Ancillary	7,875	Vent Lease, LLC.	100.00%		(7,875)	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			\$ 10,311			\$ 4,446	\$ * (5,865)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly# 0048520Report Period Beginning: 01/01/07Ending: 12/31/07

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	1 Dietary	\$ 55	Xcel Supply, LLC	100.00%	\$ 51	\$ (4)	15
16	V	3 Housekeeping	7,403	Xcel Supply, LLC	100.00%	6,806	(597)	16
17	V	4 Laundry	4,283	Xcel Supply, LLC	100.00%	3,938	(345)	17
18	V	6 Repairs & Maintenance	94	Xcel Supply, LLC	100.00%	86	(8)	18
19	V	10 Nursing	156,560	Xcel Supply, LLC	100.00%	143,933	(12,627)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	1,073	Xcel Supply, LLC	100.00%	986	(86)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	14,382	Xcel Supply, LLC	100.00%	13,222	(1,160)	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		\$ 183,850			\$ 169,022	\$ * (14,828)	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 Benefits Group	100.00%	\$ 196,138	\$ 196,138	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	196,138	CCS Employee Benefits Group	100.00%		(196,138)	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			\$ 196,138			\$ 196,138	\$ *	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			\$			\$		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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Center Home Hispanic Elderly # 0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Relative	Administrative		See Attached	1.04	2.25%		\$		1
2	Mark Steinberg	Relative	Administrative		See Attached	1.71	3.11%	Alloc. Salary	4,200	17-7	2
3	Adam Vales	Shareholder	Clerical	7.05	See Attached	1.21	3.03%	Alloc. Salary	1,688	22-7	3
4	Kim Rudolph	Shareholder	Clerical	7.05	See Attached	1.06	3.03%	Alloc. Salary	929	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,817		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 Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Center Home Hispanic Elderly# 0048520

Report Period Beginning:

01/01/07Ending: 12/31/07

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

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

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	01	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 50,523	\$ 212	1
2	02	Food	Patient Days	1,625,640	33	8,403	50,523	261	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	50,523	398	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	50,523	1,897	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	50,523	3,129	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	50,523	1,896	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	50,523	10,006	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	50,523	5,469	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	50,523	15,850	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	50,523	925	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	50,523	1,197	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	50,523	1,213	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	50,523	15,472	13
14	32	Interest	Patient Days	1,625,640	33	939,326	50,523	29,193	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	50,523	2,265	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	50,523	2,446	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	50,523	322	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	5,812	18
19	06	Maintenance	Direct Allocation			456,812	456,812	3,673	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	50,523	1,956	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	7,161	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	117,464	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	35,061	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	50,523	23,727	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 287,005	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Center 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	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 50,523	\$ 40	1	
2	05	Utilities	Patient Days	1,625,640	32	3,307	50,523	103	2	
3	06	Maintenance	Patient Days	1,625,640	32	410	50,523	13	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	50,523	1,711	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	50,523	25	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	50,523	100	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	50,523	492	7	
8	26	Insurance	Patient Days	1,625,640	32	409	50,523	13	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	50,523	650	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	50,523	2,798	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	50,523	153	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	50,523	5	12	
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	50,523	3,006	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	50,523	285	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	50,523	23,350	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	50,523	2,257	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	50,523	6,481	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	50,523	4,137	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	50,523	41,016	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	50,523	10,517	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	50,523	6,972	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		22	
23	12	Social Service Salary	Direct Allocation			8,845	8,845		23	
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			24	
25	TOTALS					\$ 3,374,561	\$ 2,809,547	\$ 104,124	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

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, 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	Gross Billable Income	4,431,674	33	94,358	276,780	5,893	1	
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	276,780	41	2	
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	276,780	1,181	3	
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	276,780	481	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	276,780	128	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	276,780	732	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	276,780	2,530	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	276,780	553	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	276,780	1,065	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	276,780	833	10	
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	276,780	1,388	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	276,780	157	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	276,780	1,093	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	276,780	267	14	
15	01	Dietary	Direct Billable Income	341,879	33	112,243	22,932	7,529	15	
16	02	Food	Direct Billable Income	25	33	8	2		16	
17	03	Housekeeping	Direct Billable Income	29	33	10			17	
18	10	Nursing	Direct Billable Income	69,616	33	22,856	1,628	535	18	
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20	
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298	29,055	9,539	21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	276,780	9,682	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	276,780	13,695	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	276,780	3,864	24	
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 61,186	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

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	Repairs	Direct Billing	892,186	27	\$ 35,557	\$ 7,875	\$ 314	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	7,875		2
3	30	Depreciation	Direct Billing	892,186	27	280,000	7,875	2,471	3
4	32	Interest	Direct Billing	892,186	27	23,404	7,875	207	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	50,523	612	5
6	32	Interest	Patient Days	1,625,640	33	27,081	50,523	842	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					\$ 385,762	\$	\$ 4,446	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	1	Dietary	Direct Allocation		\$	\$		\$ 51	1
2	3	Housekeeping	Direct Allocation					6,806	2
3	4	Laundry	Direct Allocation					3,938	3
4	6	Repairs & Maintenance	Direct Allocation					86	4
5	10	Nursing	Direct Allocation					143,933	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					986	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					13,222	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				\$	\$		\$ 169,022	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

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, Illinois 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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 196,138	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				\$	\$		\$ 196,138	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 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				
	A. Directly Facility Related											
	Long-Term											
1	US Bank		X	Term Loan			\$ 6,240,000	\$ 6,081,821			\$ 440,126	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	US Bank		X	Line of Credit				1,500,000			92,094	6
7	Lake Forest Bank		X					150,000			62,586	7
8	See Supplemental Schedule							980,000			54,202	8
9	TOTAL Facility Related						\$ 6,240,000	\$ 8,711,821			\$ 649,008	9
	B. Non-Facility Related*											
10	Interest Income										(6)	10
11												11
12												12
13	See Supplemental Schedule										1,049	13
14	TOTAL Non-Facility Related						\$	\$			\$ 1,043	14
15	TOTALS (line 9+line14)						\$ 6,240,000	\$ 8,711,821			\$ 650,051	15

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

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																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	Cole Taylor Bank		X				\$	\$ 250,000		\$ 14,455										
9	LaSalle Bank		X					100,000		6,368										
10	Due to Owner	X						630,000												
11	Alloc-Care Centers Inc.		X							29,193										
12	Alloc-Care Center Health Systems		X							1,388										
13	Alloc-Care Centers Clinical		X							2,798										
14	TOTAL Working Capital									980,000	54,202									
B. Non-Facility Related*																				
15	Alloc-Vent Lease		X				\$	\$		\$ 1,049										
16																				
17																				
18																				
19																				
20	TOTAL Non-Facility Related										1,049									

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 32,800	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.)		\$ 2,575	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (30,225)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 239,148	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 208,923	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	8	
	2003	9	
	2004	10	
	2005	11	
	2006	12	
<u>Facility used to be not-for-profit, and therefore paid no real estate taxes.</u>			
<u>Current owners have not yet begun to pay real estate taxes.</u>			
<u>2007 accrual estimated based on \$1200 per bed, plus 5% increase for 2006 and 10.25% increase for 2007.</u>			
<u>Line 2: Allocated from Care Centers Inc. \$2265, Care Centers Health Systems \$157, Care Centers Clinical \$153</u>			
	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Center Home Hispanic Elderly COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048520

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 2006 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 2006.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	Tax Index Number	Property Description	Total Tax	
1.	<u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>118,409.42</u>	\$ <u>2,505.79</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>118,409.42</u>	\$ <u>2,505.79</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Center Home Hispanic Elderly COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048520

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 Center Home Hispanic Elderly

0048520 Report Period Beginning:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,149 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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>55,145</u>	<u>2006</u>	<u>\$ 104,706</u>	1
2	<u>Allocated from Care Centers</u>			<u>13,480</u>	2
3	TOTALS	55,145		\$ 118,186	3

SEE ACCOUNTANTS' COMPILATION REPORT

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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											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Center Home Hispanic Elderly

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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		5,134,305	131,649		131,649	(0)	131,649	67
68		73,961	3,955		3,955		24,400	68
69			11,342			(11,342)		69
70		\$ 5,208,266	\$ 146,946		\$ 135,604	\$ (11,342)	\$ 156,049	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,208,266	\$ 146,946		\$ 135,604	\$ (11,342)	\$ 156,049	1
2	Seco Regifrigerator - Walk In Cooler Repair	2006	3,345		20	478	478	518	2
3	Repaired Elev Hoist Motor	2007	3,000		20	63	63	63	3
4	Decorative Fixtures	2007	4,769		20	199	199	199	4
5	Air Systems	2007	4,984		20	42	42	42	5
6	Carpeting	2007	4,399		20	105	105	105	6
7	Reception Station	2007	15,000		20	125	125	125	7
8	Boiler Repair	2007	3,020		20	151	151	151	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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

0048520

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01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	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)		\$ 5,246,783	\$ 146,946		\$ 136,767	\$ (10,179)	\$ 157,252	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	156		2006	1954	\$ 5,134,305	\$ 131,649	39	\$ 131,649	\$ (0)	\$ 131,649	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	\$	5,134,305	\$	131,649	\$	131,649	\$	(0)	\$	131,649	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Alloc - Care Centers Inc.		2002	2002	\$ 13,840	\$ 355	39	\$ 355		\$ 1,878	4
5	Alloc - Care Centers Inc.		1996	1996	23,467	602	39	602		6,644	5
6	Alloc - Care Centers Health Systems		2002	2002	1,476	38	39	38		200	6
7	Alloc - Care Centers Clinical		2002	2002	1,434	37	39	37		195	7
8											8
	Improvement Type**										
9	Alloc - Care Centers Inc.			2002	11,433	1,045	20	1,045		5,234	9
10	Alloc - Care Centers Inc.			2003	13,473	1,231	20	1,231		6,168	10
11	Alloc - Care Centers Inc.			2005	669	71	20	71		170	11
12	Alloc - Care Centers Inc.			2007	143	10	20	10		10	12
13	Alloc - Care Centers Inc.			1996	396		20			396	13
14	Alloc - Care Centers Inc.			1997	2,253	73	20	73		1,072	14
15											15
16	Alloc - Care Centers Health Systems			2002	1,220	111	20	111		558	16
17	Alloc - Care Centers Health Systems			2003	1,437	131	20	131		658	17
18	Alloc - Care Centers Health Systems			2005	71	8	20	8		18	18
19											19
20	Alloc - Care Centers Clinical			2002	1,184	108	20	108		542	20
21	Alloc - Care Centers Clinical			2003	1,396	128	20	128		639	21
22	Alloc - Care Centers Clinical			2005	69	7	20	7		18	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 Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	\$	\$ 73,961		\$ 3,955	\$ 3,955	\$ 24,400	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly # 0048520 Report Period Beginning: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,407,360	\$ 496,892	\$ 144,374	\$ (352,518)	10	\$ 219,434	71
72	Current Year Purchases	11,516	191	6,196	6,005	10	6,196	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,418,876	\$ 497,083	\$ 150,570	\$ (346,513)		\$ 225,630	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		Alloc-Care Centers Inc.	various	\$ 26,109	\$ 1,515	\$ 1,515	\$	5	\$ 21,447	76
77		Alloc-Care Centers Health System	2007	788	26	26		5	26	77
78		Alloc-Care Centers Clinical	various	2,234	330	330		5	422	78
79										79
80	TOTALS			\$ 29,131	\$ 1,871	\$ 1,871	\$		\$ 21,895	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 6,812,976	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 645,900	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 289,207	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (356,693)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 404,777	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	<u>Allocated from Care Centers Inc.</u>				<u>2,446</u>			5
6	<u>Allocated from Care Centers Health Systems</u>				<u>1,093</u>			6
7	TOTAL				\$ 3,539			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.	<u> /2008</u>	\$ _____
13.	<u> /2009</u>	\$ _____
14.	<u> /2010</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: \$ 5,967 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	\$		\$ 131,539	\$		\$ 131,539	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			89,272			89,272	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			164,102			164,102	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				200,197		200,197	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>					11,304	94,943		106,247	13
14	TOTAL			\$		\$ 396,217	\$ 295,140		\$ 691,357	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 Center Home Hispanic Elderly# 0048520Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(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	\$ 935	\$ 198,509	1
2	Cash-Patient Deposits	19,989	19,989	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,267,863	3,267,863	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	196,506	196,506	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(246,399)		8
9	Other(specify): <u>See Attached Schedule</u>	514	514	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,239,408	\$ 3,683,381	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		104,706	13
14	Buildings, at Historical Cost		5,134,305	14
15	Leasehold Improvements, at Historical Cost	30,728	30,728	15
16	Equipment, at Historical Cost	34,626	1,328,032	16
17	Accumulated Depreciation (book methods)	(12,316)	(756,947)	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>	267,583	368,255	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 320,621	\$ 6,209,079	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,560,029	\$ 9,892,460	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 694,704	\$ 694,704	26
27	Officer's Accounts Payable		801,717	27
28	Accounts Payable-Patient Deposits	20,933	20,933	28
29	Short-Term Notes Payable	2,630,000	2,786,540	29
30	Accrued Salaries Payable	282,676	282,676	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,502	13,502	31
32	Accrued Real Estate Taxes(Sch.IX-B)	239,148	239,148	32
33	Accrued Interest Payable		40,245	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)	\$ 3,880,963	\$ 4,879,465	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,925,281	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)	\$	\$ 5,925,281	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,880,963	\$ 10,804,746	46
47	TOTAL EQUITY(page 18, line 24)	\$ (320,934)	\$ (912,286)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,560,029	\$ 9,892,460	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 55,672	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 55,672	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(376,606)	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)	\$ (376,606)	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)	\$ (320,934)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly# 0048520Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 7,457,523	1
2	Discounts and Allowances for all Levels	(1,608,998)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,848,525	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,473,322	6
7	Oxygen	518	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,473,840	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	192,687	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,386	19
20	Radiology and X-Ray		20
21	Other Medical Services	43,247	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 253,320	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,668	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,668	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,577,359	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,385,358	31
32	Health Care	3,064,247	32
33	General Administration	1,727,408	33
B. Capital Expense			
34	Ownership	1,000,185	34
C. Ancillary Expense			
35	Special Cost Centers	691,357	35
36	Provider Participation Fee	85,410	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,953,965	40
41	Income before Income Taxes (line 30 minus line 40)**	(376,606)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (376,606)	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 Center Home Hispanic Elderly

0048520

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,691	1,776	\$ 73,735	\$ 41.52	1
2	Assistant Director of Nursing	387	387	13,679	35.35	2
3	Registered Nurses	12,708	13,689	427,014	31.19	3
4	Licensed Practical Nurses	32,899	35,402	853,979	24.12	4
5	CNAs & Orderlies	77,521	84,909	890,056	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,814	10,905	169,589	15.55	8
9	Activity Director	1,972	2,153	30,677	14.25	9
10	Activity Assistants	7,390	8,034	59,097	7.36	10
11	Social Service Workers	8,546	9,412	170,467	18.11	11
12	Dietician					12
13	Food Service Supervisor	2,201	2,544	41,250	16.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,949	6,497	62,794	9.67	15
16	Dishwashers	16,207	17,880	139,448	7.80	16
17	Maintenance Workers	8,345	9,174	128,947	14.06	17
18	Housekeepers	20,932	22,314	177,012	7.93	18
19	Laundry	10,645	11,452	103,521	9.04	19
20	Administrator	2,202	2,462	111,691	45.37	20
21	Assistant Administrator	2,038	2,067	67,380	32.60	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,580	9,191	105,789	11.51	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	2,230	2,613	36,808	14.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,840	4,279	85,662	20.02	33
34	TOTAL (lines 1 - 33)	236,097	257,140	\$ 3,748,595 *	\$ 14.58	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	870	\$ 32,297	01-03	35
36	Medical Director				36
37	Medical Records Consultant	monthly	514	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,547	10-03	39
40	Physical Therapy Consultant	18	1,044	10a-03	40
41	Occupational Therapy Consultant	5	267	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	119	10a-03	43
44	Activity Consultant	20	964	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	68	3,384	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	983	\$ 43,136		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 440	10-03	50
51	Licensed Practical Nurses	1,779	70,511	10-03	51
52	Certified Nurse Assistants/Aides	419	10,824	10-03	52
53	TOTAL (lines 50 - 52)	2,206	\$ 81,775		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly

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. ICLTC \$8611
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 49,522 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 85,410
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT