





**Shortcut=**  
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**To Stop Macro:**  
Hold down  
Control Key and press "Break"

Facility Name & ID Number Somerset Place# 0044289 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	450	Intermediate (ICF)	450	164,700	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	450	TOTALS	450	164,700	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	
8	SNF				8
9	SNF/PED				9
10	ICF	147,205	996		148,201
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	147,205	996		148,201

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.98%

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

5,243 (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)

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

G. Do pages 3 &amp; 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 02/01/99

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

YES  Date 02/01/99 NO 

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_Medicare Intermediary N/A

## IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 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	
	<b>A. General Services</b>											
1	Dietary	430,873	72,526	19,039	522,438		522,438	6,777	529,215			1
2	Food Purchase		587,375		587,375		587,375	1,229	588,604			2
3	Housekeeping	413,912	102,899		516,811		516,811	(6,629)	510,182			3
4	Laundry	16,625	4,782	112,612	134,019		134,019		134,019			4
5	Heat and Other Utilities			387,537	387,537		387,537	7,854	395,391			5
6	Maintenance	432,423		153,278	585,701		585,701	45,196	630,897			6
7	Other (specify):*							6,964	6,964			7
8	<b>TOTAL General Services</b>	<b>1,293,833</b>	<b>767,582</b>	<b>672,466</b>	<b>2,733,881</b>		<b>2,733,881</b>	<b>61,391</b>	<b>2,795,272</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			11,800	11,800		11,800		11,800			9
10	Nursing and Medical Records	2,996,807	109,271	21,977	3,128,055		3,128,055	71,533	3,199,588			10
10a	Therapy							6,714	6,714			10a
11	Activities	312,564	29,943		342,507		342,507		342,507			11
12	Social Services	731,877	10,565	8,969	751,411		751,411	38,982	790,393			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							16,746	16,746			15
16	<b>TOTAL Health Care and Programs</b>	<b>4,041,248</b>	<b>149,779</b>	<b>42,746</b>	<b>4,233,773</b>		<b>4,233,773</b>	<b>133,975</b>	<b>4,367,748</b>			16
	<b>C. General Administration</b>											
17	Administrative	133,845			133,845		133,845	142,425	276,270			17
18	Directors Fees											18
19	Professional Services			597,054	597,054		597,054	(464,851)	132,203			19
20	Dues, Fees, Subscriptions & Promotions			129,799	129,799		129,799	(35,922)	93,877			20
21	Clerical & General Office Expenses	236,266	37,400	789,761	1,063,427		1,063,427	(301,540)	761,887			21
22	Employee Benefits & Payroll Taxes			1,016,370	1,016,370		1,016,370	(1,478)	1,014,892			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,608	9,608		9,608	4,802	14,410			24
25	Other Admin. Staff Transportation			2,016	2,016		2,016	3,613	5,629			25
26	Insurance-Prop.Liab.Malpractice			269,501	269,501		269,501	2,678	272,179			26
27	Other (specify):*							74,866	74,866			27
28	<b>TOTAL General Administration</b>	<b>370,111</b>	<b>37,400</b>	<b>2,814,109</b>	<b>3,221,620</b>		<b>3,221,620</b>	<b>(575,407)</b>	<b>2,646,213</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,705,192</b>	<b>954,761</b>	<b>3,529,321</b>	<b>10,189,274</b>		<b>10,189,274</b>	<b>(380,042)</b>	<b>9,809,232</b>			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.

## 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	
	<b>D. Ownership</b>											
30	Depreciation			118,512	118,512		118,512	412,838	531,350			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,261,401	1,261,401			32
33	Real Estate Taxes							520,668	520,668			33
34	Rent-Facility & Grounds			2,958,000	2,958,000		2,958,000	(2,949,108)	8,892			34
35	Rent-Equipment & Vehicles			13,077	13,077		13,077	2,951	16,028			35
36	Other (specify):*							136,474	136,474			36
37	<b>TOTAL Ownership</b>			3,089,589	3,089,589		3,089,589	(614,776)	2,474,813			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			40	40		40		40			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,050	247,050		247,050		247,050			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			247,090	247,090		247,090		247,090			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,705,192	954,761	6,866,000	13,525,953		13,525,953	(994,818)	12,531,135			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 Somerset Place

# 0044289

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	(75,335)	30		9
10	Interest and Other Investment Income	(391,336)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	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				18
19	Entertainment				19
20	Contributions	(19,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(119,033)	21		24
25	Fund Raising, Advertising and Promotional	(13,297)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,020)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,530)	20		28
29	Other-Attach Schedule	(643,769)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,265,459)</b>		<b>\$</b>	<b>30</b>

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)	270,641		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 270,641</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (994,818)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY					
48		49	50	51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Somerset Place

ID# 0044289

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Patient Clothing	\$ (508)	10	1
2	Theft Loss	(1,353)	21	2
3	Collections	(148)	21	3
4	Other Income	(2,672)	21	4
5	Jury Duty	(52)	21	5
6	Non-Allowable Expense	(600,000)	21	6
7	Public Relations	(648)	20	7
8	Annual Report	(300)	20	8
9	Seminar 2008 Not In GL	95	24	9
10	COPE Dues	(6,822)	20	10
11	Professional Fees- Building Co.	(9,300)	19	11
12	Other Fees- Building Co.	(565)	20	12
13	Amortization- Building Co.	(5,562)	36	13
14	Prior Period Expense	(5,134)	21	14
15	Alliance for Living PAC	(10,800)	20	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	<b>Total</b>	(643,769)		49

Somerset Place

ID# 0044289

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 &amp; ID Number Somerset Place

# 0044289

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)	
	<b>A. General Services</b>													
1	Dietary			1,248		9,167	(3,217)	(421)					6,777	1
2	Food Purchase	(39)		1,268									1,229	2
3	Housekeeping			1,238		136		(8,003)					(6,629)	3
4	Laundry													4
5	Heat and Other Utilities			7,524		312	18						7,854	5
6	Maintenance		17,404	9,503	18,348	39	3	(101)					45,196	6
7	Other (specify):*				5,777	1,187							6,964	7
8	<b>TOTAL General Services</b>	<b>(39)</b>	<b>17,404</b>	<b>20,781</b>	<b>24,125</b>	<b>10,841</b>	<b>(3,196)</b>	<b>(8,525)</b>					<b>61,391</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(508)				78,593		(6,552)					71,533	10
10a	Therapy					6,714							6,714	10a
11	Activities													11
12	Social Services					38,982							38,982	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					16,746							16,746	15
16	<b>TOTAL Health Care and Programs</b>	<b>(508)</b>				<b>141,035</b>		<b>(6,552)</b>					<b>133,975</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			5,981	22,303	113,887	254						142,425	17
18	Directors Fees													18
19	Professional Services	(9,300)	9,300	(220,207)		(244,654)	10						(464,851)	19
20	Fees, Subscriptions & Promotions	(53,062)	565	16,544		22	9						(35,922)	20
21	Clerical & General Office Expenses	(730,412)		72,200	347,094	38,686	301			(29,409)			(301,540)	21
22	Employee Benefits & Payroll Taxes				(808)	(670)							(1,478)	22
23	Inservice Training & Education													23
24	Travel and Seminar	95		4,223		484							4,802	24
25	Other Admin. Staff Transportation			3,596			17						3,613	25
26	Insurance-Prop.Liab.Malpractice			2,615		42	21						2,678	26
27	Other (specify):*				55,149	19,647	70						74,866	27
28	<b>TOTAL General Administration</b>	<b>(792,679)</b>	<b>9,865</b>	<b>(115,048)</b>	<b>423,738</b>	<b>(72,556)</b>	<b>682</b>			<b>(29,409)</b>			<b>(575,407)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(793,226)</b>	<b>27,269</b>	<b>(94,267)</b>	<b>447,863</b>	<b>79,320</b>	<b>(2,514)</b>	<b>(15,077)</b>		<b>(29,409)</b>			<b>(380,042)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Somerset Place

# 0044289

Report Period Beginning:

01/01/08

Ending:

Summary B

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	(75,335)	431,701	34,068		2,322	19			20,063			412,838	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(391,336)	1,537,251	93,449		17,315	58			4,664			1,261,401	32
33	Real Estate Taxes		508,537	11,624		507							520,668	33
34	Rent-Facility & Grounds		(2,958,000)	8,831			61						(2,949,108)	34
35	Rent-Equipment & Vehicles			2,945			6						2,951	35
36	Other (specify):*	(5,562)	142,036										136,474	36
37	<b>TOTAL Ownership</b>	<b>(472,233)</b>	<b>(338,475)</b>	<b>150,917</b>		<b>20,144</b>	<b>144</b>			<b>24,727</b>			<b>(614,776)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,265,459)</b>	<b>(311,206)</b>	<b>56,650</b>	<b>447,863</b>	<b>99,464</b>	<b>(2,370)</b>	<b>(15,077)</b>		<b>(4,682)</b>			<b>(994,818)</b>	<b>45</b>

**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		
				Somerset Real Estate, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 2,958,000	Somerset Real Estate, LLC	100.00%	\$	\$ (2,958,000)	1
2	V	32 Interest	5,037	Somerset Real Estate, LLC	100.00%	1,542,288	1,537,251	2
3	V	19 Audit Fee		Somerset Real Estate, LLC	100.00%	9,300	9,300	3
4	V	20 Fees- Other		Somerset Real Estate, LLC	100.00%	565	565	4
5	V	36 Amortization		Somerset Real Estate, LLC	100.00%	5,562	5,562	5
6	V	33 Real Estate Tax		Somerset Real Estate, LLC	100.00%	508,537	508,537	6
7	V	36 MIP Insurance		Somerset Real Estate, LLC	100.00%	136,474	136,474	7
8	V	06 R&M		Somerset Real Estate, LLC	100.00%	17,404	17,404	8
9	V	30 Depreciation		Somerset Real Estate, LLC	100.00%	431,701	431,701	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,963,037			\$ 2,651,831	\$ * (311,206)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289Report 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	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, Inc. / Extended Care Consulting, LLC	100.00%	\$ 1,248	\$ 1,248	15
16	V	02 Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,268	1,268	16
17	V	03 Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,238	1,238	17
18	V	05 Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	7,524	7,524	18
19	V	06 Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	9,503	9,503	19
20	V	17 Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	5,981	5,981	20
21	V	19 Professional Fees	264,716	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	44,509	(220,207)	21
22	V	20 Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	16,544	16,544	22
23	V	21 Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	72,200	72,200	23
24	V	24 Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,223	4,223	24
25	V	25 Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,596	3,596	25
26	V	26 Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,615	2,615	26
27	V	30 Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	34,068	34,068	27
28	V	32 Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	93,449	93,449	28
29	V	33 Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	11,624	11,624	29
30	V	34 Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	8,831	8,831	30
31	V	35 Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,945	2,945	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 264,716			\$ 321,366	\$ * 56,650	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289Report 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	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 Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	18,348	\$	18,348	15
16	V	06 Maintenance (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	5,777		5,777	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%				18
19	V	17 Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	22,303		22,303	19
20	V	21 Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	347,094		347,094	20
21	V	21 Office and Clerical (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%				21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	55,149		55,149	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%				23
24	V								24
25	V	22 Employee Benefits	808	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%			(808)	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		\$ 808			\$ 448,671	\$ *	447,863	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289Report 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%	\$ 136	\$ 136	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	312	312	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	39	39	17	
18	V	19	Professional Fees	248,211	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,557	(244,654)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	22	22	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	598	598	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	484	484	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	42	42	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	2,322	2,322	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	17,315	17,315	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	507	507	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9,167	9,167	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,187	1,187	27	
28	V	10	Nursing Salary	5,623	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	84,216	78,593	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	6,714	6,714	29	
30	V	12	Social Service Salary	1,769	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	40,751	38,982	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	16,746	16,746	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	113,887	113,887	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	38,088	38,088	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	19,647	19,647	34	
35	V								35	
36	V	22	Emp. Ben. - Healthcare	670	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%		(670)	36	
37	V								37	
38	V								38	
39	Total			\$ 256,273			\$ 355,737	\$ * 99,464	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289Report 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	01	Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 157	\$ 157	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%	18	18	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	3	3	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	10	10	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	9	9	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	39	39	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	17	17	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	21	21	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	19	19	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	58	58	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%	61	61	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	6	6	28	
29	V	01	Dietary	5,346	Care Centers Health Systems, Inc.	100.00%	1,972	(3,374)	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		Care Centers Health Systems, Inc.	100.00%			35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	254	254	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	262	262	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	70	70	38	
39	Total			\$ 5,346			\$ 2,976	\$ * (2,370)	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	\$ 4,755	Xcel Supply, LLC	100.00%	\$ 4,334	\$ (421)	15
16	V	3 Housekeeping	90,345	Xcel Supply, LLC	100.00%	82,342	(8,003)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance	1,143	Xcel Supply, LLC	100.00%	1,042	(101)	18
19	V	10 Nursing	73,974	Xcel Supply, LLC	100.00%	67,422	(6,552)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 170,218			\$ 155,140	\$ * (15,077)	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%	\$ 212,717	\$ 212,717	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	212,717	CCS Employee Benefits Group	100.00%		(212,717)	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			\$ 212,717			\$ 212,717	\$ *	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%	\$	\$	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%			17
18	V	26	Insurance		Vent Lease, LLC.	100.00%			18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%			19
20	V	32	Interest		Vent Lease, LLC.	100.00%			20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	20,063	20,063	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	4,664	4,664	22
23	V	21	Office and Clerical	29,409	Vent Lease, LLC.	100.00%		(29,409)	23
24	V	39	Ancillary		Vent Lease, LLC.	100.00%			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			\$ 29,409			\$ 24,727	\$ * (4,682)	39

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

Facility Name & ID Number Somerset Place

# 0044289

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place # 0044289 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	0.00%	See Attached	3.02	6.54%		\$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	4.98	9.05%	Alloc Salary	13,848	17-7	2
3	Adam Vales	Shareholder	Clerical	1.78%	See Attached	1.63	4.08%	Alloc Salary	2,928	22-7	3
4	Kim Rudolph	Shareholder	Clerical	1.78%	See Attached	0.68	4.08%	Alloc Salary	594	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 17,370		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 Somerset Place

# 0044289 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 Somerset Place

# 0044289

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	\$ 148,201	\$ 1,248	1
2	02	Food	Patient Days	1,635,146	31	13,971	148,201	1,268	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	148,201	1,238	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	148,201	7,524	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	148,201	9,503	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	148,201	5,981	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	148,201	44,509	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	148,201	16,544	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	148,201	72,200	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	148,201	4,223	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	148,201	3,596	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	148,201	2,615	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	148,201	34,068	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	148,201	93,449	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	148,201	11,624	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	148,201	8,831	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	148,201	2,945	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 321,366	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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	148,201	18,348	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		148,201	5,777	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015				4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	148,201	22,303	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	148,201	347,094	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305			7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		148,201	55,149	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171				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		\$ 448,671	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289 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 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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 148,201	\$ 136	1	
2	05	Utilities	Patient Days	1,635,146	31	3,449	148,201	312	2	
3	06	Maintenance	Patient Days	1,635,146	31	431	148,201	39	3	
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	148,201	3,557	4	
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	148,201	22	5	
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	148,201	598	6	
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	148,201	484	7	
8	26	Insurance	Patient Days	1,635,146	31	465	148,201	42	8	
9	30	Depreciation	Patient Days	1,635,146	31	25,565	148,201	2,322	9	
10	32	Interest	Patient Days	1,635,146	31	191,164	148,201	17,315	10	
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	148,201	507	11	
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	148,201	9,167	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	148,201	1,187	13	
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	148,201	78,593	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	148,201	6,714	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	148,201	38,982	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	148,201	16,076	17	
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	148,201	113,887	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	148,201	38,088	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	148,201	19,647	20	
21	10	Nursing Salary	Direct Allocation			401,447	401,447	5,623	21	
22	12	Social Service Salary	Direct Allocation			61,016	61,016	1,769	22	
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816		670	23	
24									24	
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 355,737	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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		5,465	157	1
2	03	Housekeeping	Gross Billable Income	31			5,465		2
3	05	Heat and Other Utilities	Gross Billable Income	31	12,529		5,465	18	3
4	06	Maintenance	Gross Billable Income	31	2,136		5,465	3	4
5	19	Professional Fees	Gross Billable Income	31	6,873		5,465	10	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	6,095		5,465	9	6
7	21	Clerical and General Office	Gross Billable Income	31	27,280		5,465	39	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	11,773		5,465	17	8
9	26	Insurance	Gross Billable Income	31	14,568		5,465	21	9
10	30	Depreciation	Gross Billable Income	31	13,298		5,465	19	10
11	32	Interest	Gross Billable Income	31	40,850		5,465	58	11
12	33	Real Estate Taxes	Gross Billable Income	31			5,465		12
13	34	Rent - Building	Gross Billable Income	31	43,000		5,465	61	13
14	35	Rent - Equipment	Gross Billable Income	31	4,135		5,465	6	14
15	01	Dietary	Direct Billable Income	31	102,965		5,346	1,972	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				21
22	17	Administrative	Gross Billable Income	31	179,474	179,474	5,465	254	22
23	21	Clerical and General Office	Gross Billable Income	31	185,549	185,549	5,465	262	23
24	27	Employee Benefits	Gross Billable Income	31	49,573		5,465	70	24
25	TOTALS				\$ 2,134,357	\$ 365,023		\$ 2,976	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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		\$	\$		\$ 4,334	1
2	3	Housekeeping	Direct Allocation					82,342	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation					1,042	4
5	10	Nursing	Direct Allocation					67,422	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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				\$	\$		\$ 155,140	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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		\$	\$		\$ 212,717	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				\$	\$		\$ 212,717	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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 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

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	06	Repairs	Direct Billing	669,310	26	\$ 79,460		\$	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933			2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473			3
4	26	Insurance	Direct Billing	669,310	26	1,630			4
5	30	Depreciation	Direct Billing	669,310	26	264,263			5
6	32	Interest	Direct Billing	669,310	26	44,568			6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	148,201		20,063
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	148,201		4,664
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	\$	\$	24,727

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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 Somerset Place

# 0044289

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

**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		3	4	5	6		8	9	10						
		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	HUD Loan		X	Mortgage			\$	\$ 27,136,952			\$ 1,542,288	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
<b>Working Capital</b>																	
6	Allocated from CCC/ECC		X								17,315	6					
7	Allocated from CCI/ECC		X								93,449	7					
8	See Supplemental Schedule										4,722	8					
9	<b>TOTAL Facility Related</b>						\$	\$ 27,136,952			\$ 1,657,774	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income		X								(391,336)	10					
11	Interest Income- Bldg Co.	X									(5,037)	11					
12												12					
13	See Supplemental Schedule											13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (396,373)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 27,136,952			\$ 1,261,401	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 136,474 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	<b>TOTAL Long-Term</b>											7						
<b>Working Capital</b>																		
8	Allocated from CC Health Sys		X				\$	\$			\$	58						
9	Allocated from Vent Lease, LLC		X									4,664						
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Working Capital</b>											4,722						
<b>B. Non-Facility Related*</b>																		
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	<b>TOTAL Non-Facility Related</b>											20						

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>537,400</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>522,368</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(15,032)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>535,700</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>520,668</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2003	<u>527,647</u>	<u>8</u>			
2004	<u>539,368</u>	<u>9</u>			
2005	<u>563,809</u>	<u>10</u>			
2006	<u>511,830</u>	<u>11</u>			
2007	<u>510,237</u>	<u>12</u>			
<b>2008 Accrual = \$510,237 x 1.05 = \$535,700 (rounded)</b>					
<b>Allocated from CCC/ECC \$507</b>					
<b>Allocated from CCC/ECC \$11,624</b>					
			<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2007	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Somerset Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044289

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>14-08-408-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>498,664.50</u>	\$ <u>498,664.50</u>
2. <u>14-08-408-031-0000</u>	<u>Long Term Care Property</u>	\$ <u>11,572.37</u>	\$ <u>11,572.37</u>
3. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	\$ <u>122,122.75</u>	\$ <u>4,953.62</u>
4. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>29,109.02</u>	\$ <u>2,638.14</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>661,468.64</u>	\$ <u>517,828.63</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 Somerset Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044289

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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 Somerset Place

# 0044289 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 184,000 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 9

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>1999</u>	<u>\$ 1,100,000</u>	1
2	<u>Allocated From CCI/ECC</u>			<u>36,974</u>	2
3	<b>TOTALS</b>			<b>\$ 1,136,974</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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
		<b>Improvement Type**</b>									
9	Various		1999		37,488		20	1,876	1,876	18,092	9
10	Various		2000		615,158		20	31,203	31,203	273,558	10
11	Various		2001		168,415		20	8,424	8,424	66,167	11
12	Various		2002		139,167		20	13,471	13,471	92,385	12
13	Various		2003		74,297		20	6,601	6,601	36,844	13
14	Various		2004		94,863		20	9,070	9,070	42,762	14
15											15
16											16
17											17
18											18
19											19
20											20
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

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		16,081,857	431,701		327,643	(104,058)	2,928,832	67
68		206,211	10,892		10,892		71,081	68
69			118,512			(118,512)		69
70		\$ 17,417,456	\$ 561,105		\$ 409,180	\$ (151,925)	\$ 3,529,721	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Somerset Place

# 0044289

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 17,417,456	\$ 561,105		\$ 409,180	\$ (151,925)	\$ 3,529,721	1
2	Tiles	2005			20				2
3	Inspection Of Outside Walls	2005	20,000		20	2,000	2,000	8,000	3
4	New Governor	2005	3,800		20	380	380	1,520	4
5	Various Hardware Parts	2005	558		20	56	56	223	5
6	Elevator Repairs	2005			20				6
7	Elevator Repairs	2005			20				7
8	Elevator Repairs	2005			20				8
9	Paints	2005	1,064		20	71	71	248	9
10	Architect Tuckpointing	2005	22,500		20	2,250	2,250	8,813	10
11	Boiler Treatment	2005			20				11
12	Scaffold	2005			20				12
13	Toilet Parts	2005			20				13
14	Faucets & Parts	2005			20				14
15	Boiler Repair	2005			20				15
16	Electric Feed For Smoking Room	2005			20				16
17	Smoking Room	2005			20				17
18	Various Supplies	2005	590		20	59	59	226	18
19	Paints	2005	1,763		20	176	176	676	19
20	Heater Repair	2005			20				20
21	Scaffolding For Tuckpointing	2005			20				21
22	Elevator Repair	2005			20				22
23	Elevator Repair	2005			20				23
24	Elevator Recall Project	2005			20				24
25	Paints	2005	2,112		20	141	141	493	25
26	Elevator Repair	2005			20				26
27	Tiles & Adhesive	2005	576		20	58	58	211	27
28	Sewer Work	2005			20				28
29	Air Conditioning Repair	2005			20				29
30	Boiler Repair	2005			20				30
31	South Fire Escape	2005	2,628		20	263	263	898	31
32	Boiler Repairs	2005			20				32
33	Air Conditioners	2005	1,991		20	100	100	340	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,475,038	\$ 561,105		\$ 414,734	\$ (146,371)	\$ 3,551,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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	<b>Totals from Page 12B, Carried Forward</b>		\$ 17,475,038	\$ 561,105		\$ 414,734	\$ (146,371)	\$ 3,551,369	1
2	Kitchen Door	2005	1,783		20	89	89	319	2
3	Laundry Panel - Electrical	2005	1,842		20	92	92	315	3
4	Emergency Lights	2005	3,321		20	166	166	540	4
5	Condensation Pumps	2006	3,801		20	380	380	1,109	5
6	Fire Alarm	2006	4,153		20	242	242	692	6
7	Key Switch Alarm	2006	1,009		20	59	59	168	7
8	Elevator Motor Repair	2006	4,750		20	356	356	792	8
9	Elevator Emergency Signs	2006	5,606		20	420	420	934	9
10	Booster Water System	2006	29,686		20	2,226	2,226	4,949	10
11	Anderson Elevator	2006	3,979		20	298	298	663	11
12	Key Switch Alarm	2006	13,474		20	1,236	1,236	2,246	12
13	Lectro-Loc	2006	10,601		20	972	972	1,767	13
14	2 Boilers	2007	54,828		20	9,488	9,488	16,605	14
15	Remodel Rm #701 Bathroom	2007	12,700		20	1,270	1,270	1,482	15
16	Midwest Mechanical	2007	4,480		20	448	448	485	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	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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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	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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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	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)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	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)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	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)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
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)		\$ 17,631,051	\$ 561,105		\$ 432,476	\$ (128,629)	\$ 3,584,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

# 0044289

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	450		1999	1975	\$ 14,605,934	\$	39	\$ 253,846	\$ 253,846	\$ 2,506,730	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Somerset Real Estate, LLC		1999		586,916		20	29,346	29,346	264,790	9
10	Somerset Real Estate, LLC		2000		13,789		20	690	690	9,021	10
11	Somerset Real Estate, LLC		2003		52,110		20	2,606	2,606	15,640	11
12	Somerset Real Estate, LLC		2004		83,025		20	4,151	4,151	20,611	12
13	Somerset Real Estate, LLC (see attached)		2005		257,649		20	12,882	12,882	51,540	13
14	Somerset Real Estate, LLC (see attached)		2006		312,317		20	15,616	15,616	46,848	14
15	Somerset Real Estate, LLC (see attached)		2007		102,880		20	5,144	5,144	10,290	15
16	Somerset Real Estate, LLC (see attached)		2008		67,237		20	3,362	3,362	3,362	16
17											17
18	Building Company Book Depreciation					431,701			(431,701)		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 Somerset Place

# 0044289

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)	\$	16,081,857	\$	431,701	\$	327,643	\$	(104,058)	\$	2,928,832	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place

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		Allocated from EC/CC Clinical, Inc.	2002	2002	\$ 4,559	\$ 117	39	\$ 117		\$ 735	4
5		Allocated from CCI/ECC - CCI Building	1996	1996	68,105	1,746	39	1,746		21,028	5
6		Allocated from CCI/Extended Care Consulting, LLC	2002	2002	41,089	1,054	39	1,054		6,629	6
7											7
8											8
		Improvement Type**									
9		Allocated from CCI/Extended Care Consulting, LLC		2002	33,943	3,102	20	3,102		15,540	9
10		Allocated from CCI/Extended Care Consulting, LLC		2003	40,001	3,656	20	3,656		18,313	10
11		Allocated from CCI/Extended Care Consulting, LLC		2005	1,987	211	20	211		505	11
12		Allocated from CCI/Extended Care Consulting, LLC		2007	415	21	20	21		48	12
13											13
14		Allocated from CCI/ECC- CCI Building		1996	1,148	-	20	-		1,148	14
15		Allocated from CCI/ECC- CCI Building		1997	6,540	212	20	212		3,323	15
16											16
17		Allocated from CC/EC Clinical, Inc.		2002	3,766	344	20	344		1,724	17
18		Allocated from CC/EC Clinical, Inc.		2003	4,438	406	20	406		2,032	18
19		Allocated from CC/EC Clinical, Inc.		2005	220	23	20	23		56	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 Somerset Place

# 0044289

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)	\$	206,211	\$	10,892	\$	10,892	\$	71,081	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Somerset Place # 0044289 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	\$ 880,863	\$ 39,394	\$ 88,543	\$ 49,149	10	\$ 688,123	71
72	Current Year Purchases	31,947	29	3,194	3,165	10	3,194	72
73	Fully Depreciated Assets	2,281,589				10	2,281,589	73
74								74
75	TOTALS	\$ 3,194,399	\$ 39,423	\$ 91,737	\$ 52,314		\$ 2,972,906	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		VAN	1999	\$ 5,000	\$	\$	\$	5	\$ 5,000	76
77		INSTALL SEATBELTS	2000	780		78	78	5	670	77
78		1995 CADILLAC SEDAN	2004	5,500		902	902	5	4,711	78
79		Al. From CCI/ECC, Clinical, HS	2008	84,585	6,159	6,159		5	7,393	79
80	TOTALS			\$ 95,865	\$ 6,159	\$ 7,139	\$ 980		\$ 17,774	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)	\$ 22,058,289	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 606,687	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 531,352	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (75,335)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,575,115	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

Facility Name & ID Number Somerset Place

# 0044289

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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 CC Health Systems</u>				<u>61</u>			5
6	<u>Allocated from CCI/ECC</u>				<u>8,831</u>			6
7	<b>TOTAL</b>				\$ <b>8,892</b>			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: \$ 16,027

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	<b>TOTAL</b>		\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <a href="#">See Supplemental</a>					40			40	13
14	TOTAL			\$		\$ 40	\$		\$ 40	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 Somerset Place# 0044289Report 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,000	\$ 496,532	1
2	Cash-Patient Deposits	69,260	69,260	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,718,475	3,718,475	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,902	299,485	6
7	Other Prepaid Expenses	33,616	33,616	7
8	Accounts Receivable (owners or related parties)	305,185	815,185	8
9	Other(specify): <u>See Attached Schedule</u>	6,010,797	8,000,742	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 10,231,235	\$ 13,433,295	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,100,000	13
14	Buildings, at Historical Cost		9,900,000	14
15	Leasehold Improvements, at Historical Cost	1,315,335	3,959,325	15
16	Equipment, at Historical Cost	307,056	1,779,124	16
17	Accumulated Depreciation (book methods)	(1,159,698)	(6,700,540)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		194,679	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(31,055)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		13,540,678	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 462,693	\$ 23,742,211	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,693,928	\$ 37,175,506	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,943,955	\$ 2,041,744	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,812	62,812	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	632,693	632,693	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,379	25,379	31
32	Accrued Real Estate Taxes(Sch.IX-B)		535,700	32
33	Accrued Interest Payable		127,770	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	102,038	102,038	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,766,877	\$ 3,528,136	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		27,136,952	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>		2,632,910	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 29,769,862	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,766,877	\$ 33,297,998	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 7,927,051	\$ 3,877,508	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 10,693,928	\$ 37,175,506	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,592,829	1
2	Restatements (describe):		2
3	Pension Expense	(4,979)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,587,850	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	2,339,201	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)	\$ 2,339,201	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 7,927,051	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place# 0044289Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 15,471,219	1
2	Discounts and Allowances for all Levels	(15,393)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 15,455,826	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	15,393	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 15,393	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	391,336	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 391,336	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	2,599	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,599	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,865,154	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,733,881	31
32	Health Care	4,233,773	32
33	General Administration	3,221,620	33
<b>B. Capital Expense</b>			
34	Ownership	3,089,589	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	40	35
36	Provider Participation Fee	247,050	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,525,953	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,339,201	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,339,201	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 Somerset Place

# 0044289

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	1,859	2,039	\$ 74,596	\$ 36.58	1
2	Assistant Director of Nursing	3,735	4,298	143,821	33.46	2
3	Registered Nurses	13,180	14,182	347,090	24.47	3
4	Licensed Practical Nurses	39,085	43,144	1,048,219	24.30	4
5	CNAs & Orderlies	117,941	130,526	1,328,577	10.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,357	3,880	70,680	18.22	9
10	Activity Assistants	17,215	18,604	169,019	9.09	10
11	Social Service Workers	44,368	48,370	731,877	15.13	11
12	Dietician	2,776	3,094	33,641	10.87	12
13	Food Service Supervisor	3,822	4,232	59,390	14.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,122	5,710	59,648	10.45	15
16	Dishwashers	28,595	31,333	278,194	8.88	16
17	Maintenance Workers	33,981	37,531	432,423	11.52	17
18	Housekeepers	42,082	45,766	413,912	9.04	18
19	Laundry	1,807	1,959	16,625	8.49	19
20	Administrator	1,958	2,074	91,295	44.02	20
21	Assistant Administrator	1,840	2,023	42,550	21.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,726	19,056	236,266	12.40	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	3,377	3,929	54,504	13.87	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	10,510	10,569	72,865	6.89	33
34	TOTAL (lines 1 - 33)	394,336	432,319	\$ 5,705,192 *	\$ 13.20	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	427	\$ 19,039	01-03	35
36	Medical Director	Monthly	11,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,403	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	7,200	12-03	45
46	Other(specify) <u>Psychiatrist</u>	26	3,950	10-03	46
47	<u>Care Centers Allocation- See Attached</u>		1,769	12-03	47
48	<u>Care Centers Allocation- See Attached</u>		5,623	10-03	48
49	TOTAL (lines 35 - 48)	453	\$ 55,784		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	173	\$ 6,001	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	173	\$ 6,001		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Somerset Place

# 0044289

Report Period Beginning: 01/01/08

Ending: 12/31/08

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jeremy Boshes	Administrator	0	\$ 91,295	Workers' Compensation Insurance	\$ 160,497	IDPH License Fee	\$ 18,582	
Marc Halpert (01/01-01/10)	Assist. Admin	0	623	Unemployment Compensation Insurance	77,814	Advertising: Employee Recruitment		
Marlon Holcomb	Assist. Admin	0	41,927	FICA Taxes	436,447	Health Care Worker Background Check		
				Employee Health Insurance	256,994	(Indicate # of checks performed 292 )	4,862	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	47,558	
				Chicago Head Tax	7,976	Licenses & Fees	6,300	
				Pension Expense	46,383	Advertising	1,530	
				Other Employee Welfare	17,127	Public Relations	648	
				Holiday Expense	6,654	See Supplemental Schedule	29,872	
				Union Dues	5,000	Less: Public Relations Expense	(648)	
						Non-allowable advertising	(13,297)	
						Yellow page advertising	(1,530)	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)								
\$ 133,845				\$ 1,014,892			\$ 93,877	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			Seminar Expense	
(Attach a copy of any management service agreement)							1,431	
\$							Education	
							3,160	
							Inservices	
							5,112	
							See Supplemental Schedule	
							4,707	
							Entertainment Expense	
							( )	
							(agree to Sch. V, line 24, col. 8)	
							\$ 14,410	
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 597,054								

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Somerset Place

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													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. See Attached
- (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. \$ 673 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. \$ 247,050  
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? N/A
- (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. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT