

		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: 0046177

Facility Name: Chateau Nursing & Rehab Center

Address: 7050 Madison Street Willowbrook 60521
 Number City Zip Code

County: Dupage

Telephone Number: (630) 323-6380 **Fax #** (630) 323-6416

HFS ID Number: 320039566001

Date of Initial License for Current Owners: 2/1/2003

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) _____
	(Date) _____
Paid Preparer	(Type or Print Name) _____
	(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 Chateau Nursing & Rehab Center

0046177 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>150</u>	Skilled (SNF)	<u>150</u>	<u>54,750</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,750</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>29,932</u>	<u>9,737</u>	<u>8,575</u>	<u>48,244</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,932</u>	<u>9,737</u>	<u>8,575</u>	<u>48,244</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.12%

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

2 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

YES NO

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

YES NO

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

Date started 2/1/2003

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

YES Date 2/1/2003 NO

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

YES NO If YES, enter number of beds certified 150 and days of care provided 7,918

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Chateau Nursing & Rehab Center # 0046177 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	294,750	47,311	11,891	353,952		353,952	(198)	353,754		1
2	Food Purchase		248,186		248,186		248,186	(248)	247,938		2
3	Housekeeping	147,528	48,172		195,700		195,700	(3,004)	192,696		3
4	Laundry	53,457	20,373		73,830		73,830		73,830		4
5	Heat and Other Utilities			269,834	269,834		269,834	2,189	272,023		5
6	Maintenance	149,319		160,392	309,711		309,711	3,229	312,940		6
7	Other (specify):*							3,078	3,078		7
8	TOTAL General Services	645,054	364,042	442,117	1,451,213		1,451,213	5,046	1,456,259		8
	B. Health Care and Programs										
9	Medical Director			45,350	45,350		45,350		45,350		9
10	Nursing and Medical Records	3,147,964	137,848	3,063	3,288,875		3,288,875	11,615	3,300,490		10
10a	Therapy	179,186		396	179,582		179,582	2,155	181,737		10a
11	Activities	133,405	33,246	1,196	167,847		167,847		167,847		11
12	Social Services	170,587		2,178	172,765		172,765	6,339	179,104		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,142	4,142		15
16	TOTAL Health Care and Programs	3,631,142	171,094	52,183	3,854,419		3,854,419	24,251	3,878,670		16
	C. General Administration										
17	Administrative	125,699			125,699		125,699	65,361	191,060		17
18	Directors Fees										18
19	Professional Services			380,765	380,765		380,765	(333,071)	47,694		19
20	Dues, Fees, Subscriptions & Promotions			59,176	59,176		59,176	(5,240)	53,936		20
21	Clerical & General Office Expenses	104,744	37,819	340,260	482,823		482,823	(133,383)	349,440		21
22	Employee Benefits & Payroll Taxes			703,835	703,835		703,835	(3,164)	700,671		22
23	Inservice Training & Education			4,450	4,450		4,450		4,450		23
24	Travel and Seminar			2,605	2,605		2,605	3,210	5,815		24
25	Other Admin. Staff Transportation			12,947	12,947		12,947	1,274	14,221		25
26	Insurance-Prop.Liab.Malpractice			147,357	147,357		147,357	3,300	150,657		26
27	Other (specify):*							30,587	30,587		27
28	TOTAL General Administration	230,443	37,819	1,651,395	1,919,657		1,919,657	(371,126)	1,548,531		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,506,639	572,955	2,145,695	7,225,289		7,225,289	(341,829)	6,883,460		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 Chateau Nursing & Rehab Center

#0046177

Report Period Beginning:

01/01/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			55,314	55,314	55,314	218,164	273,478			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						337,355	337,355			32
33	Real Estate Taxes			54,494	54,494	54,494	2,345	56,839			33
34	Rent-Facility & Grounds			492,750	492,750	492,750	(490,156)	2,594			34
35	Rent-Equipment & Vehicles			9,695	9,695	9,695	2,539	12,234			35
36	Other (specify):*						26,123	26,123			36
37	TOTAL Ownership			612,253	612,253	612,253	96,370	708,623			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		543,149	568,258	1,111,407	1,111,407	(94,189)	1,017,218			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			82,125	82,125	82,125		82,125			42
43	Other (specify):*						65,657	65,657			43
44	TOTAL Special Cost Centers		543,149	650,383	1,193,532	1,193,532	(28,532)	1,165,000			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,506,639	1,116,104	3,408,331	9,031,074	9,031,074	(273,991)	8,757,083			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 Chateau Nursing & Rehab Center

0046177

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	10,057	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(497)	02		13
14	Non-Care Related Interest	(52,209)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(44)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(123,667)	21		24
25	Fund Raising, Advertising and Promotional	(10,994)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(109)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(163,858)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (341,321)		\$	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)	67,330		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 67,330		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (273,991)		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	Miscellaneous Income	(4,710) 21
2	Bad Debt Income	(112) 19
3	Theft Loss	(1,850) 21
4	Collection Expense	(239) 21
5	Non-Allowable Management Fees	(147,783) 21
6	Capitalized R&M	(6,250) 6
7	Annual Report	(250) 20
8	Prior Year Legal Fees (Tax Appt)	(743) 19
9	Non-Allowable Legal Fees	(1,131) 19
10	Debt Collection Statement	(750) 19
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101	Total	(163,858) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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			202	2,870	(3,242)			(28)				(198)	1
2	Food Purchase	(497)		249									(248)	2
3	Housekeeping			380	38	(9)			(3,413)				(3,004)	3
4	Laundry													4
5	Heat and Other Utilities			1,812	98	279							2,189	5
6	Maintenance	(6,290)		8,855	12	114		538					3,229	6
7	Other (specify):*			2,806	272								3,078	7
8	TOTAL General Services	(6,787)		14,304	3,290	(2,858)		538	(3,441)				5,046	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(112)			22,309	(443)			(10,139)				11,615	10
10a	Therapy				2,155								2,155	10a
11	Activities													11
12	Social Services				6,339								6,339	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,142								4,142	15
16	TOTAL Health Care and Programs	(112)			34,945	(443)			(10,139)				24,251	16
	C. General Administration													
17	Administrative			8,647	39,164	2,291	15,259						65,361	17
18	Directors Fees													18
19	Professional Services	(2,624)		(251,634)	(79,703)	30	860						(333,071)	19
20	Fees, Subscriptions & Promotions	(11,288)		5,222	24	173	715		(86)				(5,240)	20
21	Clerical & General Office Expenses	(278,358)		128,093	10,138	3,838	5,231	(2,325)					(133,383)	21
22	Employee Benefits & Payroll Taxes			(2,696)	(297)				(171)				(3,164)	22
23	Inservice Training & Education													23
24	Travel and Seminar			884	470		1,856						3,210	24
25	Other Admin. Staff Transportation			1,143		131							1,274	25
26	Insurance-Prop.Liab.Malpractice			1,159	12	252	1,877						3,300	26
27	Other (specify):*			21,161	6,658	914	1,854						30,587	27
28	TOTAL General Administration	(292,270)		(88,021)	(23,534)	7,629	27,652	(2,325)	(257)				(371,126)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(299,169)		(73,717)	14,701	4,328	27,652	(1,787)	(13,837)				(341,829)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chateau Nursing & Rehab Center # 0046177 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	10,057	186,698	14,773	620	197	998	4,821					218,164	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(52,209)	348,239	27,875	2,672	328	9,292	1,158					337,355	32
33	Real Estate Taxes			2,162	146	37							2,345	33
34	Rent-Facility & Grounds		(492,750)	2,335		259							(490,156)	34
35	Rent-Equipment & Vehicles			308	5	63	2,163						2,539	35
36	Other (specify):*		26,123										26,123	36
37	TOTAL Ownership	(42,152)	68,310	47,453	3,443	884	12,453	5,979					96,370	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(6,090)	(68,534)	(13,500)	(6,065)				(94,189)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*						65,657						65,657	43
44	TOTAL Special Cost Centers					(6,090)	(2,877)	(13,500)	(6,065)				(28,532)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(341,321)	68,310	(26,264)	18,144	(878)	37,228	(9,308)	(19,902)				(273,991)	45

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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		
				Chateau Willowbrook 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	\$ 492,750	Chateau Willowbrook Property LLC	100.00%	\$	\$ (492,750)	1
2	V	32 Interest				348,239	348,239	2
3	V	33 Real Estate Tax	54,494			54,494		3
4	V	36 Amortization				26,123	26,123	4
5	V	30 Depreciation				186,698	186,698	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		\$ 547,244			\$ 615,554	\$ * 68,310	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177Report 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	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 202	\$ 202	15
16	V	02	Food		Care Centers, Inc.	100.00%	249	249	16
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	380	380	17
18	V	05	Utilities		Care Centers, Inc.	100.00%	1,812	1,812	18
19	V	06	Maintenance		Care Centers, Inc.	100.00%	2,988	2,988	19
20	V	17	Administrative		Care Centers, Inc.	100.00%	1,810	1,810	20
21	V	19	Professional Fees	261,188	Care Centers, Inc.	100.00%	9,554	(251,634)	21
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	5,222	5,222	22
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	15,134	15,134	23
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	884	884	24
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,143	1,143	25
26	V	26	Insurance		Care Centers, Inc.	100.00%	1,159	1,159	26
27	V	30	Depreciation		Care Centers, Inc.	100.00%	14,773	14,773	27
28	V	32	Interest		Care Centers, Inc.	100.00%	27,875	27,875	28
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,162	2,162	29
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,335	2,335	30
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	308	308	31
32	V	06	Maintenance	5,791	Care Centers, Inc.	100.00%	11,658	5,867	32
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	2,806	2,806	33
34	V	17	Administrative		Care Centers, Inc.	100.00%	6,837	6,837	34
35	V	21	Office and Clerical	12,183	Care Centers, Inc.	100.00%	125,142	112,959	35
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	21,161	21,161	36
37	V	22	Employee Benefits	2,696	Care Centers, Inc.	100.00%		(2,696)	37
38	V								38
39	Total			\$ 281,858			\$ 255,594	\$ * (26,264)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177Report 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%	\$ 38	\$ 38	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	98	98	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	12	12	17	
18	V	19	Professional Fees	81,337	Care Centers Clinical, Inc.	100.00%	1,634	(79,703)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	24	24	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	96	96	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	470	470	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	12	12	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	620	620	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	2,672	2,672	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	146	146	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%	2,870	2,870	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	272	272	28	
29	V	10	Nursing Salary	392	Care Centers Clinical, Inc.	100.00%	22,701	22,309	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	2,155	2,155	30	
31	V	12	Social Service Salary	1,587	Care Centers Clinical, Inc.	100.00%	7,926	6,339	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	4,142	4,142	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	39,164	39,164	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	10,042	10,042	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	6,658	6,658	35	
36	V	22	Employee Benefits	297	Care Centers Clinical, Inc.	100.00%		(297)	36	
37	V								37	
38	V								38	
39	Total			\$ 83,613			\$ 101,757	\$ * 18,144	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177Report 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	01	Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,394	\$ 1,394	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	10	10	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	279	279	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	114	114	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	30	30	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	173	173	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	598	598	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	131	131	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	252	252	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	197	197	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	328	328	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	37	37	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	259	259	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	63	63	28	
29	V	01	Dietary	6,902	Care Centers Health Systems, Inc.	100.00%	2,266	(4,636)	29	
30	V	02	Food		Care Centers Health Systems, Inc.	100.00%			30	
31	V	03	Housekeeping	29	Care Centers Health Systems, Inc.	100.00%	10	(19)	31	
32	V	10	Nursing	660	Care Centers Health Systems, Inc.	100.00%	217	(443)	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	9,067	Care Centers Health Systems, Inc.	100.00%	2,977	(6,090)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	2,291	2,291	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	3,240	3,240	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	914	914	38	
39	Total			\$ 16,658			\$ 15,780	\$ * (878)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177Report 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	17 Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 1,068	\$ 1,068	15
16	V	19 Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	860	860	16
17	V	20 Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	715	715	17
18	V	21 Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	5,231	5,231	18
19	V	24 Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	1,856	1,856	19
20	V	26 Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	1,877	1,877	20
21	V	30 Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	998	998	21
22	V	32 Interest		Therapy Works Rehabilitation Services, LLC	100.00%	9,292	9,292	22
23	V	35 Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	2,163	2,163	23
24	V	39 Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	25,058	25,058	24
25	V	17 Administrative		Therapy Works Rehabilitation Services, LLC	100.00%	14,191	14,191	25
26	V	27 Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	1,854	1,854	26
27	V	39 Ancillary	549,359	Therapy Works Rehabilitation Services, LLC	100.00%	455,767	(93,592)	27
28	V	43 Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	65,657	65,657	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		\$ 549,359			\$ 586,587	\$ * 37,228	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 Schedule V	2 Line	3 Cost Per General Ledger		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	4 Amount	Name of Related Organization					
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 538	\$ 538	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	1	1	16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	4,237	4,237	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	354	354	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	584	584	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	804	804	20
21	V	21	Office and Clerical	2,326	Vent Lease, LLC.	100.00%		(2,326)	21
22	V	39	Ancillary	13,500	Vent Lease, LLC.	100.00%		(13,500)	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			\$ 15,826			\$ 6,518	\$ * (9,308)	39

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

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177Report 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	\$ 346	Xcel Supply, LLC	100.00%	\$ 318	\$ (28)	15
16	V	3 Housekeeping	42,320	Xcel Supply, LLC	100.00%	38,907	(3,413)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	125,713	Xcel Supply, LLC	100.00%	115,574	(10,139)	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	1,060	Xcel Supply, LLC	100.00%	975	(86)	22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	2,125	Xcel Supply, LLC	100.00%	1,954	(171)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	75,202	Xcel Supply, LLC	100.00%	69,137	(6,065)	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		\$ 246,766			\$ 226,864	\$ * (19,902)	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%	\$ 200,059	\$ 200,059	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	200,059	CCS Employee Benefits Group	100.00%		(200,059)	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			\$ 200,059			\$ 200,059	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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			\$			\$		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 Chateau Nursing & Rehab Center # 0046177 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	Shareholder	Administrative	1.00	See Attached	0.99	2.15%		\$		1
2	Mark Steinberg	Relative	Administrative		See Attached	1.63	2.96%	Salary Alloc.	4,011	17-7	2
3	Adam Vales	Relative	Clerical		See Attached	1.23	3.08%	Salary Alloc.	1,722	22-7	3
4	Kim Rudolph	Relative	Clerical		See Attached	1.08	3.09%	Salary Alloc.	948	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,681		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 Chateau Nursing & Rehab Center

0046177

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 Chateau Nursing & Rehab Center

0046177

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 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	\$ 48,242	\$ 202	1
2	02	Food	Patient Days	1,625,640	33	8,403	48,242	249	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	48,242	380	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	48,242	1,812	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	48,242	2,988	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	48,242	1,810	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	48,242	9,554	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	48,242	5,222	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	48,242	15,134	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	48,242	884	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	48,242	1,143	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	48,242	1,159	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	48,242	14,773	13
14	32	Interest	Patient Days	1,625,640	33	939,326	48,242	27,875	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	48,242	2,162	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	48,242	2,335	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	48,242	308	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	5,550	18
19	06	Maintenance	Direct Allocation			456,812	456,812	6,108	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	48,242	2,806	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	6,837	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	112,160	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	12,982	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	48,242	21,161	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 255,594	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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	\$ 48,242	\$ 38	1	
2	05	Utilities	Patient Days	1,625,640	32	3,307	48,242	98	2	
3	06	Maintenance	Patient Days	1,625,640	32	410	48,242	12	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	48,242	1,634	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	48,242	24	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	48,242	96	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	48,242	470	7	
8	26	Insurance	Patient Days	1,625,640	32	409	48,242	12	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	48,242	620	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	48,242	2,672	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	48,242	146	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	48,242	5	12	
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	48,242	2,870	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	48,242	272	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	48,242	22,296	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	48,242	2,155	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	48,242	6,189	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	48,242	3,951	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	48,242	39,164	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	48,242	10,042	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	48,242	6,658	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		405	22
23	12	Social Service Salary	Direct Allocation			8,845	8,845		1,737	23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			191	24
25	TOTALS					\$ 3,374,561	\$ 2,809,547		\$ 101,757	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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	65,480	1,394	1	
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	65,480	10	2	
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	65,480	279	3	
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	65,480	114	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	65,480	30	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	65,480	173	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	65,480	598	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	65,480	131	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	65,480	252	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	65,480	197	10	
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	65,480	328	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	65,480	37	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	65,480	259	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	65,480	63	14	
15	01	Dietary	Direct Billable Income	341,879	33	112,243	6,902	2,266	15	
16	02	Food	Direct Billable Income	25	33	8			16	
17	03	Housekeeping	Direct Billable Income	29	33	10	29	10	17	
18	10	Nursing	Direct Billable Income	69,616	33	22,856	660	217	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	9,067	2,977	21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	65,480	2,291	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	65,480	3,240	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	65,480	914	24	
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 15,780	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 Therapy Works Rehabilitation Services, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 922-0702
 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	17	Administration	Billable Income	4,671,432	16	\$ 9,000	\$ 554,272	\$ 1,068	1
2	19	Professional Fees	Billable Income	4,671,432	16	7,245	554,272	860	2
3	20	Dues and Subscriptions	Billable Income	4,671,432	16	6,024	554,272	715	3
4	21	Office & Clerical	Billable Income	4,671,432	16	44,084	554,272	5,231	4
5	24	Travel and Seminar	Billable Income	4,671,432	16	15,640	554,272	1,856	5
6	26	Insurance	Billable Income	4,671,432	16	15,816	554,272	1,877	6
7	30	Depreciation	Billable Income	4,671,432	16	8,410	554,272	998	7
8	32	Interest	Billable Income	4,671,432	16	78,317	554,272	9,292	8
9	35	Rent - Equipment	Billable Income	4,671,432	16	18,231	554,272	2,163	9
10	39	Ancillary	Billable Income	4,671,432	16	211,187	554,272	25,058	10
11	17	Administrative	Billable Income	4,671,432	16	119,603	119,603	14,191	11
12	27	Emp. Ben. - Gen. Admin.	Billable Income	4,671,432	16	15,625	554,272	1,854	12
13	39	Ancillary	Billable Income	4,671,432	16	3,841,227	3,841,227	455,767	13
14	43	Emp. Ben. - Other	Billable Income	4,671,432	16	553,364	554,272	65,657	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,943,774	\$ 3,960,830	\$ 586,587	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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	\$ 13,500	\$ 538	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	13,500	1	2
3	30	Depreciation	Direct Billing	892,186	27	280,000	13,500	4,237	3
4	32	Interest	Direct Billing	892,186	27	23,404	13,500	354	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	48,242	584	5
6	32	Interest	Patient Days	1,625,640	33	27,081	48,242	804	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	\$	\$ 6,518	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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						\$ 318	1
2	3	Housekeeping						38,907	2
3	4	Laundry							3
4	6	Repairs & Maintenance							4
5	10	Nursing						115,574	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions						975	8
9	21	Office And Clerical							9
10	22	Employee Benefits						1,954	10
11	24	Seminars & Education							11
12	39	Ancillary						69,137	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				\$	\$		\$ 226,864	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 West 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		\$	\$		\$ 200,059	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				\$	\$		\$ 200,059	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 Chateau Nursing & Rehab Center

0046177

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	Business Partners (Net)		X	Mortgage			\$	\$ 3,464,604			\$ 348,239	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6												6
7												7
8	See Supplemental Schedule										41,325	8
9	TOTAL Facility Related						\$	\$ 3,464,604			\$ 389,564	9
	B. Non-Facility Related*											
10	Interest Income										(52,209)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(52,209)	14
15	TOTALS (line 9+line14)						\$	\$ 3,464,604			\$ 337,355	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.)

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

Report Period Beginning:

01/01/07

Ending:

12/31/07

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 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							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	<u>Alloc-Care Centers Inc.</u>		X				\$	\$			\$	<u>27,875</u>	8
9	<u>Alloc-Care Centers Health Systems</u>		X									<u>328</u>	9
10	<u>Alloc-Care Centers Clinical</u>		X									<u>2,672</u>	10
11	<u>Alloc-Therapy Works</u>		X									<u>9,292</u>	11
12	<u>Alloc-Vent Lease</u>		X									<u>1,158</u>	12
13													13
14	TOTAL Working Capital											<u>41,325</u>	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

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

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177 Report Period Beginning: 01/01/07Ending: 12/31/07

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	61,600	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.)			\$	58,976	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,624)	3																			
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	59,463	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.			\$	56,839	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2002	<u>74,203</u>	8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			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
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																					
2003	<u>66,414</u>	9																						
2004	<u>69,341</u>	10																						
2005	<u>58,698</u>	11																						
2006	<u>56,631</u>	12																						
2007 Accrual = \$56,631 x 1.05 = \$59,463																								
Allocated from: Care Centers Inc. \$2162, Care Centers Health Systems \$37, Care Centers Clinical \$146																								

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 Chateau Nursing & Rehab Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

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.	09-23-407-043	Long Term Care Property	\$ 56,631.14	\$ 56,631.14
2.	See Attached	Home Office Allocation	\$ 118,409.42	\$ 2,281.54
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ <u>175,040.56</u>	\$ <u>58,912.68</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 Chateau Nursing & Rehab Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0046177

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 Chateau Nursing & Rehab Center

0046177 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,447 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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>273,121</u>	<u>2003</u>	<u>\$ 295,367</u>	<u>1</u>
2	<u>Allocated from Care Centers</u>			<u>12,103</u>	<u>2</u>
3	TOTALS	<u>273,121</u>		<u>\$ 307,470</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			2003	99,453		20	6,880	6,880	25,140	9
10											10
11											11
12											12
13											13
14											14
15											15
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31											31
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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 Chateau Nursing & Rehab Center

0046177

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
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52								52
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58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		3,486,879	186,698		173,296	(13,402)	1,073,834	67
68		67,604	3,570		3,570		23,269	68
69			55,313			(55,313)		69
70		\$ 3,653,936	\$ 245,581		\$ 183,746	\$ (61,835)	\$ 1,122,243	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,653,936	\$ 245,581		\$ 183,746	\$ (61,835)	\$ 1,122,243	1
2	Wood Flooring	2004	20,929		20	1,046	1,046	4,186	2
3	Wallpaper Borders & Adhesive	2004	2,063		20	103	103	413	3
4	Heating Unit Repair	2004	1,379		20	197	197	788	4
5	Interior Addition	2004	1,744		20	87	87	341	5
6	Pot Hole Repairs	2004	7,000		20	350	350	1,283	6
7	Electric Door Openers	2004	2,320		20	116	116	425	7
8	Fire Safety System	2004	1,691		20	338	338	1,212	8
9	Chemical Kitchen System	2004	2,278		20	114	114	399	9
10	Damper Work	2004	3,316		20	166	166	580	10
11	Plumbing Work	2004	1,187		20	59	59	208	11
12	Electric Heated Air Curtain	2004	2,617		20	523	523	1,832	12
13	Generator Service	2004	2,969		20	148	148	507	13
14	Generator Service	2004	1,645		20	82	82	281	14
15	Vestibule Doors	2004	6,820		20	341	341	1,279	15
16	Air Curtain	2004	1,600		20	80	80	260	16
17	Total Cost Of New Alarm System	2004	12,500		20	625	625	1,979	17
18	Sprinkler	2004	4,640		20	232	232	773	18
19	Roof Repair	2004	750		20	38	38	141	19
20	Roof Ventilators	2004	776		20	39	39	145	20
21	Light Fixture	2004	726		20	36	36	136	21
22	Nursing Station Repairs	2004	951		20	48	48	174	22
23	Light Fixture	2004	726		20	36	36	133	23
24	Shower Grips	2004	635		20	32	32	106	24
25	Smoke Detectors	2004	1,940		20	97	97	323	25
26	Wander Guard	2004	1,055		20	53	53	207	26
27	Wander Guard	2004	703		20	35	35	129	27
28	Replace Evaporator Coil	2004	1,604		20	80	80	281	28
29	Landscaping	2004	6,422		20	321	321	1,124	29
30	Landscaping	2004	2,198		20	110	110	385	30
31	Landscaping	2004	3,501		20	175	175	613	31
32	Concrete	2005	5,580		20	279	279	651	32
33	Ventilation System	2005	16,782		20	839	839	1,888	33
34	TOTAL (lines 1 thru 33)		\$ 3,774,983	\$ 245,581		\$ 190,571	\$ (55,010)	\$ 1,145,425	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,774,983	\$ 245,581		\$ 190,571	\$ (55,010)	\$ 1,145,425	1
2	Landmark Construction Serv. - Thatcher Oaks (Awning)	2006	18,631		20	932	932	1,475	2
3	Landmark Construction Service	2006	17,643		20	882	882	1,617	3
4	Targin Sign Systems - Monument Sign	2006	4,455		20	446	446	594	4
5	Targin Sign Systems Invoice 85075 - Custom Id Sign	2006	4,698		20	470	470	548	5
6	Aquatic Services - Sunburst 1Hp	2006	4,972		20	497	497	539	6
7	Tile For 2Nd Floor	2007	30,108		20	1,255	1,255	1,255	7
8	Air Conditioners	2007	6,284		20	393	393	393	8
9	New Doors	2007	11,675		20	341	341	341	9
10	Tiles - Shower	2007	10,725		20	417	417	417	10
11	Door Installation	2007	9,500		20	277	277	277	11
12	Elevator Repairs	2007	37,450		20	1,092	1,092	1,092	12
13	Pot Hole Patching, Sealcoating	2007	6,510		20	81	81	81	13
14	Install 7 New Actuators	2007	5,297		20	44	44	44	14
15	Sprinkler System Repair	2007	2,890		20	24	24	24	15
16	Landscaping	2007	6,290		20	315	315	315	16
17									17
18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 12C, Carried Forward		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 12D, Carried Forward		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 12E, Carried Forward		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
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3									3
4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 12F, Carried Forward		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
7									7
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 12G, Carried Forward		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 12I, Carried Forward		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 12J, Carried Forward		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
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6									6
7									7
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11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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 12L, Carried Forward		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,952,111	\$ 245,581		\$ 198,037	\$ (47,544)	\$ 1,154,437	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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	150		2003	1987	\$ 2,922,597	\$	various	\$ 136,186	\$ 136,186	\$ 923,614	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various		2003		325,640		various	25,178	25,178	126,726	9
10	Life Safety Code Improvements (net of settlement)		2006		231,242		20	11,562	11,562	23,124	10
11	Professional Fees - Architect		2007		7,400		20	370	370	370	11
12											12
13	Book Depreciation Expense					186,698			(186,698)		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 Chateau Nursing & Rehab Center

0046177

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)	\$	3,486,879	\$	186,698	\$	173,296	\$	(13,402)	\$	1,073,834	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center

0046177

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	Alloc - Care Centers Inc.		2002	2002	\$ 13,215	\$ 339	39	\$ 339		\$ 1,793	4
5	Alloc - Care Centers Inc.		1996	1996	22,408	575	39	575		6,344	5
6	Alloc - Care Centers Health Systems		2002	2002	349	9	39	9		47	6
7	Alloc - Care Centers Clinical		2002	2002	1,369	35	39	35		186	7
8											8
	Improvement Type**										
9	Alloc - Care Centers Inc.			2002	10,916	998	20	998		5,998	9
10	Alloc - Care Centers Inc.			2003	12,865	1,176	20	1,176		5,890	10
11	Alloc - Care Centers Inc.			2005	639	68	20	68		163	11
12	Alloc - Care Centers Inc.			2007	137	9	20	9		9	12
13	Alloc - Care Centers Inc.			1996	378		20			378	13
14	Alloc - Care Centers Inc.			1997	2,152	70	20	70		1,024	14
15											15
16	Alloc - Care Centers Health Systems			2002	289	26	20	26		132	16
17	Alloc - Care Centers Health Systems			2003	340	31	20	31		156	17
18	Alloc - Care Centers Health Systems			2005	17	2	20	2		4	18
19											19
20	Alloc - Care Centers Clinical			2002	1,131	103	20	103		518	20
21	Alloc - Care Centers Clinical			2003	1,333	122	20	122		610	21
22	Alloc - Care Centers Clinical			2005	66	7	20	7		17	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 Chateau Nursing & Rehab Center

0046177

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)	\$	\$ 67,604		\$ 3,570	\$	\$ 23,269	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Chateau Nursing & Rehab Center # 0046177 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	\$ 541,772	\$ 15,951	\$ 69,272	\$ 53,321	10	\$ 452,769	71
72	Current Year Purchases	1,054	122	122		10	122	72
73	Fully Depreciated Assets	7,584				10	7,584	73
74								74
75	TOTALS	\$ 550,410	\$ 16,073	\$ 69,394	\$ 53,321		\$ 460,475	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		2003 FORD ECONO VAN	2003	\$ 33,833	\$	\$ 4,147	\$ 4,147	5	\$ 23,292	76
77		TRUCK REPAIR	2004	1,083		133	133	5	619	77
78		Allocated from Care Centers	various	27,250	1,767	1,767		5	20,888	78
79										79
80	TOTALS			\$ 62,166	\$ 1,767	\$ 6,047	\$ 4,280		\$ 44,799	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 4,872,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 263,421	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 273,478	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 10,057	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,659,711	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>Allocation from Care Centers Inc.</u>				<u>2,335</u>			5
6	<u>Allocation from Care Centers Health Systems</u>				<u>259</u>			6
7	TOTAL				\$ 2,594			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: \$ 11,106 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	<u>Facility</u>	<u>2003 Ford E450</u>	\$ <u>563.87</u>	\$ <u>1,128</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 563.87	\$ 1,128	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

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$		\$ 203,018	\$		\$ 203,018	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			53,245			53,245	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			293,097			293,097	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				392,258		392,258	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>					18,898	150,891		169,789	13
14	TOTAL			\$		\$ 568,258	\$ 543,149		\$ 1,111,407	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 Chateau Nursing & Rehab Center# 0046177Report 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	\$ 78,097	\$ 102,757	1
2	Cash-Patient Deposits	34,648	34,648	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	851,242	851,242	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,809	22,809	6
7	Other Prepaid Expenses	2,479	2,479	7
8	Accounts Receivable (owners or related parties)	608,867	619,479	8
9	Other(specify): <u>See Attached Schedule</u>	655,358	655,358	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,253,500	\$ 2,288,772	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		295,367	13
14	Buildings, at Historical Cost		3,805,411	14
15	Leasehold Improvements, at Historical Cost	340,553	340,553	15
16	Equipment, at Historical Cost	194,054	194,054	16
17	Accumulated Depreciation (book methods)	(182,100)	(1,530,648)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	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>		46,364	23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 352,507	\$ 3,151,101	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,606,007	\$ 5,439,873	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 401,390	\$ 401,391	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,655	26,655	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	205,785	205,785	30
	Accrued Taxes Payable (excluding real estate taxes)	9,508	9,508	31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,463	59,463	32
33	Accrued Interest Payable		29,076	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	27,711	27,711	36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 730,512	\$ 759,589	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,464,604	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,464,604	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 730,512	\$ 4,224,193	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,875,495	\$ 1,215,680	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,606,007	\$ 5,439,873	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,984,552	1
2	Restatements (describe):		2
3	Late Entry - Accrued Profit Sharing	(6,075)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,978,477	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	265,885	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	(368,867)	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)	\$ (102,982)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,875,495	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center# 0046177Report 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	\$ 9,112,902	1
2	Discounts and Allowances for all Levels	(2,824,064)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,288,838	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,384,254	6
7	Oxygen	12,052	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,396,306	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	3,336	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	392,510	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	86,310	19
20	Radiology and X-Ray	9,090	20
21	Other Medical Services	62,917	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 554,163	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	52,209	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52,209	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	5,443	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,443	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,296,959	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,451,213	31
32	Health Care	3,854,419	32
33	General Administration	1,919,657	33
B. Capital Expense			
34	Ownership	612,253	34
C. Ancillary Expense			
35	Special Cost Centers	1,111,407	35
36	Provider Participation Fee	82,125	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,031,074	40
41	Income before Income Taxes (line 30 minus line 40)**	265,885	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 265,885	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 Chateau Nursing & Rehab Center

0046177

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	1,916	2,191	\$ 82,033	\$ 37.44	1
2	Assistant Director of Nursing	627	787	26,605	33.81	2
3	Registered Nurses	24,836	27,642	788,318	28.52	3
4	Licensed Practical Nurses	35,259	39,207	988,753	25.22	4
5	CNAs & Orderlies	95,348	103,941	1,231,160	11.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,710	10,989	179,186	16.31	8
9	Activity Director	1,840	2,085	33,171	15.91	9
10	Activity Assistants	9,161	9,992	100,234	10.03	10
11	Social Service Workers	8,357	9,621	170,587	17.73	11
12	Dietician	1,757	1,928	29,167	15.13	12
13	Food Service Supervisor	1,949	2,072	34,588	16.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,738	8,477	88,071	10.39	15
16	Dishwashers	15,436	17,102	142,924	8.36	16
17	Maintenance Workers	8,534	9,357	149,319	15.96	17
18	Housekeepers	15,269	16,992	147,528	8.68	18
19	Laundry	5,630	6,152	53,457	8.69	19
20	Administrator	1,982	2,164	96,853	44.76	20
21	Assistant Administrator	1,906	2,073	28,846	13.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,738	7,618	104,744	13.75	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	1,888	2,186	31,095	14.22	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	255,881	282,576	\$ 4,506,639 *	\$ 15.95	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	273	\$ 11,891	01-03	35
36	Medical Director	monthly	43,350	09-03	36
37	Medical Records Consultant	16	796	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,875	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,196	11-03	44
45	Social Service Consultant	12	591	12-03	45
46	Other(specify) <u>Psychiatrist</u>	monthly	2,000	09-03	46
47	<u>Therapy Service Programming</u>	8	396	10A-03	47
48	<u>CCI Allocated (See Attached)</u>		1,979	various	48
49	TOTAL (lines 35 - 48)	333	\$ 64,074		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Nursing & Rehab Center

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 Chateau Nursing & Rehab Center

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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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. \$ 71,785 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. \$ 82,125
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? Yes
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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT