

Facility Name & ID Number Center Home Hispanic Elderly N

0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,868</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,228</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>57,096</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>24,594</u>	<u>345</u>	<u>6,003</u>	<u>30,942</u>	8
9	SNF/PED					9
10	ICF	<u>19,540</u>	<u>283</u>		<u>19,823</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,134</u>	<u>628</u>	<u>6,003</u>	<u>50,765</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.91%

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

1,148 (Do not include bed-hold days in Section B.)

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

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

None

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

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

YES NO

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

YES NO

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

Date started 10/01/2006

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

YES Date 10/01/2006 NO

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

YES NO If YES, enter number of beds certified 98 and days of care provided 5,986

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	244,169	73,334	10,325	327,828		327,828	(162)	327,666		1
2	Food Purchase		254,061		254,061		254,061	397	254,458		2
3	Housekeeping	192,765	43,467		236,232		236,232	(516)	235,716		3
4	Laundry	107,449	31,471	199	139,119		139,119	(687)	138,432		4
5	Heat and Other Utilities			212,996	212,996		212,996	3,640	216,636		5
6	Maintenance	147,639		166,950	314,589		314,589	106,850	421,439		6
7	Other (specify):*							14,118	14,118		7
8	TOTAL General Services	692,022	402,333	390,470	1,484,825		1,484,825	123,640	1,608,465		8
	B. Health Care and Programs										
9	Medical Director			8,008	8,008		8,008		8,008		9
10	Nursing and Medical Records	2,510,556	179,397	160,196	2,850,149		2,850,149	14,806	2,864,955		10
10a	Therapy	171,915		423	172,338		172,338	2,299	174,637		10a
11	Activities	101,967	9,349	200	111,516		111,516		111,516		11
12	Social Services	146,294	40	1,507	147,841		147,841	13,426	161,267		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							8,779	8,779		15
16	TOTAL Health Care and Programs	2,930,732	188,786	170,334	3,289,852		3,289,852	39,310	3,329,162		16
	C. General Administration										
17	Administrative	174,037			174,037		174,037	62,500	236,537		17
18	Directors Fees										18
19	Professional Services			371,664	371,664		371,664	(321,843)	49,821		19
20	Dues, Fees, Subscriptions & Promotions			81,769	81,769		81,769	(13,645)	68,124		20
21	Clerical & General Office Expenses	91,820	23,471	313,872	429,163		429,163	(61,878)	367,285		21
22	Employee Benefits & Payroll Taxes			572,622	572,622		572,622	(11,671)	560,951		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,551	6,551		6,551	1,607	8,158		24
25	Other Admin. Staff Transportation			850	850		850	2,144	2,994		25
26	Insurance-Prop.Liab.Malpractice			154,071	154,071		154,071	2,045	156,116		26
27	Other (specify):*							32,845	32,845		27
28	TOTAL General Administration	265,857	23,471	1,501,399	1,790,727		1,790,727	(307,895)	1,482,832		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,888,611	614,590	2,062,203	6,565,404		6,565,404	(144,945)	6,420,459		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N #0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

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			79,860	79,860		79,860	429,090	508,950			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			103,265	103,265		103,265	506,405	609,670			32
33	Real Estate Taxes			196,532	196,532		196,532	4,164	200,696			33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(653,706)	6,294			34
35	Rent-Equipment & Vehicles			5,924	5,924		5,924	1,334	7,258			35
36	Other (specify):*											36
37	TOTAL Ownership			1,045,581	1,045,581		1,045,581	287,287	1,332,868			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		375,765	403,347	779,112		779,112	(33,000)	746,112			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,644	85,644		85,644		85,644			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		375,765	488,991	864,756		864,756	(33,000)	831,756			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,888,611	990,355	3,596,775	8,475,741		8,475,741	109,341	8,585,082			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	(18,569)	30		9
10	Interest and Other Investment Income	(4,903)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	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	(629)	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	(223,049)	21		24
25	Fund Raising, Advertising and Promotional	(17,689)	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	(21,477)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (286,348)		\$	30

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)	395,689		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 395,689		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 109,341		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49	50	51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Center Home Hispanic Elderly N

ID# 0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Pharmacy Repayment	\$ (130)	10 1
2	Medical Records - Cash Payment	(104)	10 2
3	Donation for Therapy Staff Luncheon	(250)	10 3
4	KCI Credit	(294)	21 4
5	Jury Duty	(17)	10 5
6	Charitable Donations	(1,218)	20 6
7	Theft Loss	(1,095)	21 7
8	Collection Expense	(270)	21 8
9	Public Relations	(648)	20 9
10	Non Allowable Legal	(2,005)	19 10
11	Bldg-Co Amortization Expense	(15,196)	36 11
12	Annual Report Fee	(250)	20 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
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(21,477)	49

Center Home Hispanic Elderly N

ID# 0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

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			429		3,149	(3,696)	(44)					(162)	1
2	Food Purchase	(31)		428									397	2
3	Housekeeping			427		47		(990)					(516)	3
4	Laundry							(687)					(687)	4
5	Heat and Other Utilities			2,581		107	952						3,640	5
6	Maintenance			3,258	101,996	13	162	(210)		1,631			106,850	6
7	Other (specify):*				13,711	407							14,118	7
8	TOTAL General Services	(31)		7,123	115,707	3,723	(2,582)	(1,931)		1,631			123,640	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(501)				26,995		(11,688)					14,806	10
10a	Therapy					2,299							2,299	10a
11	Activities													11
12	Social Services					13,430		(4)					13,426	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,779							8,779	15
16	TOTAL Health Care and Programs	(501)				51,503		(11,692)					39,310	16
	C. General Administration													
17	Administrative			2,050	7,657	39,158	13,635						62,500	17
18	Directors Fees													18
19	Professional Services	(2,005)		(235,441)		(84,919)	522						(321,843)	19
20	Fees, Subscriptions & Promotions	(19,805)		5,690		7	463						(13,645)	20
21	Clerical & General Office Expenses	(225,337)		24,856	119,019	13,305	16,170			(9,891)			(61,878)	21
22	Employee Benefits & Payroll Taxes				(8,317)	(3,262)		(92)					(11,671)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,444		163							1,607	24
25	Other Admin. Staff Transportation			1,240			894			10			2,144	25
26	Insurance-Prop.Liab.Malpractice			891		14	1,107			33			2,045	26
27	Other (specify):*				22,335	6,744	3,766						32,845	27
28	TOTAL General Administration	(247,147)		(199,270)	140,694	(28,790)	36,557	(92)		(9,848)			(307,895)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(247,679)		(192,147)	256,401	26,436	33,975	(13,714)		(8,217)			(144,945)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	(18,569)	421,372	12,201		779	1,010			12,297			429,090	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,903)	467,485	32,239		5,967	3,104			2,513			506,405	32
33	Real Estate Taxes			3,990		174							4,164	33
34	Rent-Facility & Grounds		(660,000)	3,027			3,267						(653,706)	34
35	Rent-Equipment & Vehicles			1,020			314						1,334	35
36	Other (specify):*	(15,196)	15,196											36
37	TOTAL Ownership	(38,668)	244,053	52,477		6,920	7,695			14,810			287,287	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(14,330)	(4,930)		(13,740)			(33,000)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(14,330)	(4,930)		(13,740)			(33,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(286,348)	244,053	(139,670)	256,401	33,356	27,340	(18,645)		(7,147)			109,341	45

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Center Home Property, LLC		Building Company

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 660,000	Center Home Property, LLC	100.00%	\$	\$ (660,000)	1
2	V	30 Depreciation				421,372	421,372	2
3	V	36 Amortization				15,196	15,196	3
4	V	32 Interest				467,485	467,485	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 660,000			\$ 904,053	\$ * 244,053	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	\$ 429	\$ 429	15
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	428	428	16
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	427	427	17
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,581	2,581	18
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,258	3,258	19
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,050	2,050	20
21	V	19	Professional Fees	250,761	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	15,320	(235,441)	21
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	5,690	5,690	22
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	24,856	24,856	23
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,444	1,444	24
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,240	1,240	25
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	891	891	26
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	12,201	12,201	27
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	32,239	32,239	28
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,990	3,990	29
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,027	3,027	30
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,020	1,020	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 250,761			\$ 111,091	\$ * (139,670)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	6,289	\$ 6,289	15
16	V	06	Maintenance (Direct)	8,053	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	103,760	95,707	16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,957	1,957	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	11,754	11,754	18
19	V	17	Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	7,657	7,657	19
20	V	21	Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	119,019	119,019	20
21	V	21	Office and Clerical (Direct)	30,354	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	30,354		21
22	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	18,900	18,900	22
23	V	27	Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,435	3,435	23
24	V	22	Emp. Ben. - Gen. Admin. (Direct)	8,317	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%		(8,317)	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		\$ 46,724				\$ 303,125	\$ * 256,401	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N# 0048520Report Period Beginning: 01/01/08Ending: 12/31/08

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. / Extended Care Clinical, LLC	100.00%	\$ 47	\$ 47	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	107	107	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	13	13	17	
18	V	19	Professional Fees	86,115	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,196	(84,919)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7	7	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	204	204	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	163	163	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	14	14	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	779	779	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	5,967	5,967	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	174	174	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,149	3,149	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	407	407	27	
28	V	10	Nursing Salary	18,341	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	45,336	26,995	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	2,299	2,299	29	
30	V	12	Social Service Salary	1,507	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	14,937	13,430	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	8,779	8,779	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	39,158	39,158	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	13,101	13,101	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	6,744	6,744	34	
35	V	22	Emp. Ben.	3,262				(3,262)	35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 109,225			\$ 142,581	\$ * 33,356	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 8,440	\$ 8,440	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	952	952	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	162	162	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	522	522	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	463	463	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,073	2,073	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	894	894	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	1,107	1,107	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	1,010	1,010	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	3,104	3,104	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	3,267	3,267	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	314	314	28
29	V	01 Dietary	19,227	Care Centers Health Systems, Inc.	100.00%	7,091	(12,136)	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	22,702	Care Centers Health Systems, Inc.	100.00%	8,372	(14,330)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	13,635	13,635	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	14,097	14,097	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	3,766	3,766	38
39	Total		\$ 41,929			\$ 69,269	\$ *	27,340 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	1 Dietary	\$ 495	Xcel Supply, LLC	100.00%	\$ 451	\$ (44)	15
16	V	3 Housekeeping	11,171	Xcel Supply, LLC	100.00%	10,182	(990)	16
17	V	4 Laundry	7,762	Xcel Supply, LLC	100.00%	7,074	(687)	17
18	V	6 Repairs & Maintenance	2,370	Xcel Supply, LLC	100.00%	2,160	(210)	18
19	V	10 Nursing	131,954	Xcel Supply, LLC	100.00%	120,266	(11,688)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service	40	Xcel Supply, LLC	100.00%	36	(4)	21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	1,033	Xcel Supply, LLC	100.00%	942	(92)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	55,663	Xcel Supply, LLC	100.00%	50,732	(4,930)	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		\$ 210,488			\$ 191,844	\$ * (18,645)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 152,855	\$ 152,855	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	152,855	CCS Employee Benefits Group	100.00%		(152,855)	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			\$ 152,855			\$ 152,855	\$ *	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	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 1,631	\$ 1,631	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	183	183	16
17	V	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%	10	10	17
18	V	26	Insurance		Vent Lease, LLC.	100.00%	33	33	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	5,425	5,425	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	915	915	20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	6,872	6,872	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	1,598	1,598	22
23	V	21	Office and Clerical	10,074	Vent Lease, LLC.	100.00%		(10,074)	23
24	V	39	Ancillary	13,740	Vent Lease, LLC.	100.00%		(13,740)	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		\$ 23,814				\$ 16,667	\$ * (7,147)	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.

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative		See Attached	1.04	2.25%		\$		1
2	Mark Steinberg	Relative	Administrative		See Attached	1.71	3.11%	Alloc. Salary	4,746	17-7	2
3	Adam Vales	Shareholder	Clerical	7.05	See Attached	1.17	2.93%	Alloc. Salary	2,104	22-7	3
4	Kim Rudolph	Shareholder	Clerical	7.05	See Attached	0.49	2.94%	Alloc. Salary	427	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,277		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Inc/Extended Care Consulting LLC
 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	Patient Days	1,635,146	31	\$ 13,778	\$ 50,765	\$ 429	1
2	02	Food	Patient Days	1,635,146	31	13,971	50,765	428	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	50,765	427	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	50,765	2,581	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	50,765	3,258	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	50,765	2,050	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	50,765	15,320	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	50,765	5,690	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	50,765	24,856	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	50,765	1,444	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	50,765	1,240	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	50,765	891	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	50,765	12,201	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	50,765	32,239	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	50,765	3,990	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	50,765	3,027	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	50,765	1,020	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 111,091	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Inc/Extended Care Consulting LLC
 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	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	50,765	6,289	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013		103,760	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		50,765	1,957	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015			11,754	4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	50,765	7,657	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	50,765	119,019	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		30,354	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		50,765	18,900	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			3,435	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					\$ 6,211,280	\$ 5,395,924		\$ 303,125	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

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/Extended Care Clinical
 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	1,635,146	31	\$ 1,505	\$ 50,765	\$ 47	1	
2	05	Utilities	Patient Days	1,635,146	31	3,449	50,765	107	2	
3	06	Maintenance	Patient Days	1,635,146	31	431	50,765	13	3	
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	50,765	1,196	4	
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	50,765	7	5	
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	50,765	204	6	
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	50,765	163	7	
8	26	Insurance	Patient Days	1,635,146	31	465	50,765	14	8	
9	30	Depreciation	Patient Days	1,635,146	31	25,565	50,765	779	9	
10	32	Interest	Patient Days	1,635,146	31	191,164	50,765	5,967	10	
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	50,765	174	11	
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	50,765	3,149	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	50,765	407	13	
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	50,765	26,995	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	50,765	2,299	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	50,765	13,430	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	50,765	5,517	17	
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	50,765	39,158	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	50,765	13,101	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	50,765	6,744	20	
21	10	Nursing Salary	Direct Allocation			401,447	401,447		18,341	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016		1,507	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816			3,262	23
24										24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 142,581		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 200 Howard
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612-5662
 Fax Number (224) 612-5862

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	31	111,096		293,794	8,440	1
2	03	Housekeeping	Gross Billable Income	31			293,794		2
3	05	Heat and Other Utilities	Gross Billable Income	31	12,529		293,794	952	3
4	06	Maintenance	Gross Billable Income	31	2,136		293,794	162	4
5	19	Professional Fees	Gross Billable Income	31	6,873		293,794	522	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	6,095		293,794	463	6
7	21	Clerical and General Office	Gross Billable Income	31	27,280		293,794	2,073	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	11,773		293,794	894	8
9	26	Insurance	Gross Billable Income	31	14,568		293,794	1,107	9
10	30	Depreciation	Gross Billable Income	31	13,298		293,794	1,010	10
11	32	Interest	Gross Billable Income	31	40,850		293,794	3,104	11
12	33	Real Estate Taxes	Gross Billable Income	31			293,794		12
13	34	Rent - Building	Gross Billable Income	31	43,000		293,794	3,267	13
14	35	Rent - Equipment	Gross Billable Income	31	4,135		293,794	314	14
15	01	Dietary	Direct Billable Income	31	102,965		19,227	7,091	15
16	02	Food	Direct Billable Income	31	1,612				16
17	03	Housekeeping	Direct Billable Income	31					17
18	10	Nursing	Direct Billable Income	31					18
19	21	Clerical and General Office	Direct Billable Income	31					19
20	25	Other Admin. Staff Transport.	Direct Billable Income	31					20
21	39	Ancillary	Direct Billable Income	31	1,321,550		22,702	8,372	21
22	17	Administrative	Gross Billable Income	31	179,474	179,474	293,794	13,635	22
23	21	Clerical and General Office	Gross Billable Income	31	185,549	185,549	293,794	14,097	23
24	27	Employee Benefits	Gross Billable Income	31	49,573		293,794	3,766	24
25	TOTALS				\$ 2,134,357	\$ 365,023		\$ 69,269	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		451	1
2	3	Housekeeping	Direct Allocation					10,182	2
3	4	Laundry	Direct Allocation					7,074	3
4	6	Repairs & Maintenance	Direct Allocation					2,160	4
5	10	Nursing	Direct Allocation					120,266	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation					36	7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					942	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					50,732	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				\$	\$		191,844	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		152,855	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				\$	\$		152,855	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	669,310	26	\$ 79,460	\$ 13,740	\$ 1,631	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933	13,740	183	2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473	13,740	10	3
4	26	Insurance	Direct Billing	669,310	26	1,630	13,740	33	4
5	30	Depreciation	Direct Billing	669,310	26	264,263	13,740	5,425	5
6	32	Interest	Direct Billing	669,310	26	44,568	13,740	915	6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	50,765	6,872	7
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	50,765	1,598	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					\$ 672,138	\$	\$ 16,667	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	US Bank		X	Term Loan			\$ 6,240,000	\$ 5,926,206			\$ 429,277	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	US Bank		X	Line of Credit				1,500,000			61,237	6
7	Various		X	Line of Credit				1,130,000			42,028	7
8	See Supplemental Schedule							801,717			38,207	8
9	TOTAL Facility Related						\$ 6,240,000	\$ 9,357,923			\$ 570,749	9
	B. Non-Facility Related*											
10	DAIWA Loan		X								(4,590)	10
11	Misc. Income		X								(313)	11
12	Allocated from CCI/ECC		X								32,239	12
13	See Supplemental Schedule										11,584	13
14	TOTAL Non-Facility Related						\$	\$			\$ 38,920	14
15	TOTALS (line 9+line14)						\$ 6,240,000	\$ 9,357,923			\$ 609,669	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	Shareholder Loan		X	Line of Credit			\$	\$ 801,717		\$ 38,207										
9																				
10																				
11																				
12																				
13																				
14	TOTAL Working Capital																			
B. Non-Facility Related*																				
15	Allocated from CC/EC Clinical		X				\$	\$		\$ 5,967										
16	Allocated from CC Health Sys.		X							3,104										
17	Allocated from Vent Lease		X							2,513										
18																				
19																				
20	TOTAL Non-Facility Related																			

* 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Center Home Hispanic Elderly N COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048520

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. <u>16-01-208-0035</u>	<u>Nursing Facility</u>	\$ <u>62,236.38</u>	\$ <u>62,236.38</u>
2. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	\$ <u>122,122.75</u>	\$ <u>1,697.72</u>
3. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>43,667.89</u>	\$ <u>904.15</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>228,027.02</u>	\$ <u>64,838.25</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Center Home Hispanic Elderly N COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048520

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>55,145</u>	<u>2006</u>	<u>\$ 104,706</u>	1
2	<u>Allocated From CCI/ECC</u>			<u>13,166</u>	2
3	TOTALS	55,145		\$ 117,872	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
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29											29
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31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

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
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53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		5,134,305	131,649		131,649	(0)	290,725	67
68		73,554	3,879		3,879		25,352	68
69			79,861			(79,861)		69
70		\$ 5,207,859	\$ 215,389		\$ 135,528	\$ (79,861)	\$ 316,077	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,207,859	\$ 215,389		\$ 135,528	\$ (79,861)	\$ 316,077	1
2	Seco Regifrigerator - Walk In Cooler Repair	2006	3,345		20	478	478	996	2
3	Repaired Elev Hoist Motor	2007	3,000		20	150	150	213	3
4	Decorative Fixtures	2007	4,769		20	477	477	676	4
5	Air Systems	2007	4,984		20	249	249	291	5
6	Carpeting	2007	4,399		20	628	628	733	6
7	Reception Station	2007	15,000		20	750	750	875	7
8	Boiler Repair	2007	3,020		20	151	151	214	8
9	Phone System	2008	3,864		20	354	354	354	9
10	Painting (Transfer From Home Office)	2008	16,809		20	15,408	15,408	15,408	10
11	Wiring	2008	7,800		20	293	293	293	11
12	Painting (Transfer From Home Office)	2008	9,851		20	7,388	7,388	7,388	12
13	Drive Unit	2008	6,500		20	244	244	244	13
14	Painting (Transfer From Home Office)	2008	16,257		20	10,838	10,838	10,838	14
15	Second Floor Patio	2008	129,000		20	3,763	3,763	3,763	15
16	Painting (Transfer From Home Office)	2008	8,785		20	5,125	5,125	5,125	16
17	Painting (Transfer From Home Office)	2008	8,057		20	4,029	4,029	4,029	17
18	Painting (Transfer From Home Office)	2008	12,827		20	5,345	5,345	5,345	18
19	Painting (Transfer From Home Office)	2008	21,271		20	355	355	355	19
20	Masonry Restoration	2008	29,230		20	487	487	487	20
21	Paint	2008	5,149		20	86	86	86	21
22	Painting (Transfer From Home Office)	2008	6,982		20	87	87	87	22
23	Masonry Restoration	2008	3,820		20	48	48	48	23
24	Roof Repair	2008	2,950		20	37	37	37	24
25	Magnetic Doors	2008	3,300		20	41	41	41	25
26	Painting (Transfer From Home Office)	2008	6,725		20	1,121	1,121	1,121	26
27	Electric Lines	2008	6,575		20	55	55	55	27
28	Painting	2008	3,500		20	583	583	583	28
29	Home Office - Painting	2008	7,359		20	613	613	613	29
30	Tile	2008	30,793		20	171	171	171	30
31	Blinds	2008	7,552		20	63	63	63	31
32	Steam Vacuum Repair	2008	5,400		20	23	23	23	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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18									18
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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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21									21
22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	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)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,606,732	\$ 215,389		\$ 194,968	\$ (20,421)	\$ 376,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	156		2006	1954	\$ 5,134,305	\$ 131,649	39	\$ 131,649	\$ (0)	\$ 290,725	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	5,134,305	\$	131,649	\$	131,649	\$	(0)	\$	290,725	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		Allocated from EC/CC Clinical, Inc.	2002	2002	\$ 1,528	\$ 39	39	\$ 39		\$ 246	4
5		Allocated from CCI/ECC - CCI Building	1996	1996	24,391	625	39	625		7,531	5
6		Allocated from CCI/Extended Care Consulting, LLC	2002	2002	14,716	377	39	377		2,374	6
7											7
8											8
		Improvement Type**									
9		Allocated from CCI/Extended Care Consulting, LLC		2002	12,156	1,111	20	1,111		5,565	9
10		Allocated from CCI/Extended Care Consulting, LLC		2003	14,326	1,309	20	1,309		6,559	10
11		Allocated from CCI/Extended Care Consulting, LLC		2005	712	76	20	76		181	11
12		Allocated from CCI/Extended Care Consulting, LLC		2007	149	7	20	7		17	12
13											13
14		Allocated from CCI/ECC- CCI Building		1996	411	-	20	-		411	14
15		Allocated from CCI/ECC- CCI Building		1997	2,342	76	20	76		1,190	15
16											16
17		Allocated from CC/EC Clinical, Inc.		2002	1,262	115	20	115		578	17
18		Allocated from CC/EC Clinical, Inc.		2003	1,487	136	20	136		681	18
19		Allocated from CC/EC Clinical, Inc.		2005	74	8	20	8		19	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	73,554	\$	3,879	\$	3,879	\$	25,352	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Center Home Hispanic Elderly N # 0048520 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,416,849	\$ 309,668	\$ 301,954	\$ (7,714)	10	\$ 709,396	71
72	Current Year Purchases	59,504	95	9,661	9,566	10	9,661	72
73	Fully Depreciated Assets	5,964				10	5,964	73
74								74
75	TOTALS	\$ 1,482,317	\$ 309,763	\$ 311,615	\$ 1,852		\$ 725,021	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		Allocated from CCC/EC Clinical	2008	\$ 2,188	\$ 438	\$ 438	\$	5	\$ 851	76
77		Allocated from CCI/ECC	2008	27,948	1,737	1,737		5	24,028	77
78		Allocated from CC Health Sys	2008	958	192	192		5	224	78
79										79
80	TOTALS			\$ 31,094	\$ 2,367	\$ 2,367	\$		\$ 25,103	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)	\$ 7,238,015	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 527,519	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 508,950	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,569)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,126,756	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from Care Centers Inc.</u>				<u>3,027</u>			5
6	<u>Allocated from Care Health Systems</u>				<u>3,267</u>			6
7	TOTAL				\$ 6,294			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u> /2009</u>	\$ <u> </u>
13.	<u> /2010</u>	\$ <u> </u>
14.	<u> /2011</u>	\$ <u> </u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,258

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 160,268	\$		\$ 160,268	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			34,742			34,742	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			173,440			173,440	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				277,670		277,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					34,897	98,095		132,992	13
14	TOTAL			\$		\$ 403,347	\$ 375,765		\$ 779,112	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N# 0048520Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 935	\$ 226,250	1
2	Cash-Patient Deposits	32,496	32,496	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,850,494	3,850,494	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	184,499	184,499	6
7	Other Prepaid Expenses	1,392	1,392	7
8	Accounts Receivable (owners or related parties)		251,399	8
9	Other(specify): <u>See Attached Schedule</u>	334,434	334,434	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,404,250	\$ 4,880,964	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		104,706	13
14	Buildings, at Historical Cost		5,134,305	14
15	Leasehold Improvements, at Historical Cost	391,082	391,082	15
16	Equipment, at Historical Cost	92,651	1,386,057	16
17	Accumulated Depreciation (book methods)	(92,176)	(1,241,723)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	267,583	353,059	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 659,140	\$ 6,127,486	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,063,390	\$ 11,008,450	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,543,348	\$ 1,543,348	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,302	27,302	28
29	Short-Term Notes Payable	2,630,000	3,431,717	29
30	Accrued Salaries Payable	508,007	508,007	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,552	15,552	31
32	Accrued Real Estate Taxes(Sch.IX-B)	196,532	196,532	32
33	Accrued Interest Payable	11,916	48,343	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	513,358	513,358	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,446,015	\$ 6,284,159	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,926,206	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,926,206	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,446,015	\$ 12,210,365	46
47	TOTAL EQUITY (page 18, line 24)	\$ (382,625)	\$ (1,201,915)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,063,390	\$ 11,008,450	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (320,937)	1
2	Restatements (describe):		2
3	Pension Expense	(1,346)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (322,283)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(60,342)	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)	\$ (60,342)	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)	\$ (382,625)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N# 0048520Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 8,345,011	1
2	Discounts and Allowances for all Levels	(1,864,902)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,480,109	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,553,856	6
7	Oxygen	2,055	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,555,911	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	271,134	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,947	19
20	Radiology and X-Ray	6,700	20
21	Other Medical Services	61,900	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 373,681	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,903	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,903	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	795	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 795	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,415,399	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,484,825	31
32	Health Care	3,289,852	32
33	General Administration	1,790,727	33
B. Capital Expense			
34	Ownership	1,045,581	34
C. Ancillary Expense			
35	Special Cost Centers	779,112	35
36	Provider Participation Fee	85,644	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,475,741	40
41	Income before Income Taxes (line 30 minus line 40)**	(60,342)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (60,342)	43

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

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

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

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

Facility Name & ID Number Center Home Hispanic Elderly N

0048520

Report Period Beginning: 01/01/08

Ending:

12/31/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,886	2,027	\$ 88,602	\$ 43.71	1
2	Assistant Director of Nursing	328	352	13,108	37.24	2
3	Registered Nurses	11,756	12,682	387,424	30.55	3
4	Licensed Practical Nurses	37,336	40,367	1,006,323	24.93	4
5	CNAs & Orderlies	75,467	82,409	920,202	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,185	10,317	171,915	16.66	8
9	Activity Director	1,886	2,058	32,518	15.80	9
10	Activity Assistants	7,904	8,491	69,449	8.18	10
11	Social Service Workers	7,420	8,147	146,294	17.96	11
12	Dietician					12
13	Food Service Supervisor	1,769	2,012	36,873	18.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,773	7,533	81,861	10.87	15
16	Dishwashers	14,843	15,579	125,435	8.05	16
17	Maintenance Workers	8,871	9,527	147,639	15.50	17
18	Housekeepers	21,506	23,004	192,765	8.38	18
19	Laundry	10,041	11,067	107,449	9.71	19
20	Administrator	1,960	2,127	105,071	49.40	20
21	Assistant Administrator	2,026	2,090	68,966	33.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,231	8,005	91,820	11.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,055	2,178	32,557	14.95	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,451	3,787	62,340	16.46	33
34	TOTAL (lines 1 - 33)	233,694	253,759	\$ 3,888,611 *	\$ 15.32	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	207	\$ 10,325	01-03	35
36	Medical Director	Monthly	8,008	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,547	10-03	39
40	Physical Therapy Consultant	7	423	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	200	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>See Attached</u>		19,849		48
49	TOTAL (lines 35 - 48)	218	\$ 43,352		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	290	\$ 11,991	10-03	50
51	Licensed Practical Nurses	3,132	125,011	10-03	51
52	Certified Nurse Assistants/Aides	9	305	10-03	52
53	TOTAL (lines 50 - 52)	3,431	\$ 137,307		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Center Home Hispanic Elderly N

Report Period Beginning: 01/01/08 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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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? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$8393
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,174 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 85,644
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT