

Facility Name & ID Number Concord Extended Care

0026914 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>134</u>	Skilled (SNF)	<u>134</u>	<u>48,910</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>134</u>	TOTALS	<u>134</u>	<u>48,910</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>30,464</u>	<u>7,057</u>	<u>5,487</u>	<u>43,008</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>30,464</u>	<u>7,057</u>	<u>5,487</u>	<u>43,008</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.93%

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

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

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

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

None

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

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

YES NO

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

YES NO

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

Date started 1962

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

YES Date 1962 NO

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

YES NO If YES, enter number of beds certified 134 and days of care provided 4,987

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 Concord Extended Care # 0026914 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	209,283	59,982	8,759	278,024		278,024	(1,382)	276,642		1
2	Food Purchase		197,803		197,803		197,803	(103)	197,700		2
3	Housekeeping	162,009	43,469		205,478		205,478	(2,820)	202,658		3
4	Laundry	92,351	26,694		119,045		119,045	(3)	119,042		4
5	Heat and Other Utilities			131,060	131,060		131,060	2,438	133,498		5
6	Maintenance	73,127		159,224	232,351		232,351	22,735	255,086		6
7	Other (specify):*							11,875	11,875		7
8	TOTAL General Services	536,770	327,948	299,043	1,163,761		1,163,761	32,740	1,196,501		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	2,157,946	88,180	5,547	2,251,673		2,251,673	9,015	2,260,688		10
10a	Therapy	117,741		3,828	121,569		121,569	1,919	123,488		10a
11	Activities	81,864	9,334	2,184	93,382		93,382		93,382		11
12	Social Services	109,619	220	3,265	113,104		113,104	5,578	118,682		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,587	3,587		15
16	TOTAL Health Care and Programs	2,467,170	97,734	25,824	2,590,728		2,590,728	20,099	2,610,827		16
	C. General Administration										
17	Administrative	78,721		8,000	86,721		86,721	48,607	135,328		17
18	Directors Fees										18
19	Professional Services			296,995	296,995		296,995	(254,501)	42,494		19
20	Dues, Fees, Subscriptions & Promotions			32,412	32,412		32,412	(8,827)	23,585		20
21	Clerical & General Office Expenses	115,242	27,012	313,485	455,739		455,739	(149,833)	305,906		21
22	Employee Benefits & Payroll Taxes			506,600	506,600		506,600	(1,880)	504,720		22
23	Inservice Training & Education			3,348	3,348		3,348		3,348		23
24	Travel and Seminar			1,631	1,631		1,631	1,205	2,836		24
25	Other Admin. Staff Transportation			5,272	5,272		5,272	1,364	6,636		25
26	Insurance-Prop.Liab.Malpractice			134,965	134,965		134,965	4,888	139,853		26
27	Other (specify):*							24,670	24,670		27
28	TOTAL General Administration	193,963	27,012	1,302,708	1,523,683		1,523,683	(334,307)	1,189,376		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,197,903	452,694	1,627,575	5,278,172		5,278,172	(281,468)	4,996,704		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care #0026914 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			64,867	64,867	64,867	123,883	188,750			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			43,322	43,322	43,322	282,163	325,485			32
33	Real Estate Taxes						165,002	165,002			33
34	Rent-Facility & Grounds			516,203	516,203	516,203	(513,441)	2,762			34
35	Rent-Equipment & Vehicles			4,718	4,718	4,718	445	5,163			35
36	Other (specify):*						19,578	19,578			36
37	TOTAL Ownership			629,110	629,110	629,110	77,630	706,740			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		271,818	350,929	622,747	622,747	(33,199)	589,548			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			73,365	73,365	73,365		73,365			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		271,818	424,294	696,112	696,112	(33,199)	662,913			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,197,903	724,512	2,680,979	6,603,394	6,603,394	(237,037)	6,366,357			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/07

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	26,059	30		9
10	Interest and Other Investment Income	(157)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(325)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(30)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(114,297)	21		24
25	Fund Raising, Advertising and Promotional	(11,144)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,216)	20		28
29	Other-Attach Schedule	(196,551)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (297,661)		\$	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)	60,624		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 60,624		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (237,037)		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	Sch. V Line
1	Miscellaneous Income	21
2	Bury Dues	10
3	Patient Clothing	10
4	Collection Expense	21
5	V/A Pharmacy	10
6	V/A Speech Therapy	10
7	C/OPD Dues	20
8	PPA Professional Fees	19
9	PPA Ancillary Expense	19
10	Non-Allowable Expense	21
11	Prize Year Legal Fees	19
12	Non-Allowable Legal	19
13		13
14		14
15		15
16		16
17		17
18		18
19		19
20		20
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96		96
97		97
98		98
99		99
100		100
101	Total	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concord Extended Care

0026914

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			180	2,555	(4,106)		(11)					(1,382)	1
2	Food Purchase	(325)		222									(103)	2
3	Housekeeping			338	34	26		(3,218)					(2,820)	3
4	Laundry							(3)					(3)	4
5	Heat and Other Utilities			1,613	87	738							2,438	5
6	Maintenance		13,150	9,111	11	300	239	(76)					22,735	6
7	Other (specify):*			11,632	243								11,875	7
8	TOTAL General Services	(325)	13,150	23,096	2,930	(3,042)	239	(3,308)					32,740	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,309)			19,847	(142)		(6,381)					9,015	10
10a	Therapy				1,919								1,919	10a
11	Activities													11
12	Social Services				5,578								5,578	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,587								3,587	15
16	TOTAL Health Care and Programs	(4,309)			30,931	(142)		(6,381)					20,099	16
	C. General Administration													
17	Administrative			7,697	34,863	6,047							48,607	17
18	Directors Fees													18
19	Professional Services	(11,870)		(172,046)	(70,665)	80							(254,501)	19
20	Fees, Subscriptions & Promotions	(13,954)		4,649	21	457							(8,827)	20
21	Clerical & General Office Expenses	(280,234)		113,315	9,024	10,132	(2,070)						(149,833)	21
22	Employee Benefits & Payroll Taxes			(1,414)	(108)			(358)					(1,880)	22
23	Inservice Training & Education													23
24	Travel and Seminar			786	419								1,205	24
25	Other Admin. Staff Transportation			1,018		346							1,364	25
26	Insurance-Prop.Liab.Malpractice		3,181	1,031	11	665							4,888	26
27	Other (specify):*			16,331	5,926	2,413							24,670	27
28	TOTAL General Administration	(306,058)	3,181	(28,633)	(20,509)	20,140	(2,070)	(358)					(334,307)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(310,692)	16,331	(5,537)	13,352	16,956	(1,831)	(10,047)					(281,468)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concord Extended Care

0026914

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	26,059	81,203	13,151	552	520	2,398						123,883	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(157)	253,388	24,814	2,379	867	872						282,163	32
33	Real Estate Taxes		162,849	1,925	130	98							165,002	33
34	Rent-Facility & Grounds		(516,203)	2,079		683							(513,441)	34
35	Rent-Equipment & Vehicles			274	4	167							445	35
36	Other (specify):*		19,578										19,578	36
37	TOTAL Ownership	25,902	815	42,243	3,065	2,335	3,270						77,630	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(12,871)				(10,085)	(5,985)	(4,258)					(33,199)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(12,871)				(10,085)	(5,985)	(4,258)					(33,199)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(297,661)	17,146	36,706	16,417	9,206	(4,546)	(14,305)					(237,037)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 516,203	Concord Health Care Properties, LLC	100.00%	\$	\$ (516,203)	1
2	V	32 Interest	373			253,761	253,388	2
3	V	30 Depreciation				81,203	81,203	3
4	V	33 Real Estate Tax Expense				162,849	162,849	4
5	V	26 Property / Liability Insurance				3,181	3,181	5
6	V	36 MIP Expense				19,578	19,578	6
7	V	06 Repairs and Maintenance				13,150	13,150	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 516,576			\$ 533,722	\$ * 17,146	14

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

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		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	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 180	\$ 180	15
16	V	02	Food		Care Centers, Inc.	100.00%	222	222	16
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	338	338	17
18	V	05	Utilities		Care Centers, Inc.	100.00%	1,613	1,613	18
19	V	06	Maintenance		Care Centers, Inc.	100.00%	2,660	2,660	19
20	V	17	Administrative		Care Centers, Inc.	100.00%	1,611	1,611	20
21	V	19	Professional Fees	180,551	Care Centers, Inc.	100.00%	8,505	(172,046)	21
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	4,649	4,649	22
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	13,472	13,472	23
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	786	786	24
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,018	1,018	25
26	V	26	Insurance		Care Centers, Inc.	100.00%	1,031	1,031	26
27	V	30	Depreciation		Care Centers, Inc.	100.00%	13,151	13,151	27
28	V	32	Interest		Care Centers, Inc.	100.00%	24,814	24,814	28
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,925	1,925	29
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,079	2,079	30
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	274	274	31
32	V	06	Maintenance	71,440	Care Centers, Inc.	100.00%	77,891	6,451	32
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	11,632	11,632	33
34	V	17	Administrative		Care Centers, Inc.	100.00%	6,086	6,086	34
35	V	21	Office and Clerical		Care Centers, Inc.	100.00%	99,843	99,843	35
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	16,331	16,331	36
37	V	22	Employee Benefits	1,414	Care Centers, Inc.	100.00%		(1,414)	37
38	V								38
39	Total			\$ 253,405			\$ 290,111	\$ * 36,706	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping		Care Centers Clinical, Inc.	100.00%	\$ 34	\$ 34	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	87	87	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	11	11	17	
18	V	19	Professional Fees	72,119	Care Centers Clinical, Inc.	100.00%	1,454	(70,665)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	21	21	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	85	85	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	419	419	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	11	11	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	552	552	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	2,379	2,379	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	130	130	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	4	4	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	2,555	2,555	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	243	243	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	19,847	19,847	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,919	1,919	30	
31	V	12	Social Service Salary	721	Care Centers Clinical, Inc.	100.00%	6,299	5,578	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	3,587	3,587	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	34,863	34,863	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	8,939	8,939	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	5,926	5,926	35	
36	V	22	Employee Benefits	108	Care Centers Clinical, Inc.	100.00%		(108)	36	
37	V								37	
38	V								38	
39	Total			\$ 72,948			\$ 89,365	\$ * 16,417	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 3,680	\$ 3,680	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	26	26	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	738	738	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	300	300	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	80	80	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	457	457	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,580	1,580	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	346	346	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	665	665	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	520	520	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	867	867	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	98	98	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	683	683	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	167	167	28	
29	V	01	Dietary	11,591	Care Centers Health Systems, Inc.	100.00%	3,805	(7,786)	29	
30	V	02	Food		Care Centers Health Systems, Inc.	100.00%			30	
31	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%			31	
32	V	10	Nursing	211	Care Centers Health Systems, Inc.	100.00%	69	(142)	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	15,014	Care Centers Health Systems, Inc.	100.00%	4,929	(10,085)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	6,047	6,047	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	8,552	8,552	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	2,413	2,413	38	
39	Total			\$ 26,816			\$ 36,022	\$ *	9,206	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 239	\$ 239	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	1,878	1,878	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	157	157	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	520	520	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	715	715	20
21	V	21	Office and Clerical	2,070	Vent Lease, LLC.	100.00%		(2,070)	21
22	V	39	Ancillary	5,985	Vent Lease, LLC.	100.00%		(5,985)	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		\$ 8,055				\$ 3,509	\$ * (4,546)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$ 131	Xcel Supply, LLC	100.00%	\$ 120	\$ (11)	15
16	V	3 Housekeeping	39,890	Xcel Supply, LLC	100.00%	36,672	(3,218)	16
17	V	4 Laundry	33	Xcel Supply, LLC	100.00%	30	(3)	17
18	V	6 Repairs & Maintenance	945	Xcel Supply, LLC	100.00%	869	(76)	18
19	V	10 Nursing	79,117	Xcel Supply, LLC	100.00%	72,736	(6,381)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	4,435	Xcel Supply, LLC	100.00%	4,077	(358)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	52,801	Xcel Supply, LLC	100.00%	48,543	(4,258)	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		\$ 177,352			\$ 163,047	\$ * (14,305)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 122,246	\$ 122,246	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	122,246	CCS Employee Benefits Group	100.00%		(122,246)	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			\$ 122,246			\$ 122,246	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 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	Owner	Administrative	33.33%	See Attached	0.88	1.91%		\$	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.45	2.63%	Alloc. Salary	3,570	17-7	2
3	Noah Wolff	Owner	Administrative	16.67%	See Attached	10.00	27.78%	Mgmt Fees	8,000	17-3	3
4	Adam Vales	Relative	Clerical	0.00%	See Attached	0.75	1.87%	Alloc. Salary	1,052	22-7	4
5	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.66	1.88%	Alloc. Salary	579	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,201		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/07

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 Concord Extended Care

0026914

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	\$ 42,944	\$ 180	1
2	02	Food	Patient Days	1,625,640	33	8,403	42,944	222	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	42,944	338	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	42,944	1,613	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	42,944	2,660	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	42,944	1,611	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	42,944	8,505	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	42,944	4,649	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	42,944	13,472	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	42,944	786	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	42,944	1,018	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	42,944	1,031	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	42,944	13,151	13
14	32	Interest	Patient Days	1,625,640	33	939,326	42,944	24,814	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	42,944	1,925	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	42,944	2,079	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	42,944	274	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	4,940	18
19	06	Maintenance	Direct Allocation			456,812	456,812	72,951	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	42,944	11,632	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	6,086	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	99,843	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346		23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	42,944	16,331	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 290,111	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care# 0026914

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care 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

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	3	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 42,944	\$ 34	1	
2	5	Utilities	Patient Days	1,625,640	32	3,307	42,944	87	2	
3	6	Maintenance	Patient Days	1,625,640	32	410	42,944	11	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	42,944	1,454	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	42,944	21	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	42,944	85	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	42,944	419	7	
8	26	Insurance	Patient Days	1,625,640	32	409	42,944	11	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	42,944	552	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	42,944	2,379	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	42,944	130	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	42,944	4	12	
13	1	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	42,944	2,555	13
14	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	42,944	243	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	42,944	19,847	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	42,944	1,919	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	42,944	5,509	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	42,944	3,517	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	42,944	34,863	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	42,944	8,939	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	42,944	5,926	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		22	
23	12	Social Service Salary	Direct Allocation			8,845	8,845	790	23	
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994		70	24	
25	TOTALS					\$ 3,374,560	\$ 2,809,548	\$ 89,365	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

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	1	Dietary	Gross Billable Income	4,431,674	33	94,358	172,853	3,680	1	
2	3	Housekeeping	Gross Billable Income	4,431,674	33	663	172,853	26	2	
3	5	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	172,853	738	3	
4	6	Maintenance	Gross Billable Income	4,431,674	33	7,696	172,853	300	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	172,853	80	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	172,853	457	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	172,853	1,580	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	172,853	346	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	172,853	665	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	172,853	520	10	
11	32	Insurance	Gross Billable Income	4,431,674	33	22,225	172,853	867	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	172,853	98	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	172,853	683	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	172,853	167	14	
15	1	Dietary	Direct Billable Income	341,879	33	112,243	11,591	3,805	15	
16	2	Food	Direct Billable Income	25	33	8			16	
17	3	Housekeeping	Direct Billable Income	29	33	10			17	
18	10	Nursing	Direct Billable Income	69,616	33	22,856	211	69	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	15,014	4,929	21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	172,853	6,047	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	172,853	8,552	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	172,853	2,413	24	
25	TOTALS					\$ 2,152,813	\$ 374,301	\$ 36,022	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

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	6	Repairs	Direct Billing	892,186	27	\$ 35,557	\$ 5,985	\$ 239	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	5,985		2
3	30	Depreciation	Direct Billing	892,186	27	280,000	5,985	1,878	3
4	32	Interest	Direct Billing	892,186	27	23,404	5,985	157	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	42,944	520	5
6	32	Interest	Patient Days	1,625,640	33	27,081	42,944	715	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					\$ 385,763	\$	\$ 3,509	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

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						\$ 120	1
2	3	Housekeeping						36,672	2
3	4	Laundry						30	3
4	6	Repairs & Maintenance						869	4
5	10	Nursing						72,736	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions							8
9	21	Office And Clerical							9
10	22	Employee Benefits						4,077	10
11	24	Seminars & Education							11
12	39	Ancillary						48,543	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				\$	\$		\$ 163,047	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 122,246	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				\$	\$		\$ 122,246	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

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 Concord Extended Care

0026914

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 Concord Extended Care

0026914

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	HUD Mortgage		X	Mortgage			\$	\$ 3,887,129			\$ 253,761	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
Working Capital												
6	Diawa Loan		X	Working Capital				696,053			43,322	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						\$	\$ 4,583,182			\$ 297,083	9
B. Non-Facility Related*												
10	Interest Income		X								(157)	10
11	Interest Income - Bldg. Co.		X								(373)	11
12												12
13	See Supplemental Schedule										28,932	13
14	TOTAL Non-Facility Related						\$	\$			\$ 28,402	14
15	TOTALS (line 9+line14)						\$	\$ 4,583,182			\$ 325,485	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,578 Line # 36

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

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

Facility Name & ID Number

Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15	Allocate Care Centers, Inc.		X				\$	\$			\$	24,814	15						
16	Allocate CC Clinical		X									2,379	16						
17	Allocate CC Health Sys.		X									867	17						
18	Allocate Ventlease LLC		X									872	18						
19													19						
20	TOTAL Non-Facility Related											28,932	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.)

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 Concord Extended Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-05-302-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>154,148.97</u>	\$ <u>154,148.97</u>
2. <u>See Attached</u>	<u>Care Centers, Inc. Allocation</u>	\$ <u>46,662.50</u>	\$ <u>1,232.67</u>
3. <u>See Attached</u>	<u>Care Centers Clinical, Inc.</u>	\$ <u>4,834.42</u>	\$ <u>127.71</u>
4. <u>See Attached</u>	<u>Care Centers Health Sys. Alloc.</u>	\$ <u>2,476.87</u>	\$ <u>96.61</u>
5. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>24,152.48</u>	\$ <u>683.03</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>232,275.24</u>	\$ <u>156,288.99</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 Concord Extended Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Concord Extended Care

0026914 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>56,110</u>	<u>1962</u>	<u>\$ 27,417</u>	<u>1</u>
2	<u>Allocated from Care Centers, Inc.</u>			<u>11,216</u>	<u>2</u>
3	TOTALS	56,110		\$ 38,633	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1974		1,435		20			1,435	9
10	Various		1976		4,663		20			4,663	10
11	Various		1977		2,336		20			2,336	11
12	Various		1978		765		20			765	12
13	Various		1980		33,145		20			33,145	13
14	Various		1982		2,378		20			2,292	14
15	Various		1983		45,375		20	1,815	1,815	43,601	15
16	Various		1985		21,344		20			21,344	16
17	Various		1986		31,133		20			31,065	17
18	Various		1988		41,219		20	1,662	1,662	32,755	18
19	Various		1989		3,324		20	166	166	3,042	19
20	Various		1990		8,400		20	420	420	7,175	20
21	Various		1991		34,006		20	1,702	1,702	28,563	21
22	Various		1992		8,695		20	435	435	6,677	22
23	Various		1993		11,679		20	585	585	8,584	23
24	Various		1994		29,410		20	1,472	1,472	19,938	24
25	Various		1995		118,494		20	5,927	5,927	72,951	25
26	Various		1996		68,945		20	3,449	3,449	38,726	26
27	Various		1997		54,013		20	2,701	2,701	28,225	27
28	Various		1998		158,651		20	7,933	7,933	75,243	28
29	Various		1999		40,891		20	2,045	2,045	18,141	29
30	Various		2000		123,534		20	6,179	6,179	45,659	30
31	Various		2001		17,052		20	777	777	4,558	31
32	Various		2002		17,598		20	1,991	1,991	11,749	32
33	Various		2003		24,512		20	2,185	2,185	9,836	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,105,389	57,477		58,690	1,213	1,361,459	67
68		61,922	3,296		3,296		20,415	68
69			64,867			(64,867)		69
70		\$ 3,070,308	\$ 125,640		\$ 103,430	\$ (22,210)	\$ 1,934,342	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,070,308	\$ 125,640		\$ 103,430	\$ (22,210)	\$ 1,934,342	1
2	Install Panic Device	2004	2,521		20	252	252	1,008	2
3	Repair Concrete Ramp	2004	4,250		20	425	425	1,523	3
4	Office Equipment	2004	572		20	57	57	195	4
5	Replace Door Holder	2004	1,657		20	331	331	1,270	5
6	Fire Rated Device	2004	961		20	137	137	526	6
7	100 Watt Amplifier	2004			20				7
8	A/C Startup	2004	1,301		20	260	260	954	8
9	Keypad For Elevator	2004	955		20	96	96	374	9
10	Static Pressure Test	2004	2,850		20	285	285	1,093	10
11	Repair Walls	2004	4,475		20	448	448	1,641	11
12	Carpeting	2004	2,578		20	368	368	1,320	12
13	Electrical Work	2004	582		20	58	58	223	13
14	Plumbing Repairs	2004	2,100		20	105	105	420	14
15	Repair Valve In Boiler Room	2004	2,219		20	111	111	444	15
16	Repair Water Lines	2004	1,253		20	63	63	245	16
17	Landscaping	2004	471		20	47	47	169	17
18	Locks And Key Pads	2004	1,804		20	180	180	646	18
19	Keypad For Elevator	2004	573		20	57	57	205	19
20	Painting	2004	19,700		20	1,970	1,970	7,059	20
21	Hvac	2004	18,705		20	1,871	1,871	6,703	21
22	Parking Lot	2004	4,750		20	475	475	1,702	22
23	Concrete West Side Entrance	2004	4,750		20	475	475	1,702	23
24	Concrete West Side Entrance	2004	275		20	28	28	99	24
25	Northside Ramp	2004	2,300		20	230	230	824	25
26	Water Heater	2005			20				26
27	5/04 Payment	2005	(4,475)		20	(448)	(448)	(1,268)	27
28	Electrical	2005	2,125		20	106	106	257	28
29	Door Frames	2005	2,178		20	109	109	227	29
30	Duct Work	2005	1,995		20	100	100	224	30
31	Guardian Air Units	2006	6,750		20	675	675	1,350	31
32	Line Location Proposal	2006	675		20	68	68	124	32
33	Lovitt & Sons	2006	3,133		20	209	209	235	33
34	TOTAL (lines 1 thru 33)		\$ 3,164,291	\$ 125,640		\$ 112,578	\$ (13,062)	\$ 1,965,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,164,291	\$ 125,640		\$ 112,578	\$ (13,062)	\$ 1,965,836	1
2	35' Interior Drain Tile Installation	2007	7,248		20	604	604	604	2
3	Painting (Transfer Expense From Home Office)	2007	56,787		20	4,732	4,732	4,732	3
4	Corridors	2007	2,506		20	21	21	21	4
5	Baseboard Covers	2007	5,445		20	45	45	45	5
6	5 Ton Ac Unit	2007	9,500		20	79	79	79	6
7	Painting (Transfer Expense From Home Office)	2007	14,359		20	1,197	1,197	1,197	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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	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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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	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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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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18									18
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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	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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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	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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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	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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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

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Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	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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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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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)		\$ 3,260,136	\$ 125,640		\$ 119,256	\$ (6,384)	\$ 1,972,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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			1962	1962	\$ 371,832	\$	39	\$	\$	\$ 371,832	4
5			1964	1988	1,529,289	48,549	39	48,540	(9)	924,471	5
6			1962	1962	112,250	1,792	39		(1,792)	33,975	6
7											7
8											8
		Improvement Type**									
9		Concord Health Care Properties		2004	63,738	4,661	20	7,675	3,014	26,727	9
10		Concord Health Care Properties		2005	6,103	611	20	611		1,615	10
11		Concord Health Care Properties		2006	17,302	1,574	20	1,574		2,549	11
12		Concord Health Care Properties		2007	4,875	290	20	290		290	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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				
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56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	2,105,389	\$	57,477	\$	58,690	\$	1,213	\$	1,361,459	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed*s*	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	Allocate Care Centers, Inc. 2201 Main LLC	2002	2002	\$ 11,764	\$ 302	39	\$ 302	\$	\$ 1,596	4
5	Allocate Care Centers, Inc. - CCI Building		1996	19,947	511	39	511		5,647	5
6	Allocate Care Centers Clinical, Inc.	2002	2002	1,219	31	39	31		165	6
7	Allocate Care Centers Health Systems, Inc.	2002	2002	922	24	39	24		125	7
8										8
	Improvement Type**									
9	Allocate Care Centers, Inc. 2201 Main LLC		2002	9,718	888	20	888		4,449	9
10	Allocate Care Centers, Inc. 2201 Main LLC		2003	11,452	1,047	20	1,047		5,243	10
11	Allocate Care Centers, Inc. 2201 Main LLC		2005	569	60	20	60		145	11
12										12
13	Allocate Care Centers, Inc.		2007	122	8	20	8		8	13
14										14
15	Allocate Care Centers, Inc. - CCI Building		1996	336	-	20	-		336	15
16	Allocate Care Centers, Inc. - CCI Building		1997	1,916	62	20	62		911	16
17										17
18	Allocate Care Centers Clinical, Inc.		2002	1,007	92	20	92		461	18
19	Allocate Care Centers Clinical, Inc.		2003	1,186	108	20	108		543	19
20	Allocate Care Centers Clinical, Inc.		2005	59	6	20	6		15	20
21										21
22	Allocate Care Centers Health Systems, Inc.		2002	762	70	20	70		349	22
23	Allocate Care Centers Health Systems, Inc.		2003	898	82	20	82		411	23
24	Allocate Care Centers Health Systems, Inc.		2005	45	5	20	5		11	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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		
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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)	\$	61,922	\$	3,296	\$	3,296	\$	20,415	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/07 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	\$ 571,981	\$ 34,550	\$ 65,873	\$ 31,323	10	\$ 436,300	71
72	Current Year Purchases	20,438	916	2,036	1,120	10	1,569	72
73	Fully Depreciated Assets	454,066				10	454,066	73
74								74
75	TOTALS	\$ 1,046,485	\$ 35,466	\$ 67,909	\$ 32,443		\$ 891,935	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		Allocate Care Centers, Inc.	2007	\$ 22,192	\$ 1,288	\$ 1,288	\$	5	\$ 18,230	76
77		Allocate CC Clinical, Inc.	2007	1,899	281	281		5	359	77
78		Allocate CC Health Systems, Inc.	2007	492	16	16		5	16	78
79										79
80	TOTALS			\$ 24,583	\$ 1,585	\$ 1,585	\$		\$ 18,605	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)		\$ 4,369,837	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 162,691	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 188,750	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 26,059	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,883,054	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>Allocate Care Centers, Inc.</u>				<u>2,079</u>			5
6	<u>Allocate Care Centers Health Systems, Inc.</u>				<u>683</u>			6
7	TOTAL				\$ <u>2,762</u>			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: \$ 2,510 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>2005 Toyota 4Runner</u>	\$ <u>528.00</u>	\$ <u>2,653</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>528.00</u>	\$ <u>2,653</u>	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 Concord Extended Care# 0026914

Report Period Beginning:

01/01/07

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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	\$		\$ 161,757	\$		\$ 161,757	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			56,563			56,563	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			132,217			132,217	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				161,166		161,166	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>					392	110,652		111,044	13
14	TOTAL			\$		\$ 350,929	\$ 271,818		\$ 622,747	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care# 0026914Report Period Beginning: 01/01/07

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	\$ 1,000	\$ 26,021	1
2	Cash-Patient Deposits	62,017	62,017	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,014,436	1,014,436	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	159,499	183,537	6
7	Other Prepaid Expenses	530	530	7
8	Accounts Receivable (owners or related parties)	41,115	38,729	8
9	Other(specify): <u>See Attached Schedule</u>	108,148	247,494	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,386,745	\$ 1,572,764	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		27,417	13
14	Buildings, at Historical Cost		2,069,821	14
15	Leasehold Improvements, at Historical Cost	982,847	1,052,875	15
16	Equipment, at Historical Cost	939,191	1,063,630	16
17	Accumulated Depreciation (book methods)	(1,621,851)	(2,962,427)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		66,239	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 300,187	\$ 1,317,555	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,686,932	\$ 2,890,319	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,607,890	\$ 1,627,005	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,690	49,690	28
29	Short-Term Notes Payable	696,053	696,053	29
30	Accrued Salaries Payable	123,957	123,957	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,541	5,541	31
32	Accrued Real Estate Taxes(Sch.IX-B)		161,900	32
33	Accrued Interest Payable		20,991	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,483,131	\$ 2,685,137	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,887,129	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,887,129	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,483,131	\$ 6,572,266	46
47	TOTAL EQUITY (page 18, line 24)	\$ (796,199)	\$ (3,681,947)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,686,932	\$ 2,890,319	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (437,316)	1
2	Restatements (describe):		2
3	Pension Expense	(912)	3
4	Bad Debt	(123,983)	4
5	Repairs & Maintenance \$(9), Rounding \$1	8	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (562,203)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(233,996)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (233,996)	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)	\$ (796,199)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/07

Ending: 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	\$ 6,308,244	1
2	Discounts and Allowances for all Levels	(1,375,371)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,932,873	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,210,765	6
7	Oxygen	27,823	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,238,588	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	141,222	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,399	19
20	Radiology and X-Ray	4,440	20
21	Other Medical Services	31,590	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 197,651	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	157	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 157	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	129	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 129	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,369,398	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,163,761	31
32	Health Care	2,590,728	32
33	General Administration	1,523,683	33
B. Capital Expense			
34	Ownership	629,110	34
C. Ancillary Expense			
35	Special Cost Centers	622,747	35
36	Provider Participation Fee	73,365	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,603,394	40
41	Income before Income Taxes (line 30 minus line 40)**	(233,996)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (233,996)	43

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

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

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

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/07

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	1,918	2,248	\$ 83,015	\$ 36.93	1
2	Assistant Director of Nursing	1,777	2,170	72,885	33.59	2
3	Registered Nurses	10,553	11,673	289,877	24.83	3
4	Licensed Practical Nurses	32,652	35,989	881,060	24.48	4
5	CNAs & Orderlies	71,432	76,839	773,262	10.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,829	8,552	117,741	13.77	8
9	Activity Director	1,702	1,910	24,760	12.96	9
10	Activity Assistants	6,550	7,177	57,104	7.96	10
11	Social Service Workers	5,471	5,835	109,619	18.79	11
12	Dietician					12
13	Food Service Supervisor	1,848	2,096	37,090	17.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,682	4,936	47,246	9.57	15
16	Dishwashers	13,257	14,298	124,947	8.74	16
17	Maintenance Workers	3,778	4,150	73,127	17.62	17
18	Housekeepers	16,317	17,523	162,009	9.25	18
19	Laundry	8,211	9,104	92,351	10.14	19
20	Administrator	2,003	2,139	78,721	36.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,449	8,255	115,242	13.96	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	1,819	2,035	23,868	11.73	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,979	2,382	33,979	14.26	33
34	TOTAL (lines 1 - 33)	201,227	219,311	\$ 3,197,903 *	\$ 14.58	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	201	\$ 8,759	01-03	35
36	Medical Director	Monthly	11,000	09-03	36
37	Medical Records Consultant	33	1,844	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,001	10-03	39
40	Physical Therapy Consultant	12	480	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,184	11-03	44
45	Social Service Consultant	66	3,265	12-03	45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	84	3,348	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	440	\$ 32,881		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	41	1,702	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	41	\$ 1,702		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
David Berkowitz	Administrator	0	\$ 48,057	Workers' Compensation Insurance	\$ 113,456	IDPH License Fee	\$ 1,990	
Rafi Zimmerman	Administrator	0	30,664	Unemployment Compensation Insurance	59,616	Advertising: Employee Recruitment	4,371	
				FICA Taxes	238,701	Health Care Worker Background Check		
				Employee Health Insurance	76,276	(Indicate # of checks performed <u>188</u>)	3,158	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	3,376	
				Employee Physicals	10,691	Dues & Subscriptions	5,563	
				Pension Expense	29	Advertising & Promotions	11,144	
				Other Employee Welfare	3,951	Yellow Page Advertising	1,216	
				Holiday Expense	2,000	See Supplemental Schedule	5,127	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(11,144)	
						Yellow page advertising	(1,216)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 78,721			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Management Fees - Noah Wolff							Out-of-State Travel	
\$ 8,000							\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)			In-State Travel	
\$ 8,000								
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee				Amount			Allocate Care Centers, Inc.	
Type							Allocate Care Centers Clinical, Inc.	
Amount							419	
Frost, Ruttenberg & Rothblatt				Accounting			1,631	
Care Centers				Other Professional Fees			786	
Blymas, Inc.				WOTC Tax Credit			419	
Prospect Resources				Natural Gas Procurement				
Allegiance, Inc.				Employee Compliance				
HFG				Audit / Line of Credit				
Personnel Planners				Unemployment Consult.				
ADP				Payroll Processing				
eHealth Data				MDS Software				
National Data Corp				Data Processing				
Care Centers				Home Office Expense				
See Supplemental Schedule								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 296,994			TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 2,836	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Concord Extended Care

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

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													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council On LTC \$6,158
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (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. \$ 37,982 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 73,365
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. \$ No 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT