

Facility Name & ID Number Montebello Healthcare Center

0047340 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 139

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,735	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	14,805	2,535	2,233	19,573	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,805	2,535	2,233	19,573	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 38.58%

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

N/A (Do not include bed-hold days in Section B.)

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

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 06/01/1993

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 139 and days of care provided 1,720

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	92,246	10,445	7,952	110,643		110,643		110,643		1
2	Food Purchase		87,455		87,455		87,455	(57)	87,398		2
3	Housekeeping	57,063	13,078		70,141		70,141		70,141		3
4	Laundry	21,438	9,844	34	31,316		31,316		31,316		4
5	Heat and Other Utilities			119,164	119,164		119,164	26	119,190		5
6	Maintenance	13,471	36,358	6,946	56,775	(310)	56,465	5,624	62,089		6
7	Other (specify):*			12,570	12,570		12,570		12,570		7
8	TOTAL General Services	184,218	157,180	146,666	488,064	(310)	487,754	5,593	493,347		8
B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	744,179	49,461	11,580	805,220		805,220		805,220		10
10a	Therapy		10,030	150,417	160,447		160,447		160,447		10a
11	Activities	28,319	2,221	3,424	33,964	7,020	40,984		40,984		11
12	Social Services	30,079		2,499	32,578		32,578		32,578		12
13	CNA Training										13
14	Program Transportation	23,399	1,982	2	25,383	(23,399)	1,984		1,984		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	825,976	63,694	175,122	1,064,792	(16,379)	1,048,413		1,048,413		16
C. General Administration											
17	Administrative	74,834			74,834		74,834		74,834		17
18	Directors Fees			724	724		724		724		18
19	Professional Services			1,916	1,916		1,916		1,916		19
20	Dues, Fees, Subscriptions & Promotions			22,769	22,769		22,769	(2,621)	20,148		20
21	Clerical & General Office Expenses	97,103	8,813	133,442	239,358		239,358	(35,148)	204,210		21
22	Employee Benefits & Payroll Taxes			236,036	236,036		236,036	5,321	241,357		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,599	17,599		17,599	7,758	25,357		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			132,650	132,650		132,650	(106,332)	26,318		26
27	Other (specify):*										27
28	TOTAL General Administration	171,937	8,813	545,136	725,886		725,886	(131,022)	594,864		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,182,131	229,687	866,924	2,278,742	(16,689)	2,262,053	(125,429)	2,136,624		29

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

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

STATE OF ILLINOIS

Report Period:

Beginning: 1/1/2007

Page -3.1

Facility Name & ID Number Montebello HealthCare Center

#

0031468

Ending: 12/31/2007

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - pg 3 Line 7

Amount

Infectious Waste Disposal <> Default <> Nursing Admin/Supv	800019000008000	4,996
Infectious Waste Disposal <> Default <> Physical Plant	800019000008210	
Garbage Service<>Default<>Prod<>Physical Plant	810002000008210	7,574
<u>Garbage Service <> Default <> Physical Plant</u>	<u>810072000008210</u>	
		<u>12,570</u>

Health Care Program - pg 3 Line 15

Amount

<u>Salaries - Regular <> Non Supervisor <> HHA (General)</u>	<u>700000700203500</u>	
		<u>0</u>

General & Administrative - Line 27

Amount

N/A		
		<u>0</u>

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

Amount

N/A		
		<u>0</u>

STATE OF ILLINOIS

Report Period:

Beginning: 1/1/2007

Page -3.2

Facility Name & ID Number Montebello HealthCare Center # 0031468

Ending: 12/31/2007

Meals - adjustment

Sales Tax - adjustment

50,735 Days (Total Patient days)
 3 Mult (3 meals a day)
 152,205 Sub total
 0 meals to employess (reported by facility)
 152,205 Add Sub
 87,455 Divide -Pg 3, line 2, column 2
 0.57 Cost per day

87,455 Total Food Cost (page 3,Line 2, col 2)
 0.01 Mult
 874.55 Sub total
 6.48% Mult (Pvt pay div by total census)
 57 = adjust for nonallowable sale tax
 for page 5A,

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

Reclassification V

Page 3 Line 6

Repair & Maint <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 83001000003850 (310) Reclass From
 (443 x 70% = 310.10)
 Page 4 line 38 310 Reclass to

Page 3 Line 14

Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 (18,840) Reclass From
 Salaries - Inservice - Driver 700400750408170 (122) Reclass From
 Vacation Pay - Earned Lve Acc.DriverTransport Non-Emergency 730012750403850 (1,628) Reclass From
 Holiday Pay - Earned Lve TakenDriverTransport Non-Emergency 730013750403850 (611) Reclass From
 Sick Pay - Earned Leave Taken Driver TransportNon-Emergency 730031750403850 (2,198) Reclass From
 (\$23,277 multiplied by 70% & 30%) 70% is Medical 30% is Activities) (23,399) total

Activities - Page 3 line 11 7,020 Reclass to
 Medical - Page 4 line 38 16,379 Reclass to

Page 4 Line 35 Rent

Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 841005000003850 (86) Reclass From
 (\$123 x 70% = 86.10 lease for Medical)
 Page 4 line 38 86 Reclass to

Facility Name & ID Number

Montebello Healthcare Center

#0047340

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			23,609	23,609		23,609		23,609			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(2,089)	(2,089)		(2,089)	16,524	14,435			32
33	Real Estate Taxes			60,070	60,070		60,070	85	60,155			33
34	Rent-Facility & Grounds			17,665	17,665		17,665		17,665			34
35	Rent-Equipment & Vehicles			123	123	(86)	37	7,139	7,176			35
36	Other (specify):*							7,658	7,658			36
37	TOTAL Ownership			99,378	99,378	(86)	99,292	31,406	130,698			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					16,775	16,775		16,775			38
39	Ancillary Service Centers		31,097	14,751	45,848		45,848	13,072	58,920			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,104	76,104		76,104		76,104			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		31,097	90,855	121,952	16,775	138,727	13,072	151,799			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,182,131	260,784	1,057,157	2,500,072		2,500,072	(80,951)	2,419,121			45

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007 Page -4.1
Ending: 12/31/2007

Facility Name & ID Number Montebello HealthCare Center # 0031468

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36 -Column 3

	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead 940101940058888	0
	-

Ancillary Expenses - Line 43 -Column 2

	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory 800630000003330	0
Ancillary Supplies <> Default <> Laboratory 810041000003330	0
	0

Ancillary Expenses - Line 43 -Column 3

	Amount
Contract Svcs - Chgbl <> Default <> Laboratory 652000000003330	
Contract Svcs - Chgbl <> Default <> X/Ray 652000000003332	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora 810030752993330	0
Professional Services - NonchgPhysicianX/Ray 810030752103332	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray 810030752993332	0
Professional Services <> Nonchg<>Medical Director<>Laboratory 810030795003330	0
Professional Services <> Nonchg<>Medical Director<>X/Ray 810030795003332	0
Professional Services Chgble <> Default <> X/Ray 652100000003332	0
Professional Services Chgble <> General / Other <> X/Ray 652100600003332	0
	-

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

Lease Expense Facility <>Relalty <> Default <> Parod 841011000008220	2,765
Lease Expense Facility <> Default <> Realty 841010000008220	14,900
	17,665

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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	7,987	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule page 5A	(256,579)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (248,592)		\$	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)	167,340		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 167,340		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (81,252)		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.	x		\$ 2	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 2		47

Montebello Healthcare Center

ID# 0047340

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Sales Taxes	\$ (57)	2	1
2	Small Balance Adjustment	(9)	21	2
3	Memorium/ Benevolence	(60)	21	3
4	Depreciation Reconciliation		30	4
5	Activities Program Receipts		11	5
6	Property Taxes Adjust to actual	189	33	6
7	Professional liability Insurance	(111,661)	26	7
8	Barber & beauty	0	40	8
9	Public Relations Expenses	0	20	9
10	Non Allowable Advertising	(4,016)	20	10
11	Entertainment		24	11
12	Fresh Start	0	36	12
13	Civic Dues	0	20	13
14	Penalties	(7,800)	21	14
15	Vending receipts	(358)	21	15
16	Misc Receipts	0	21	16
17	Marketing Wages 70% Disallowed	(13,688)	21	17
18	Marketing Bonus	0	21	18
19	Marketing Holiday	0	21	19
20	Maketing Sick	0	21	20
21	Marketing Vacation	0	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	0	21	23
24	Donations/ Contributions	0	21	24
25	Legal Fees - Bankruptcy	0	21	25
26	Legal Structure Management Fees	(117,030)	21	26
27	Undocumented Travel	0	24	27
28	Interest Income	(2,089)	32	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(256,579)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello Healthcare Center# 0047340

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(57)	0	0	0	0	0	0	0	0	0	0	(57)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	26	0	0	0	0	0	0	0	0	0	26	5
6	Maintenance	0	5,624	0	0	0	0	0	0	0	0	0	5,624	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(57)	5,650	0	0	0	0	0	0	0	0	0	5,593	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,016)	1,395	0	0	0	0	0	0	0	0	0	(2,621)	20
21	Clerical & General Office Expenses	(130,958)	95,810	0	0	0	0	0	0	0	0	0	(35,148)	21
22	Employee Benefits & Payroll Taxes	0	5,321	0	0	0	0	0	0	0	0	0	5,321	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,758	0	0	0	0	0	0	0	0	0	7,758	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(111,661)	5,329	0	0	0	0	0	0	0	0	0	(106,332)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(246,635)	115,613	0	0	0	0	0	0	0	0	0	(131,022)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(246,692)	121,263	0	0	0	0	0	0	0	0	0	(125,429)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montebello Healthcare Center# 0047340

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(2,089)	18,613	0	0	0	0	0	0	0	0	0	16,524 32
33	Real Estate Taxes	189	(104)	0	0	0	0	0	0	0	0	0	85 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	7,139	0	0	0	0	0	0	0	0	0	7,139 35
36	Other (specify):*	0	7,658	0	0	0	0	0	0	0	0	0	7,658 36
37	TOTAL Ownership	(1,900)	33,306	0	31,406 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	13,072	0	0	0	0	0	0	0	0	0	13,072 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	13,072	0	13,072 44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(248,592)	167,641	0	(80,951) 45								

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC	100	See Attachment Page 6.1		SSC Equity Holdings,	Atlanta, GA	Management

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	SSC Equity Holdings, LLC	100.00%	\$ 26	\$ 26 1
2	V	6 Repair & Maintenance		SSC Equity Holdings, LLC	100.00%	5,624	5,624 2
3	V	39 Professional Services		SSC Equity Holdings, LLC	100.00%	13,072	13,072 3
4	V	20 Fees, Subscriptions, Promotions		SSC Equity Holdings, LLC	100.00%	1,395	1,395 4
5	V	10 Nursing & Medical Records		SSC Equity Holdings, LLC	100.00%		
6	V	21 Clerical & General Office Exp		SSC Equity Holdings, LLC	100.00%	95,810	95,810 6
7	V	24 Travel & Seminar		SSC Equity Holdings, LLC	100.00%	7,758	7,758 7
8	V	26 Insurance Premium		SSC Equity Holdings, LLC	100.00%	5,329	5,329 8
9	V	36 Depreciation		SSC Equity Holdings, LLC	100.00%	7,658	7,658 9
10	V	33 Taxes - Property		SSC Equity Holdings, LLC	100.00%	(104)	(104) 10
11	V	35 Rental & Leasing		SSC Equity Holdings, LLC	100.00%	7,139	7,139 11
12	V	32 Intrest Income/Expense		SSC Equity Holdings, LLC	100.00%	18,613	18,613 12
13	V	22 P/R Taxes		SSC Equity Holdings, LLC	100.00%	5,321	5,321 13
14	Total		\$			\$ 167,641	\$ * 167,641 14

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007
Ending: 12/31/2007

Facility Name & ID Number: Montebello HealthCare Center # 0031468

Related Illinois Nursing Homes
as of
12/31/2007

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

SSC Equity Holdings, LLC

Montebello Healthcare Center	0047340
Nature Trail HealthCare Center	0047357
Odin HealthCare Center	0047365
Mariner Health of Westchester	0047373

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Montebello Healthcare Center

0047340 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization SSC Equity Holdings LLC
 Street Address One Ravinia Dr. Suite 1500
 City / State / Zip Code Atlanta, GA
 Phone Number (770-379-8203
 Fax Number (770-393-8054

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	1		\$ 26	\$	1	\$ 26	1
2	6	Repair & Maintenance	1		5,624		1	5,624	2
3	39	Professional Services	1		13,072		1	13,072	3
4	20	Fees, Subscriptions, Promotions	1		1,395		1	1,395	4
5	10	Nursing & Medical Records							5
6	21	Clerical & General Office Exp	1		95,810		1	95,810	6
7	24	Travel & Seminar	1		7,758		1	7,758	7
8	26	Insurance Premium	1		5,329		1	5,329	8
9	36	Depreciation	1		7,658		1	7,658	9
10	33	Taxes - Property	1		(104)		1	(104)	10
11	35	Rental & Leasing	1		7,139		1	7,139	11
12	32	Intrest Income/Expense	1		18,613		1	18,613	12
13	22	P/R Taxes	1		5,321		1	5,321	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				\$ 167,641	\$		\$ 167,641	25

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	2	3	4	5	6		7	8	9	10
						Original	Balance				
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									
A. Directly Facility Related											
Long-Term											
1	N/A					\$	\$			\$	1
2											2
3											3
4											4
5											5
Working Capital											
6											6
7											7
8											8
9	TOTAL Facility Related					\$	\$			\$	9
B. Non-Facility Related*											
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$	\$			\$	15

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

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

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

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2006 report.		\$ 59,620	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 60,259	2
3.	Under or (over) accrual (line 2 minus line 1).		\$ 639	3
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 59,431	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 60,070	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2002	52,531	8	
	2003	53,913	9	
	2004	54,772	10	
	2005	57,210	11	
	2006	60,259	12	
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

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,

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montebello Healthcare Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0047340

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE 832-467-6244 FAX #: 832-467-6324

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of total cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. <u>11-29-999-119</u>	<u>Lot B Sub (EX 2A SE COR & 377)</u>	<u>\$ 60,258.68</u>	<u>\$ 60,258.68</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 60,258.68</u>	<u>\$ 60,258.68</u>

B. Real Estate Tax Cost Allocation:

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

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

C. Tax Bills

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,581 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	139	1993	1974	\$ 2,576,687	\$ 122,699	21	\$ 122,699		\$ 1,152,741	4
5				46,664	2,333	20	2,333		9,332	5
6										6
7										7
8										8
Improvement Type**										
9	Interior Building Improvements		1995	8,889	444	20	444		6,548	9
10	A/C Units		1996	2,775	139	20	139		5,633	10
11	Sprinkle Guard System		1996	887	44	20	44		1,440	11
12	Sprinkler Repair		1997	2,239	112	20	112		752	12
13	Sprinkler Repair		1997	2,317	116	20	116		1,337	13
14	Carpet in Lobby		1997	1,890	95	20	95		1,196	14
15	Nurses Station		1997	2,363	118	20	118		1,044	15
16	A/C Systems		1997	8,325	416	20	416		2,270	16
17	Nurses Station		1997	2,613	131	20	131		3,910	17
18	A/C Systems		1997	2,969	148	20	148		1,393	18
19	Light Fixtures		1997	1,002	50	20	50		1,284	19
20	Sprinkler Repair		1997	797	40	20	40		503	20
21	2: Exterior Signs #73		1998	663	5	12	5		371	21
22	Heating, Ventilation & A/C		1998	2,643	264	10	264		1,105	22
23	Rplc 6: 18K BTU Heating, Ventilation & A/C #77		1998	4,070	407	10	407		2,939	23
24	2: 60 K BTU Kitchen Heating, Ventilation & A/C #78		1998	6,800	407	10	407		3,801	24
25	Phone System #72		1998	1,338	134	10	134		4,436	25
26	Nurses Station #71		1998	1,925	128	20	128		1,321	26
27	Adjustment 1998		1998		(35)			35		27
28	Water Heater #80 & 81 & 82		1999	3,092	309	10	309		2,575	28
29	Water Pipe Hook-up #83 & 84		1999	256	26	10	26		1,726	29
30	Generator 100 AMP XFER Switch #93		2001	5,137	257	20	257		907	30
31	3: Door Relay Instl #94		2001	912	91	10	91		1,301	31
32	2: W/G Monitor Digat Reset #95		2001	1,892	189	10	189		916	32
33	Use Tax 2: W/G Montor Digat #96		2001	8,191	819	10	819		3,183	33
34	Kohler Sink W/ Sink Rims #97		2001	592	30	20	30		3,230	34
35	Use Tax: Kohler Sink W/ Sink Rims #98		2001	34	2	20	2		120	35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Royal 3.5 Gal Water Sver #99	2001	\$ 325	\$ 17	20	\$ 17	\$	\$ 97	37
38	Use Tax: Royal 3.5 Gal Water Sver #100	2001	20	1	20	1		6	38
39	Wanderguard & Lock System Instl #102	2001	8,360	836	10	836		404	39
40	Air Handler & Coil Instl, Kitchen #105	2001	915	46	20	46		260	40
41	2:Push-Button & Digital reset #106	2001	822	82	10	82		465	41
42	Instl 5Ton A./C Unit Kitchen #107	2001	1,475	148	10	148		813	42
43	Instl Charge W/G System #110	2001	325	33	10	33		175	43
44	E Elec Water Heater Instl #111	2001	3,275	327	10	327		1,745	44
45									45
46	DuKane Nurse Call system #5010	2002	17,665	1,767	10	1,767		9,865	46
47	DuKane Nurse Call system # 5011	2002	6,837	684	10	684		3,761	47
48	Service Call - Old Nurse Call System # 5022	2002	863	86	10	86		1,392	48
49	Nurse Call System # 5026	2002	17,748	1,775	10	1,775		9,466	49
50	Nurse Call System -Bal Due # 5026	2002	17,748	1,775	10	1,775		9,318	50
51	Instl Nurse Call System #5027	2002	2,532	253	10	253		1,329	51
52									52
53	New Nurse Call Station #5030	2003	4,720	472	10	472		2,399	53
54	Breaker Instl Range Hood #5032	2003	2,135	214	10	214		1,105	54
55	155: Brass Dry Pendants Instl #5035	2003	1,086	43	25	43		198	55
56	Carrier -RTU NW Wing #5042	2003	7,548	755	10	755		3,397	56
57	Add sprinkler Head Stairs # 5047	2003	760	30	25	30		131	57
58	Rplc Roof UltraPlus (29% Dwn) # 5048	2003	43,215	4,322	10	4,322		19,078	58
59	CREDIT Maglock Sngl Door (#15580) #5049	2003	(691)	(69)	10	(69)		(460)	59
60	Wanderguard Instl #5050	2003	338	34	10	34		226	60
61	7: Verticle Blinds #5052	2003	840	168	5	168		742	61
62	7: Rodpocket Draps, 7 Rods # 5053	2003	869	174	5	174		754	62
63	Replc Roof #5054	2003	86,443	8,644	10	8,644		36,737	63
64	Blinds 30 Resident Rooms # 5055	2003	1,371	274	5	274		1,170	64
65									65
66	2:120 Gallon Water Heater	2004	7,770	583	120	583		2,332	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,933,275	\$ 153,390		\$ 153,425	\$ 35	\$ 1,324,216	70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 2,933,275	\$ 153,390		\$ 153,425	\$ 35	\$ 1,324,216		1
2	Watermain Repair	2005 8,950	209	25	209		627		2
3	Retaining Wall - Partial Pmt	2005 6,550	136	20	136	0	408		3
4	Fire Alarm Control Panel	2005 2,531	84	10	84		252		4
5	Construct Walkway Cover	2005 5,225	145	15	145		435		5
6	Leveled Ground Around Stairway	2005 546	15	15	15		45		6
7	Fire Alarm System	2005 1,920	64	10	64		192		7
8	Instl New handrails	2005 429	10	15	10		30		8
9	Fire Alarm Control Panel	2005 926	39	10	39		117		9
10	Drywall Repairs-Water Break	2005 4,065	45	15	45		135		10
11	6 Ton 230V, RTU	2005 27,558	919	10	919		2,757		11
12	Four heat Run-Duct System	2005 1,500	25	10	25		75		12
13	Rpr-Damaged Phone System	2005 1,576	53	10	53		159		13
14	Watermain Repair	2005 8,682	87	25	87		261		14
15	Retaining Wall - Partial Pmt	2005 6,359	79	20	79		237		15
16	Fire Alarm Control Panel	2005 2,404	60	10	60		180		16
17	Construct Walkway Cover	2005 5,022	84	15	84		252		17
18	Leveled Ground Around Stairway	2005 525	9	15	9		27		18
19	Fire Alarm System	2005 1,824	46	10	46		138		19
20	Instl New handrails	2005 415	7	15	7		21		20
21	Fire Alarm Control Panel	2005 872	22	10	22		66		21
22	Drywall Repairs-Water Break	2005 3,975	66	15	66		198		22
23									23
24	119 Gal Electric W/H	2006 4,362	400	10	400		800		24
25	Use Tax - 119 Gal Electric W/H	2006 268	25	10	25		49		25
26	Instl Water Heater	2006 659	60	10	60		121		26
27	Instl Electric - Water Heater	2006 384	35	10	35		70		27
28	42' Sidewalk / Outside Patio	2006 1,820	60	10	60		119		28
29	Sprinkler	2006 2,296	75	10	75		151		29
30	Rpr Sprinkler System	2006 6,893	46	25	46		92		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,041,809	\$ 156,293		\$ 156,329	\$ 35	\$ 1,332,229		34

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

STATE OF ILLINOIS

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 3,041,809	\$ 156,293		\$ 156,329	\$ 35	\$ 1,332,229		1
2	Deposit Vinyl Floor	2007 1,928	208	9.25	508		508		2
3	Vinyl Flooring	2007 2,153	237	9.08	237	(0)	237		3
4	Sprinkler System	2007 1,744	190	9.16	190		190		4
5	Vinyl Flooring 2 Shower Bathrooms	2007 475	53	9	53	(0)	53		5
6	Caretracker Facility 5 Kiosks	2007 2,623	874	3	874	0	874		6
7	Use Tax: Caretracker 5 Kiosks	2007 164	55	3	55	(0)	55		7
8	Replace A/C Compressor in Laundry	2007 1,663	183	9.08	183	0	183		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)	\$ 3,052,559	\$ 158,094		\$ 158,429	\$ 35	\$ 1,334,329		34

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

Facility Name & ID Number **Montebello Healthcare Center** # **0047340** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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	\$ 493,465	\$ 34,178	\$ 34,178	\$ (0)		\$ 424,404	71
72	Current Year Purchases	20,336	2,519	2,519			2,519	72
73	Fully Depreciated Assets	(40,672)						73
74								74
75	TOTALS	\$ 473,129	\$ 36,698	\$ 36,697	\$ (0)		\$ 426,923	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,569,436	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 194,792	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,609	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 334	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,761,253	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 06/01/1996	\$ 636	\$ 32	\$ 370	86
87	O/H Allocation 12/01/1996	1,136	57	631	87
88	O/H Allocation 08/01/1997	2,127	106	1,104	88
89	O/H Allocation 10/01/1997	360	18	184	89
90					90
91	TOTALS	\$ 4,259	\$ 213	\$ 2,289	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	139	01/01/2005	\$ 14,900	20		3
4	Additions						4
5							5
6							6
7	TOTAL	139		\$ 14,900			7

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

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

	Fiscal Year Ending	Annual Rent
12.	<u>/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: \$ 10,984 Description: See Schedule 14.1
(Attach a schedule detailing the breakdown of movable equipment)

* 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.

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007

Page -14.1

Facility Name & ID Number

Montebello HealthCare Center

0031468

Ending: 12/31/2007

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

Name of G/L	G/L #	EQUIPMENT	Amount	Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	84100000001011	Specialty Mattress/ Beds	3,603.00	03/10/03
Lease Exp - Eqpt - <> Default <> Prod Oxygen	84100000002022	Oxygen Concentrators	664.00	03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	84100000002102			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	84100000007000			03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	84100000007030	Diswasher	1,245.00	03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeeping / Janitorial	84100000007040			03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	84100000007050			03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admin/Supv	84100000008000	Mattress		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	84100000008100	Copies, Stamp machine Cable	5,025.00	03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plant	84100000008210	SNF Supplies	447.00	03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	84100000008220			04/35/03
Lease Exp - Other <> Default <> Administrative	84102000008100			03/21/03
			10,984.00 Grand Total	

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$								1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39	# of prescripts							31,097			31,097	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$	31,097		\$	31,097		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.

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	35,659		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	262,643		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	271		6
7	Other Prepaid Expenses	91,354		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 390,477	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,749		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	106,858		15
16	Equipment, at Historical Cost	51,432		16
17	Accumulated Depreciation (book methods)	(32,122)		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>Leasehold Rigts</u>	56,546		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 219,464	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 609,941	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 98,142	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,015		30
31	Accrued Taxes Payable (excluding real estate taxes)	630		31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,021		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attachment 17.1</u>	31		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 316,839	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attachment 17.1</u>	736,815		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 736,815	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,053,654	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (443,713)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 609,941	\$	48

*(See instructions.)

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007 Page -17.1
Ending: 12/31/2007

Facility Name & ID Number Montebello HealthCare Center # 0031468

SUPPLEMENTAL SCHEDULE OF ASSETS & LIABILITIES

<u>OTHER CURRENT ASSETS:</u>	<u>AMOUNT</u>	<u>OTHER CURRENT LIABILITIES:</u>	<u>AMOUNT</u>
		Benefits Dedctns - EmployeeEmployee Dedctns 401K MarinerDefault-Dept	201400201460000 0.00 17 36-1
		Misc Dedctns - EmployeeFlexible Spending AccountDefault-Dept	201500201510000 0.00
		Misc Dedctns - EmployeeUnion DuesDefault-Dept	201500201520000 0.00
		Misc Dedctns - EmployeeMiscellaneousDefault-Dept	201500201530000 0.00
		Accrued OtherAccrued OtherDefault-Dept	221000221220000 (66.30)
		Accrued OtherPC Maintenance AccrualDefault-Dept	221000221040000 0.00
		Accrued OtherAccrued Legal FeesDefault-Dept	221000221230000 0.00
		Accrued OtherTelephone Maintenance AccrualDefault-Dept	221000221280000 0.00
		Accrued OtherEngineering ReserveDefault-Dept	221000221420000 0.00
		Accrued TaxesOther TaxesDefault-Dept	220100220110000 (1.00)
		Accrued TaxesState Sales & UseDefault-Dept	220100220130000 (163.97)
		Accrued TaxesCity Sales & UseDefault-Dept	220100220140000 0.00
		Franchise Tax PayableFranchise TaxDefault-Dept	226200226200000 200.00
	Total		Total (31) Difference
Reconcile with schedule XV, line 9:	0		(31) -
<u>OTHER NON-CURRENT ASSETS: pg 17 line 23 Col 1</u>		<u>OTHER NON-CURRENT LIABILITIES:</u>	
Leasehold RightsContract RightsDefault-Dept	185200185200000 503	I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	240500000000000 (475,344)
Leasehold RightsContract RightsDefault-Dept	185200185210000 56,043	Intercompany Revolver - SSC-Default-Dept-Default-Prod	260000210140000 (178,295) 17 43-1
Asset ClearingPS AM Capital Expenditures-FSRealty	174900171008220 -	L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claims	260000210160000 (34,474)
Asset ClearingPS AM Capital Expenditures SSCRealty	174900171018220 -	Other Non-Current Lby-Default-Dept-Deferred CLO Gain/Loss	260500225030000
		Other Non-Current Lby <=> Rent Accrual <=> Default	260500260540000 (48,702)
	Total		Total (736,815) Difference
Reconcile with schedule XV, line 23:	56,546		(736,815) 0

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 484,170	1
2	Restatements (describe):		2
3	Prior year correction - amount entered incorrectly	(3,294)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 480,876	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(158,518)	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)	\$ (158,518)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (766,071)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (443,713)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2007

Ending:

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,020,034	1
2	Discounts and Allowances for all Levels	(976,102)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,043,932	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	231,695	6
7	Oxygen	7,470	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 239,165	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	199	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	58,358	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,908	19
20	Radiology and X-Ray		20
21	Other Medical Services	(5,756)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 57,709	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. & General Revenue (See Schedule 19.1)	748	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 748	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,341,554	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	488,074	31
32	Health Care	1,063,997	32
33	General Administration	726,671	33
B. Capital Expense			
34	Ownership	99,378	34
C. Ancillary Expense			
35	Special Cost Centers	121,952	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,500,072	40
41	Income before Income Taxes (line 30 minus line 40)**	(158,518)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (158,518)	43

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

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

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

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007 Page -19.1
Ending: 12/31/2007

Facility Name & ID Number Montebello Health Care Center # 0031468

SUPPLEMENATAL INCOME SCHEDULE

DESCRIPTION - Line 19 26a 1 & 19 28 1

	<u>AMOUNT</u>	
Miscellaneous Receipts<-Default->Prod<->Administrative 600057000008100		
General Rental Receipts<-Default->Prod<->Administrative 600060000008100	(390)	
Miscellaneous Receipts<-Default->Prod<->Vending 600057000004102	(358)	
	<u>(748.00)</u>	Difference
Reconcile with schedule XVII, line 28:	(748)	0

DESCRIPTIONS - Line 19 28a 1

Miscellaneous Receipts<-Default->Prod<->Activities 600057000007000		
	-	Difference
Reconcile with schedule XVII, line 28a:	0	-

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

12/31/2007

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	1,824	2,040	\$ 52,424	\$ 25.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,210	5,654	131,653	23.28	3
4	Licensed Practical Nurses	11,665	12,688	193,351	15.24	4
5	CNAs & Orderlies	35,479	38,695	366,751	9.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,733	1,907	19,676	10.32	9
10	Activity Assistants	1,109	1,213	8,643	7.13	10
11	Social Service Workers	1,899	2,082	30,079	14.45	11
12	Dietician					12
13	Food Service Supervisor	1,320	1,593	15,292	9.60	13
14	Head Cook	3,824	4,115	31,720	7.71	14
15	Cook Helpers/Assistants	5,651	6,081	45,234	7.44	15
16	Dishwashers					16
17	Maintenance Workers	1,313	1,447	13,471	9.31	17
18	Housekeepers	6,112	6,607	57,063	8.64	18
19	Laundry	2,822	3,061	21,438	7.00	19
20	Administrator	1,856	2,080	73,409	35.29	20
21	Assistant Administrator					21
22	Other Administrative	1,935	3,578	79,471	22.21	22
23	Office Manager					23
24	Clerical	1,830	1,986	19,057	9.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Driver-Non Emer	1,497	1,856	23,399	12.61	33
34	TOTAL (lines 1 - 33)	87,079	96,683	\$ 1,182,131 *	\$ 12.23	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	131	\$ 6,707	1-3	35
36	Medical Director	72	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	264	1,927	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,389	11-3	44
45	Social Service Consultant	36	2,499	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	539	\$ 20,722		49

C. CONTRACT NURSES

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$7,788.49
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,297 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 76,104
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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? _____
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.