

		FOR BHF USE				

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0046292</u></p> <p>Facility Name: <u>Pinnacle Health Care of Berwyn</u></p> <p>Address: <u>3601 South Harlem Avenue</u> <u>Berwyn</u> <u>60402</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708)749-4160</u> Fax # <u>(708)749-7696</u></p> <p>HFS ID Number: <u>050541135001</u></p> <p>Date of Initial License for Current Owners: <u>3/31/1993</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/07</u> to <u>12/31/07</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Edward N. Slack, C.P.A.</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> <td></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>			(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>			(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292 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 _____

	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	145	Skilled (SNF)	145	52,925	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	145	TOTALS	145	52,925	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	25,966	3,739	6,272	35,977	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,966	3,739	6,272	35,977	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.98%

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

None (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 4/16/1993

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

YES Date 4/16/1993 NO

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

YES NO If YES, enter number of beds certified 133 and days of care provided 5,566

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 Pinnacle Health Care of Berwyn # 0046292 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	199,302	22,944	7,556	229,802		229,802	824	230,626		1
2	Food Purchase		167,238		167,238		167,238	(129)	167,109		2
3	Housekeeping	130,920			130,920		130,920	78	130,998		3
4	Laundry	110,551	21,087		131,638		131,638		131,638		4
5	Heat and Other Utilities			152,335	152,335		152,335	399	152,734		5
6	Maintenance	110,804	59,891	71,332	242,027		242,027	1,583	243,610		6
7	Other (specify):*							383	383		7
8	TOTAL General Services	551,577	271,160	231,223	1,053,960		1,053,960	3,138	1,057,098		8
	B. Health Care and Programs										
9	Medical Director			17,800	17,800		17,800		17,800		9
10	Nursing and Medical Records	2,222,157	266,919	134,331	2,623,407		2,623,407	3,028	2,626,435		10
10a	Therapy	218,317			218,317		218,317	389	218,706		10a
11	Activities	126,824	4,201		131,025		131,025		131,025		11
12	Social Services	102,550		363	102,913		102,913	1,117	104,030		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							713	713		15
16	TOTAL Health Care and Programs	2,669,848	271,120	152,494	3,093,462		3,093,462	5,247	3,098,709		16
	C. General Administration										
17	Administrative	96,490			96,490		96,490	10,289	106,779		17
18	Directors Fees										18
19	Professional Services			127,840	127,840		127,840	(98,696)	29,144		19
20	Dues, Fees, Subscriptions & Promotions			7,062	7,062		7,062	(850)	6,212		20
21	Clerical & General Office Expenses	175,549		515,800	691,349		691,349	(481,664)	209,685		21
22	Employee Benefits & Payroll Taxes			827,691	827,691		827,691	4,996	832,687		22
23	Inservice Training & Education										23
24	Travel and Seminar			317	317		317	392	709		24
25	Other Admin. Staff Transportation			3,362	3,362		3,362	(919)	2,443		25
26	Insurance-Prop.Liab.Malpractice			42,949	42,949		42,949	410	43,359		26
27	Other (specify):*							4,897	4,897		27
28	TOTAL General Administration	272,039		1,525,021	1,797,060		1,797,060	(561,145)	1,235,915		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,493,464	542,280	1,908,738	5,944,482		5,944,482	(552,760)	5,391,722		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 Pinnacle Health Care of Berwyn #0046292 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			47,769	47,769		47,769	231,173	278,942		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			132,752	132,752		132,752	6,462	139,214		32
33	Real Estate Taxes			193,111	193,111		193,111	423	193,534		33
34	Rent-Facility & Grounds			490,815	490,815		490,815	(486,308)	4,507		34
35	Rent-Equipment & Vehicles			16,690	16,690		16,690	242	16,932		35
36	Other (specify):*			352,907	352,907		352,907	(352,907)	(0)		36
37	TOTAL Ownership			1,234,044	1,234,044		1,234,044	(600,915)	633,129		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	361,358	505,351	473,745	1,340,454		1,340,454	(1,099)	1,339,355		39
40	Barber and Beauty Shops			418	418		418		418		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			79,387	79,387		79,387		79,387		42
43	Other (specify):*			12,683	12,683		12,683	(12,683)			43
44	TOTAL Special Cost Centers	361,358	505,351	566,233	1,432,942		1,432,942	(13,782)	1,419,160		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,854,822	1,047,631	3,709,015	8,611,468		8,611,468	(1,167,457)	7,444,011		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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	153,645	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(174)	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	(25)	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	(329,112)	21		24
25	Fund Raising, Advertising and Promotional	(1,543)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(592,803)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (770,012)		\$	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)	(397,445)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (397,445)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,167,457)		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	Reference
1 Miscellaneous Income	\$ (8,304)	21	1
2 Marketing Expense	(34)	20	2
3 Bank Charges	(13,923)	21	3
4 Jury Duty Income	(52)	10	4
5 Penalty Charge	(125,324)	21	5
6 Non-Allowable Legal	(47,174)	19	6
7 Non-Allowable Travel	(1,150)	28	7
8 Bad Tax Expense	(12,680)	43	8
9 Loss on Abandonment of Fixed Assets	(152,307)	26	9
10 Excl Medical Supplies	(944)	10	10
11			11
12			12
13			13
14			14
15			15
16			16
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97			97
98			98
99			99
100			100
101 Total	(592,803)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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					37	518	269					824	1
2	Food Purchase	(174)				45							(129)	2
3	Housekeeping					69	7	2					78	3
4	Laundry													4
5	Heat and Other Utilities					327	18	54					399	5
6	Maintenance					1,559	2	22					1,583	6
7	Other (specify):*					334	49						383	7
8	TOTAL General Services	(174)				2,371	594	347					3,138	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(995)					4,023						3,028	10
10a	Therapy						389						389	10a
11	Activities													11
12	Social Services						1,117						1,117	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						713						713	15
16	TOTAL Health Care and Programs	(995)					6,242						5,247	16
	C. General Administration													
17	Administrative				1,219	1,561	7,067	442					10,289	17
18	Directors Fees													18
19	Professional Services	(47,174)	(8,616)		69	(43,276)	295	6					(98,696)	19
20	Fees, Subscriptions & Promotions	(1,886)			57	942	4	33					(850)	20
21	Clerical & General Office Expenses	(506,688)			418	22,035	1,829	742					(481,664)	21
22	Employee Benefits & Payroll Taxes				5,393	(397)							4,996	22
23	Inservice Training & Education													23
24	Travel and Seminar				148	159	85						392	24
25	Other Admin. Staff Transportation	(1,150)				206		25					(919)	25
26	Insurance-Prop.Liab.Malpractice				150	209	2	49					410	26
27	Other (specify):*					3,519	1,201	177					4,897	27
28	TOTAL General Administration	(556,898)	(8,616)		7,454	(15,042)	10,483	1,474					(561,145)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(558,067)	(8,616)		7,454	(12,671)	17,319	1,821					(552,760)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pinnacle Health Care of Berwyn # 0046292 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	153,645	74,527	105	80	2,666	112	38					231,173	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			145	742	5,030	482	63					6,462	32
33	Real Estate Taxes					390	26	7					423	33
34	Rent-Facility & Grounds		(486,779)			421		50					(486,308)	34
35	Rent-Equipment & Vehicles				173	56	1	12					242	35
36	Other (specify):*	(352,907)											(352,907)	36
37	TOTAL Ownership	(199,262)	(412,252)	250	995	8,563	621	170					(600,915)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			16,500	(5,867)			(11,732)					(1,099)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(12,683)											(12,683)	43
44	TOTAL Special Cost Centers	(12,683)		16,500	(5,867)			(11,732)					(13,782)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(770,012)	(420,868)	16,750	2,582	(4,108)	17,940	(9,741)					(1,167,457)	45

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 486,779	Fairfax Health Care Prperties	100.00%	\$	\$ (486,779)	1
2	V	30 Depreciation		Fairfax Health Care Prperties	100.00%	74,527	74,527	2
3	V							3
4	V							4
5	V	19 Bookeeping	223	Pinnacle Care Health Services	100.00%		(223)	5
6	V	19 Data Processing	8,393	Pinnacle Care Health Services	100.00%		(8,393)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 495,395			\$ 74,527	\$ * (420,868)	14

* 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%	\$		15
16	V	30 Depreciation		Vent Lease, LLC.	100.00%	105	105	16
17	V	32 Interest		Vent Lease, LLC.	100.00%	145	145	17
18	V	39 Vent/Ancillary Reimbursement	(16,500)	Vent Lease, LLC.	100.00%		16,500	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		\$ (16,500)			\$ 250	\$ * 16,750	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 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	17	Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 85	\$	85	15
16	V	19	Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	69		69	16
17	V	20	Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	57		57	17
18	V	21	Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	418		418	18
19	V	24	Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	148		148	19
20	V	26	Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	150		150	20
21	V	30	Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	80		80	21
22	V	32	Interest		Therapy Works Rehabilitation Services, LLC	100.00%	742		742	22
23	V	35	Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	173		173	23
24	V	39	Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	2,002		2,002	24
25	V	17	Administration		Therapy Works Rehabilitation Services, LLC	100.00%	1,134		1,134	25
26	V	22	Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	148		148	26
27	V	39	Ancillary	44,279	Therapy Works Rehabilitation Services, LLC	100.00%	36,410		(7,869)	27
28	V	22	Emp, Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	5,245		5,245	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			\$ 44,279			\$ 46,861	\$ *	2,582	39

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

Facility Name & ID Number Pinnacle Health Care of Berwyn # 0046292 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	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 37	\$ 37	15
16	V	02	Food		Care Centers, Inc.	100.00%	45	45	16
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	69	69	17
18	V	05	Utilities		Care Centers, Inc.	100.00%	327	327	18
19	V	06	Maintenance		Care Centers, Inc.	100.00%	539	539	19
20	V	17	Administrative		Care Centers, Inc.	100.00%	327	327	20
21	V	19	Professional Fees	45,000	Care Centers, Inc.	100.00%	1,724	(43,276)	21
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	942	942	22
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	2,731	2,731	23
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	159	159	24
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	206	206	25
26	V	26	Insurance		Care Centers, Inc.	100.00%	209	209	26
27	V	30	Depreciation		Care Centers, Inc.	100.00%	2,666	2,666	27
28	V	32	Interest		Care Centers, Inc.	100.00%	5,030	5,030	28
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	390	390	29
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	421	421	30
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	56	56	31
32	V	06	Maintenance	591	Care Centers, Inc.	100.00%	1,611	1,020	32
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	334	334	33
34	V	17	Administrative		Care Centers, Inc.	100.00%	1,234	1,234	34
35	V	21	Office and Clerical	2,999	Care Centers, Inc.	100.00%	22,303	19,304	35
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	3,519	3,519	36
37	V	22	Employee Benefits	397	Care Centers, Inc.	100.00%		(397)	37
38	V								38
39	Total			\$ 48,987			\$ 44,879	\$ * (4,108)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn# 0046292Report Period Beginning: 01/01/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 7	\$ 7	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	18	18	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	2	2	17	
18	V	19	Professional Fees		Care Centers Clinical, Inc.	100.00%	295	295	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	4	4	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	17	17	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	85	85	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	2	2	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	112	112	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	482	482	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	26	26	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	1	1	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	518	518	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	49	49	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	4,023	4,023	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	389	389	30	
31	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	1,117	1,117	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	713	713	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	7,067	7,067	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	1,812	1,812	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	1,201	1,201	35	
36	V	22	Employee Benefits		Care Centers Clinical, Inc.	100.00%			36	
37	V								37	
38	V								38	
39	Total			\$			\$ 17,940	\$ * 17,940	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn# 0046292Report Period Beginning: 01/01/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 269	\$ 269	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%	2	2	16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	54	54	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	22	22	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	6	6	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	33	33	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	116	116	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	25	25	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	49	49	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	38	38	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	63	63	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	7	7	26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	50	50	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	12	12	28
29	V	01 Dietary		Care Centers Health Systems, Inc.	100.00%			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		Care Centers Health Systems, Inc.	100.00%			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	11,732	Care Centers Health Systems, Inc.	100.00%		(11,732)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	442	442	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	626	626	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	177	177	38
39	Total		\$ 11,732			\$ 1,991	\$ * (9,741)	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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Pinnacle Health Care of Berwyn # 0046292 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	4.82%	See Attached	0.18	0.39%		\$		1
2	Martk Steinberg	Relative	Administrative		See Attached	0.29	0.53%	Alloc. Salary	724	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 724		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 Pinnacle Health Care of Berwyn

0046292

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 Pinnacle Health Care of Berwyn

0046292

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			1
2	21	Office and Clerical	Direct Billing	892,186	27	44			2
3	30	Depreciation	Direct Billing	892,186	27	280,000			3
4	32	Interest	Direct Billing	892,186	27	23,404			4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	8,705	105	5
6	32	Interest	Patient Days	1,625,640	33	27,081	8,705	145	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	\$	250	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Therapy Works Rehabilitation Services, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 922-0702
 Fax Number (847) 905-4040

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Administration	Billable Income	4,671,432	16	\$ 9,000	\$ 44,279	\$ 85	1	
2	19	Professional Fees	Billable Income	4,671,432	16	7,245	44,279	69	2	
3	20	Dues and Subscriptions	Billable Income	4,671,432	16	6,024	44,279	57	3	
4	21	Office & Clerical	Billable Income	4,671,432	16	44,084	44,279	418	4	
5	24	Travel and Seminar	Billable Income	4,671,432	16	15,640	44,279	148	5	
6	26	Insurance	Billable Income	4,671,432	16	15,816	44,279	150	6	
7	30	Depreciation	Billable Income	4,671,432	16	8,410	44,279	80	7	
8	32	Interest	Billable Income	4,671,432	16	78,317	44,279	742	8	
9	35	Rent - Equipment	Billable Income	4,671,432	16	18,231	44,279	173	9	
10	39	Ancillary	Billable Income	4,671,432	16	211,187	44,279	2,002	10	
11	17	Administrative	Billable Income	4,671,432	16	119,603	119,603	44,279	1,134	11
12	27	Emp. Ben. - Gen. Admin.	Billable Income	4,671,432	16	15,625	44,279	148	12	
13	39	Ancillary	Billable Income	4,671,432	16	3,841,227	3,841,227	44,279	36,410	13
14	43	Emp. Ben. - Other	Billable Income	4,671,432	16	553,364	44,279	5,245	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,943,773	\$ 3,960,830	\$ 46,861	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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	\$ 8,705	\$ 37	1
2	02	Food	Patient Days	1,625,640	33	8,403	8,705	45	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	8,705	69	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	8,705	327	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	8,705	539	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	8,705	327	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	8,705	1,724	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	8,705	942	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	8,705	2,731	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	8,705	159	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	8,705	206	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	8,705	209	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	8,705	2,666	13
14	32	Interest	Patient Days	1,625,640	33	939,326	8,705	5,030	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	8,705	390	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	8,705	421	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	8,705	56	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	1,001	18
19	06	Maintenance	Direct Allocation			456,812	456,812	610	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	8,705	334	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	1,234	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	20,239	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	2,064	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	8,705	3,519	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 44,879	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Center Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 8,705	\$ 7	1	
2	05	Utilities	Patient Days	1,625,640	32	3,307	8,705	18	2	
3	06	Maintenance	Patient Days	1,625,640	32	410	8,705	2	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	8,705	295	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	8,705	4	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	8,705	17	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	8,705	85	7	
8	26	Insurance	Patient Days	1,625,640	32	409	8,705	2	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	8,705	112	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	8,705	482	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	8,705	26	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	8,705	1	12	
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	8,705	518	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	8,705	49	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	8,705	4,023	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	8,705	389	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	8,705	1,117	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	8,705	713	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	8,705	7,067	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	8,705	1,812	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	8,705	1,201	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		22	
23	12	Social Service Salary	Direct Allocation			8,845	8,845		23	
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			24	
25	TOTALS					\$ 3,374,561	\$ 2,809,547	\$ 17,940	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Health Systems, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietary	Gross Billable Income	4,431,674	33	94,358	12,648	269	1	
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	12,648	2	2	
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	12,648	54	3	
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	12,648	22	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	12,648	6	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	12,648	33	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	12,648	116	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	12,648	25	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	12,648	49	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	12,648	38	10	
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	12,648	63	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	12,648	7	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	12,648	50	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	12,648	12	14	
15	01	Dietary	Direct Billable Income	341,879	33	112,243			15	
16	02	Food	Direct Billable Income	25	33	8			16	
17	03	Housekeeping	Direct Billable Income	29	33	10			17	
18	10	Nursing	Direct Billable Income	69,616	33	22,856			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			21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	12,648	442	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	12,648	626	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873		12,648	177	24
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 1,991	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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 Pinnacle Health Care of Berwyn

0046292

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 Pinnacle Health Care of Berwyn

0046292

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 Pinnacle Health Care of Berwyn

0046292

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	Premier Bank		X	Capital Improvement	\$10,455.22	03/22/03	\$	\$	04/10/08	8.7500	\$ 125,463	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Permier Bank		X	Line of Credit							7,289	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				\$10,455.22		\$	\$			\$ 132,752	9
	B. Non-Facility Related*											
10	Allocate Vent Lease, LLC		X								145	10
11	Allocate Therapy Works		X								742	11
12	Allocate Care Centers		X								5,575	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			\$ 6,462	14
15	TOTALS (line 9+line14)						\$	\$			\$ 139,214	15

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										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										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									20										

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

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

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 Pinnacle Health Care of Berwyn COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046292

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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-31-308-001-0000</u>	<u>Long Term Care Property</u>	<u>\$ 74,535.72</u>	<u>\$ 74,535.72</u>
2. <u>16-31-308-002-0000</u>	<u>Long Term Care Property</u>	<u>\$ 70,039.43</u>	<u>\$ 70,039.43</u>
3. <u>16-31-308-003-0000</u>	<u>Long Term Care Property</u>	<u>\$ 21,999.26</u>	<u>\$ 21,999.26</u>
4. <u>16-31-308-004-0000</u>	<u>Long Term Care Property</u>	<u>\$ 72,865.55</u>	<u>\$ 72,865.55</u>
5. <u>16-31-308-005-0000</u>	<u>Long Term Care Property</u>	<u>\$ 70,039.43</u>	<u>\$ 70,039.43</u>
6. <u>See Attached</u>	<u>Care Centers, Inc. Allocation</u>	<u>\$ 46,662.50</u>	<u>\$ 249.87</u>
7. <u>See Attached</u>	<u>Care Centers Clinical, Inc.</u>	<u>\$ 4,834.42</u>	<u>\$ 25.89</u>
8. <u>See Attached</u>	<u>Care Centers Health Sys. Alloc.</u>	<u>\$ 2,476.87</u>	<u>\$ 7.07</u>
9. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	<u>\$ 24,152.48</u>	<u>\$ 129.33</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
	TOTALS	<u>\$ 387,605.66</u>	<u>\$ 309,891.55</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? 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.

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 Pinnacle Health Care of Berwyn COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046292

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 Pinnacle Health Care of Berwyn

0046292 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,431 B. General Construction Type: Exterior Brick Frame Concrete Steel Number of Stories 3

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).

Adult days Service - Adjacent to Property, 3615 S. Harlem Ave. Berwyn, IL 60402

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>1994</u>	\$ <u>50,387</u>	1
2	<u>Allocated from Care Centers</u>			<u>2,186</u>	2
3	TOTALS			\$ <u>52,573</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1993		21,055		20	1,053	1,053	15,250	9
10	Various		1994		115,390		20	5,770	5,770	77,133	10
11	Various		1995		20,692		20	1,033	1,033	12,754	11
12	Various		1996		183,389		20	9,170	9,170	100,649	12
13	Various		1997		79,923		20	3,285	3,285	34,374	13
14	Various		1998		205,326		20	10,984	10,984	107,059	14
15	Various		1999		113,257		20	5,667	5,667	49,904	15
16	Various		2000		85,897		20	4,700	4,700	35,278	16
17	Various		2001		15,879		20	794	794	5,349	17
18	Various		2002		120,456		20	12,699	12,699	76,174	18
19	Various		2003		52,980		20	2,925	2,925	13,279	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,906,534	74,527		145,327	70,800	1,840,808	67
68		12,211	645		645		4,522	68
69			47,770			(47,770)		69
70		\$ 3,932,989	\$ 122,942		\$ 204,052	\$ 81,110	\$ 2,372,533	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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 12A, Carried Forward		\$ 3,932,989	\$ 122,942		\$ 204,052	\$ 81,110	\$ 2,372,533	1
2	Roof Repairs	2004	1,500		20	75	75	300	2
3	Roof Repair	2004	2,200		20	110	110	422	3
4	Duro-Last Roof	2004	67,300		20	3,365	3,365	12,338	4
5	Roofing	2004	865		20	43	43	144	5
6	Downspout Line Repairs	2004	1,510		20	302	302	1,107	6
7	Plumbing	2004	585		20	117	117	429	7
8	Plumbing	2004	2,097		20	419	419	1,467	8
9	Repair Cracks In Foundation	2004	1,836		20	184	184	689	9
10	Water Tank System	2004	899		20	90	90	337	10
11	Plumbing	2004	4,710		20	471	471	1,609	11
12	Water Heater	2006	7,370		20	369	369	738	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)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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 12B, Carried Forward		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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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)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	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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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)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	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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18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	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
19									19
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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)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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 12I, Carried Forward	\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)	\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
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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)		\$ 4,023,861	\$ 122,942		\$ 209,597	\$ 86,655	\$ 2,392,113	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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	145		1993	1964	\$ 2,906,534	\$ 74,527		\$ 145,327	\$ 70,800	\$ 1,840,808	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	2,906,534	\$	74,527	\$	145,327	\$	70,800	\$	1,840,808	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocate Care Centers, Inc. 2201 Main LLC		2002	2002	\$ 2,385	\$ 61	39	\$ 61	\$	\$ 324	4
5	Allocate Care Centers, Inc. - CCI Building		1996	1996	4,043	104	39	104		1,145	5
6	Allocate Care Centers Clinical, Inc.		2002	2002	247	6	39	6		34	6
7	Allocate Care Centers Health Systems, Inc.		2002	2002	67	2	39	2		9	7
8											8
	Improvement Type**										
9	Allocate Care Centers, Inc. 2201 Main LLC			2002	1,970	180	20	180		902	9
10	Allocate Care Centers, Inc. 2201 Main LLC			2003	2,321	212	20	212		1,063	10
11	Allocate Care Centers, Inc. 2201 Main LLC			2005	115	12	20	12		29	11
12											12
13	Allocate Care Centers, Inc.			2007	25	2	20	2		2	13
14											14
15	Allocate Care Centers, Inc. - CCI Building			1996	68		20			68	15
16	Allocate Care Centers, Inc. - CCI Building			1997	388	13	20	13		683	16
17											17
18	Allocate Care Centers Clinical, Inc.			2002	204	19	20	19		93	18
19	Allocate Care Centers Clinical, Inc.			2003	241	22	20	22		110	19
20	Allocate Care Centers Clinical, Inc.			2005	12	1	20	1		3	20
21											21
22	Allocate Care Centers Health Systems, Inc.			2002	56	5	20	5		26	22
23	Allocate Care Centers Health Systems, Inc.			2003	66	6	20	6		30	23
24	Allocate Care Centers Health Systems, Inc.			2005	3	-	20	-		1	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 Pinnacle Health Care of Berwyn

0046292

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	12,211	\$	645	\$	645	\$	4,522	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Pinnacle Health Care of Berwyn # 0046292 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	\$ 590,759	\$ 2,014	\$ 68,782	\$ 66,768	10	\$ 487,792	71
72	Current Year Purchases	10,158	22	245	223	10	245	72
73	Fully Depreciated Assets	134,505				10	134,505	73
74								74
75	TOTALS	\$ 735,422	\$ 2,036	\$ 69,027	\$ 66,991		\$ 622,542	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	\$ 4,499	\$ 261	\$ 261	\$	5	\$ 3,695	76
77		Allocate Care Centers Clinical	2007	1,424	57	57		5	73	77
78		Allocate Care Centers Health Sys.	2007	36	1	1		5	1	78
79										79
80	TOTALS			\$ 5,959	\$ 319	\$ 319	\$		\$ 3,769	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)		\$ 4,817,815	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 125,297	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 278,942	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 153,645	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,018,424	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	GRAJER - 2003	\$ 1,500	\$ 38	\$ 215	86
87	ADULT DAY CARE CENTER - 2002	83,500	2,102	12,155	87
88	ADULT DAY CARE CENTER - 2002	1,845	47	274	88
89	PAINTING - 2002	9,500			89
90					90
91	TOTALS	\$ 96,345	\$ 2,187	\$ 12,644	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: _____

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	Storage Rental				4,035			5
6	Allocated Care Centers				472			6
7	TOTAL				\$ 4,507			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 15,932 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	Facility	Rental Car	\$ _____	\$ 1,000	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 1,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 178,137	\$		\$ 178,137	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			19,428			19,428	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			176,435			176,435	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			79,137	195,450		274,587	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>			361,358		20,608	309,901		691,867	13
14	TOTAL			\$ 361,358		\$ 473,745	\$ 505,351		\$ 1,340,454	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 Pinnacle Health Care of Berwyn# 0046292Report 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
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,630,483		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,597		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	12,798		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,764,878	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,188		15
16	Equipment, at Historical Cost	6,777		16
17	Accumulated Depreciation (book methods)	(354)		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>	(93,646)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ (84,035)	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,680,843	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 629,377	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,336		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,857		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,336		31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,783		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,004,235		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,809,924	\$	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 Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,809,924	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (129,081)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,680,843	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,652,296)	1
2	Restatements (describe):		2
3	Adj Journal Entries	5,491,271	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 838,975	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(968,056)	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)	\$ (968,056)	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)	\$ (129,081)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinnacle Health Care of Berwyn

0046292

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	\$ 6,411,748	1
2	Discounts and Allowances for all Levels	(1,200,714)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,211,034	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,011,907	6
7	Oxygen	8,798	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,020,705	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	273,350	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,465	19
20	Radiology and X-Ray	3,420	20
21	Other Medical Services	82,082	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 373,317	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	<u>See Supplemental Schedule</u>	38,356	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38,356	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,643,412	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,053,960	31
32	Health Care	3,093,462	32
33	General Administration	1,797,060	33
B. Capital Expense			
34	Ownership	1,234,044	34
C. Ancillary Expense			
35	Special Cost Centers	1,353,555	35
36	Provider Participation Fee	79,387	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,611,468	40
41	Income before Income Taxes (line 30 minus line 40)**	(968,056)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (968,056)	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 Pinnacle Health Care of Berwyn

0046292

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	2,325	2,818	\$ 104,563	\$ 37.10	1
2	Assistant Director of Nursing	604	845	28,271	33.48	2
3	Registered Nurses	10,215	12,457	278,231	22.33	3
4	Licensed Practical Nurses	29,897	38,240	930,916	24.34	4
5	CNAs & Orderlies	65,439	77,256	847,301	10.97	5
6	CNA Trainees					6
7	Licensed Therapist	13,770	15,040	361,358	24.03	7
8	Rehab/Therapy Aides	4,077	4,848	218,317	45.04	8
9	Activity Director	2,470	2,988	48,823	16.34	9
10	Activity Assistants	7,259	8,027	78,001	9.72	10
11	Social Service Workers	4,517	4,737	102,550	21.65	11
12	Dietician					12
13	Food Service Supervisor	1,086	1,178	23,459	19.92	13
14	Head Cook	4,314	4,765	48,012	10.08	14
15	Cook Helpers/Assistants	11,971	12,726	127,831	10.05	15
16	Dishwashers					16
17	Maintenance Workers	9,550	10,420	110,804	10.63	17
18	Housekeepers	11,714	12,401	130,920	10.56	18
19	Laundry	10,766	12,064	110,551	9.16	19
20	Administrator	2,227	2,298	96,490	41.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,087	11,018	175,549	15.93	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	1,823	2,044	32,875	16.08	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	204,109	236,170	\$ 3,854,822 *	\$ 16.32	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	176	\$ 7,556	01-03	35
36	Medical Director	Monthly	17,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	310	10-03	38
39	Pharmacist Consultant	Monthly	2,477	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	363	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	176	\$ 28,506		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	140	\$ 6,287	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	3,579	125,257	10-03	52
53	TOTAL (lines 50 - 52)	3,719	\$ 131,544		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
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11													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? 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? 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. \$ 1,435 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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Fairfax Nursing Home, IDPH #0038752, 01/01/03
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,387
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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