

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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

I. IDPH Facility ID Number: 0042325

Facility Name: Westshire Nursing & Rehab Center

Address: 5825 West Cermak Road Cicero 60804
 Number City Zip Code

County: Cook

Telephone Number: (708) 656-9120 **Fax #** (708) 656-9128

HFS ID Number: 364096965

Date of Initial License for Current Owners: 09/01/96

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,010</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>411</u>	Intermediate (ICF)	<u>411</u>	<u>150,015</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>485</u>	TOTALS	<u>485</u>	<u>177,025</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>95,809</u>		<u>2,249</u>	<u>98,058</u>	8
9	SNF/PED					9
10	ICF	<u>6,874</u>	<u>3,788</u>		<u>10,662</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>102,683</u>	<u>3,788</u>	<u>2,249</u>	<u>108,720</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.42%

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

None (Do not include bed-hold days in Section B.)

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

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

None

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

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

YES NO

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

YES NO

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

Date started 9/1/96

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

YES Date 9/1/96 NO

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

YES NO If YES, enter number of beds certified 33 and days of care provided 2,249

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number Westshire Nursing & Rehab Center # 0042325 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	563,589	63,188	2,413	629,190		629,190	570	629,760			1
2	Food Purchase		420,724		420,724	(34,456)	386,268	2,880	389,148			2
3	Housekeeping	343,849	83,380		427,229		427,229	(4,588)	422,641			3
4	Laundry	169,638	24,246		193,884		193,884	(149)	193,735			4
5	Heat and Other Utilities			333,192	333,192		333,192	1,661	334,853			5
6	Maintenance	307,205		181,166	488,371		488,371	(10,122)	478,249			6
7	Other (specify):*							2,407	2,407			7
8	TOTAL General Services	1,384,281	591,538	516,771	2,492,590	(34,456)	2,458,134	(7,341)	2,450,793			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500		13,500			9
10	Nursing and Medical Records	3,515,573	208,233	73,054	3,796,860		3,796,860	(14,215)	3,782,645			10
10a	Therapy	198,695		177	198,872		198,872	397	199,269			10a
11	Activities	204,210	14,264	2,450	220,924		220,924		220,924			11
12	Social Services	355,691	3,255	1,674	360,620		360,620		360,620			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							1,973	1,973			15
16	TOTAL Health Care and Programs	4,274,169	225,752	90,855	4,590,776		4,590,776	(11,845)	4,578,931			16
	C. General Administration											
17	Administrative	178,967			178,967		178,967	24,866	203,833			17
18	Directors Fees											18
19	Professional Services			81,804	81,804	(13,750)	68,054	(3,410)	64,644			19
20	Dues, Fees, Subscriptions & Promotions			61,114	61,114		61,114	(18,238)	42,876			20
21	Clerical & General Office Expenses	183,902	40,680	1,676,107	1,900,689		1,900,689	(1,476,417)	424,272			21
22	Employee Benefits & Payroll Taxes			990,983	990,983	34,456	1,025,439	(2,956)	1,022,483			22
23	Inservice Training & Education			572	572		572		572			23
24	Travel and Seminar			5,562	5,562		5,562	3,600	9,162			24
25	Other Admin. Staff Transportation			1,677	1,677		1,677		1,677			25
26	Insurance-Prop.Liab.Malpractice			245,675	245,675		245,675	1,358	247,033			26
27	Other (specify):*							20,392	20,392			27
28	TOTAL General Administration	362,869	40,680	3,063,494	3,467,043	20,706	3,487,749	(1,450,805)	2,036,944			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,021,319	857,970	3,671,120	10,550,409	(13,750)	10,536,659	(1,469,991)	9,066,668			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center #0042325 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			1,049	1,049		1,049	651,755	652,804		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			218,073	218,073		218,073	1,471,335	1,689,408		32
33	Real Estate Taxes					13,750	13,750	793,866	807,616		33
34	Rent-Facility & Grounds			2,794,449	2,794,449		2,794,449	(2,785,032)	9,417		34
35	Rent-Equipment & Vehicles			32,871	32,871		32,871	1,177	34,048		35
36	Other (specify):*							104,954	104,954		36
37	TOTAL Ownership			3,046,442	3,046,442	13,750	3,060,192	238,055	3,298,247		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		171,908	153,233	325,141		325,141	(6,211)	318,930		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			265,538	265,538		265,538		265,538		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		171,908	418,771	590,679		590,679	(6,211)	584,468		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,021,319	1,029,878	7,136,333	14,187,530		14,187,530	(1,238,147)	12,949,383		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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(142)	02		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	105,059	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(146)	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	(4,307)	21		18
19	Entertainment				19
20	Contributions	(1,325)	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	(1,591,593)	21		24
25	Fund Raising, Advertising and Promotional	(20,488)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(143,183)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,656,124)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	417,977		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 417,977		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,238,147)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line
1 Misc. Income	\$ (4,283)	21
2 Jury Duty Income	(15)	10
3 Patient Clothing	(1,199)	10
4 Theft Loss	(48)	21
5 Capitalized R&M	(2,697)	6
6 Non-Allowable Legal	(12,456)	19
7 Amortization of Deferred Maint (page 22)	4,828	6
8 Non-Allowable Professional Fees	(6,200)	19
9 Shareholder Interest	(91,010)	21
10 Building Co. Misc. Admin. Expense	(50)	21
11		11
12		12
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14		14
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100		100
101 Total	(143,183)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			264		3,010	(2,704)						570	1
2	Food Purchase	(288)					2,977		190				2,880	2
3	Housekeeping								(4,588)				(4,588)	3
4	Laundry								(149)				(149)	4
5	Heat and Other Utilities			1,661									1,661	5
6	Maintenance	(17,782)		4,060		3,662	23		(85)				(10,122)	6
7	Other (specify):*				1,099	959	349						2,407	7
8	TOTAL General Services	(18,070)		5,985	1,099	7,631	645		(4,632)				(7,341)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,354)							(12,861)				(14,215)	10
10a	Therapy					397							397	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				1,919	54							1,973	15
16	TOTAL Health Care and Programs	(1,354)			1,919	451			(12,861)				(11,845)	16
	C. General Administration													
17	Administrative			2,722		21,975	169						24,866	17
18	Directors Fees													18
19	Professional Services	(18,656)		15,242			4						(3,410)	19
20	Fees, Subscriptions & Promotions	(21,813)		3,570			5						(18,238)	20
21	Clerical & General Office Expenses	(1,610,281)	50	13,269		120,158	387						(1,476,417)	21
22	Employee Benefits & Payroll Taxes				(2,956)								(2,956)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,466			134						3,600	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,238			120						1,358	26
27	Other (specify):*					20,392							20,392	27
28	TOTAL General Administration	(1,650,750)	50	39,507	(2,956)	162,525	819						(1,450,805)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,670,174)	50	45,492	62	170,607	1,464		(17,493)				(1,469,991)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westshire Nursing & Rehab Center # 0042325 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	105,059	529,329	17,303			64						651,755	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(91,010)	1,559,240	2,889			216						1,471,335	32
33	Real Estate Taxes		792,500	1,366									793,866	33
34	Rent-Facility & Grounds		(2,791,500)	6,468									(2,785,032)	34
35	Rent-Equipment & Vehicles			1,165			12						1,177	35
36	Other (specify):*		104,954										104,954	36
37	TOTAL Ownership	14,049	194,523	29,191			292						238,055	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,612)		(2,599)				(6,211)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(3,612)		(2,599)				(6,211)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,656,124)	194,573	74,683	62	170,607	(1,856)		(20,092)				(1,238,147)	45

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		
				Westshire Healthcare Properties		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	\$ 2,791,500	Westshire Health Care Properties		\$	\$(2,791,500)	1
2	V	32 Interest Income	7,219			1,566,459	1,559,240	2
3	V	21 Misc. Admin. Expense				50	50	3
4	V	30 Depreciation				529,329	529,329	4
5	V	36 Amortization - Mortgage Cost				5,180	5,180	5
6	V	33 Real Estate Tax				792,500	792,500	6
7	V	36 MIP Insurance				99,774	99,774	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,798,719			\$ 2,993,292	\$ * 194,573	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center# 0042325Report Period Beginning: 01/01/05Ending: 12/31/05

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, Inc.	100.00%	\$ 264	\$ 264	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,661	1,661	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	4,060	4,060	17	
18	V				Care Centers, Inc.	100.00%			18	
19	V	17	Administration		Care Centers, Inc.	100.00%	2,722	2,722	19	
20	V	19	Professional Fees		Care Centers, Inc.	100.00%	15,242	15,242	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	3,570	3,570	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	13,269	13,269	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	3,466	3,466	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,238	1,238	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	17,303	17,303	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	2,889	2,889	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,366	1,366	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	6,468	6,468	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,165	1,165	29	
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30	
31	V	02	Food		Care Centers, Inc.	100.00%			31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$			\$ 74,683	\$ * 74,683	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 7,413	Care Centers, Inc.	100.00%	\$ 7,413		15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,099	1,099	16
17	V	10 Nursing Salary	12,162	Care Centers, Inc.	100.00%	12,162		17
18	V	10a Rehab Salary	129	Care Centers, Inc.	100.00%	129		18
19	V							19
20	V							20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,919	1,919	21
22	V	17 Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21 Office Salary		Care Centers, Inc.	100.00%			23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			24
25	V	22 Employee Benefits	2,956	Care Centers, Inc.	100.00%		(2,956)	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		\$ 22,660			\$ 22,722	\$ *	62 39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	01	Dietary Salary	\$	Care Centers, Inc.	100.00%	\$ 3,010	\$ 3,010	15
16	V								16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	3,662	3,662	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	959	959	18
19	V								19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	397	397	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	54	54	21
22	V								22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	21,975	21,975	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	120,158	120,158	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	20,392	20,392	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			\$			\$ 170,607	\$ * 170,607	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	01 Dietary	\$ 5,659	Care Centers, Inc. - Health Systems Division	100.00%	\$ 658	\$ (5,001)	15
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	2,977	2,977	16
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	23	23	17
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	169	169	18
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	4	4	19
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	5	5	20
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	387	387	21
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	134	134	22
23	V	26 Insurance		Care Centers, Inc. - Health Systems Division	100.00%	120	120	23
24	V	30 Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	64	64	24
25	V	32 Interest		Care Centers, Inc. - Health Systems Division	100.00%	216	216	25
26	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	12	12	26
27	V	39 Ancillary Enteral Supplies	7,621	Care Centers, Inc. - Health Systems Division	100.00%	4,009	(3,612)	27
28	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,297	2,297	28
29	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	349	349	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		\$ 13,280			\$ 11,424	\$ * (1,856)	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 BENEFIT GROUP	100.00%	\$ 145,183	\$ 145,183	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	145,183	CCS EMPLOYEE BENEFIT GROUP	100.00%		(145,183)	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			\$ 145,183			\$ 145,183	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	01	DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$	15
16	V	02	FOOD	(1,920)	XCEL MEDICAL SUPPLY, LLC	100.00%	(1,730)	190	16
17	V	03	HOUSEKEEPING	46,273	XCEL MEDICAL SUPPLY, LLC	100.00%	41,686	(4,588)	17
18	V	04	LAUNDRY	1,503	XCEL MEDICAL SUPPLY, LLC	100.00%	1,354	(149)	18
19	V	06	REPAIRS & MAINTENANCE	860	XCEL MEDICAL SUPPLY, LLC	100.00%	774	(85)	19
20	V	10	NURSING	129,725	XCEL MEDICAL SUPPLY, LLC	100.00%	116,864	(12,861)	20
21	V	11	ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	20	DUES, FEES, SUBSCRIPTIONS & PROM		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY	26,215	XCEL MEDICAL SUPPLY, LLC	100.00%	23,616	(2,599)	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			\$ 202,656			\$ 182,564	\$ * (20,092)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Westshire Nursing & Rehab Center # 0042325 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	9.60%	See Attached	0.89	1.93%	Allocation	\$ 2,144	17-7	1
2	Gale Rothner	Owner	Administrative	31.00%	See Attached	0.98	2.80%	Allocation	2,189	17-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.54	2.80%	Allocation	2,065	17-7	3
4	Adam Vales	Relative	Clerical	0.00%	See Attached	0.96	2.40%	Allocation	1,183	22-7	4
5	Kimberly Rudolph	Relative	Clerical	0.00%	See Attached	0.86	2.46%	Allocation	1,148	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,729		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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers, Inc.
 Street Address _____
 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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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.
 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	1,497,287	32	\$ 9,406	\$ 42,018	\$ 264	1
2	05	Utilities	Patient Days	1,497,287	32	59,188	42,018	1,661	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661	42,018	4,060	3
4									4
5	17	Administration	Patient Days	1,497,287	32	97,000	42,018	2,722	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148	42,018	15,242	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217	42,018	3,570	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845	42,018	13,269	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511	42,018	3,466	9
10	26	Insurance	Patient Days	1,497,287	32	44,126	42,018	1,238	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575	42,018	17,303	11
12	32	Interest	Patient Days	1,497,287	32	102,930	42,018	2,889	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662	42,018	1,366	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488	42,018	6,468	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530	42,018	1,165	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,661,288	\$	\$ 74,683	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending: 12/31/05

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.
 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 Salary	Direct Cost		301,710	301,710		7,413	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost		46,639			1,099	2
3	10	Nursing Salary	Direct Cost		425,833	425,833		12,162	3
4	10a	Rehab Salary	Direct Cost		55,464	55,464		129	4
5									5
6									6
7	15	Emp. Ben. - Healthcare	Direct Cost		67,757			1,919	7
8	17	Administration Salary	Direct Cost		5,566	5,566			8
9	21	Office Salary	Direct Cost		419,879	419,879			9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost		71,906				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				\$ 1,394,755	\$ 1,208,453		\$ 22,722	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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.
 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 Salary	Patient Days	1,497,287	32	107,276	107,276	42,018	3,010	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	42,018	3,662	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		42,018	959	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	42,018	397	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		42,018	54	7
8										8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	42,018	21,975	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	42,018	120,158	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		42,018	20,392	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					\$ 6,079,517	\$ 5,316,753		\$ 170,607	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending: 12/31/05

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.
 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	Billable Income	928,452		46,000	13,280	658	1
2	02	Food	Income			160,931		2,977	2
3	06	Maintenance	Billable Income	928,452		1,614	13,280	23	3
4	17	Administration	Billable Income	928,452		11,797	13,280	169	4
5	19	Professional Fees	Billable Income	928,452		262	13,280	4	5
6	20	Dues & Subscriptions	Billable Income	928,452		342	13,280	5	6
7	21	Office & Clerical	Billable Income	928,452		27,087	13,280	387	7
8	24	Travel & Seminar	Billable Income	928,452		9,381	13,280	134	8
9	26	Insurance	Billable Income	928,452		8,379	13,280	120	9
10	30	Depreciaton	Billable Income	928,452		4,499	13,280	64	10
11	32	Interest	Billable Income	928,452		15,077	13,280	216	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843	13,280	12	12
13	39	Ancillary Enteral Supplies	Income			327,517		4,009	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	2,297	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382	13,280	349	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 798,679	\$ 160,568	\$ 11,424	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 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		\$	\$		145,183	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				\$	\$		145,183	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 MEDICAL SUPPLY, LLC
 Street Address 2201 W. 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	01	DIETARY	Direct Allocation		\$	\$		\$	1
2	02	FOOD	Direct Allocation					(1,730)	2
3	03	HOUSEKEEPING	Direct Allocation					41,686	3
4	04	LAUNDRY	Direct Allocation					1,354	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					774	5
6	10	NURSING	Direct Allocation					116,864	6
7	11	ACTIVITIES	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation					23,616	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				\$	\$		\$ 182,564	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning: 01/01/05

Ending: 12/31/05

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			
A. Directly Facility Related																	
Long-Term																	
1	HUD		X	Mortgage			\$	\$ 19,874,694			\$ 1,566,459	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
Working Capital																	
6	First Bank		X	Working Capital				1,796,681			89,649	6					
7	Bank Leumi USA		X	Working Capital				430,000			24,672	7					
8	See Supplemental Schedule							1,857,010			15,847	8					
9	TOTAL Facility Related						\$	\$ 23,958,385			\$ 1,696,627	9					
B. Non-Facility Related*																	
10	Interest Income (Bldg Co)										(7,219)	10					
11												11					
12												12					
13	See Supplemental Schedule											13					
14	TOTAL Non-Facility Related						\$	\$			(7,219)	14					
15	TOTALS (line 9+line14)						\$	\$ 23,958,385			\$ 1,689,408	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 99,774 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 Westshire Nursing & Rehab Center # 0042325 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Shareholder Interest	X		Working Capital			\$	\$ 1,857,010			\$ 91,010	8
9	Adjust Shareholder Interest	X									(91,010)	9
10	Allocated from Care Centers		X								3,105	10
11	CIB Bank		X	Working Capital							12,528	11
12	Patient Trust Fund		X								214	12
13												13
14	TOTAL Working Capital							1,857,010			15,847	14
	B. Non-Facility Related*											
15							\$	\$			\$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westshire Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042325

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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-29-202-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>105,754.52</u>	\$ <u>105,754.52</u>
2. <u>16-29-202-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>105,754.52</u>	\$ <u>105,754.52</u>
3. <u>16-29-202-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>211,509.04</u>	\$ <u>211,509.04</u>
4. <u>16-29-202-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>120,308.22</u>	\$ <u>120,308.22</u>
5. <u>16-29-202-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>211,401.30</u>	\$ <u>211,401.30</u>
6. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>113,458.70</u>	\$ <u>1,365.60</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>868,186.30</u>	\$ <u>756,093.20</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westshire Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042325

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 2004 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 2004.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 130,527 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories _____

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>1996</u>	<u>\$ 120,000</u>	1
2	<u>2201 Main LLC Allocation</u>		<u>2002</u>	<u>9,870</u>	2
3	TOTALS			\$ 129,870	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1996	3,490		20	175	175	887	9
10	Various			1997	58,633		20	2,932	2,932	14,268	10
11	Various			1998	73,844		20	3,692	3,692	16,293	11
12	Various			1999	19,521		20	976	976	3,752	12
13	Various			2000	37,266		20	1,863	1,863	8,018	13
14	Various			2001	53,553		20	2,678	2,678	9,574	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		19,706,384	529,329		507,645	(21,684)	4,742,238	67
68		38,734	1,588		1,588		4,784	68
69			1,049			(1,049)		69
70		\$ 19,991,425	\$ 531,966		\$ 521,548	\$ (10,418)	\$ 4,799,813	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 19,991,425	\$ 531,966		\$ 521,548	\$ (10,418)	\$ 4,799,813	1
2	Re-Wire Fire Alarm System	2002	4,645		20	232	232	662	2
3	Hot Water Boiler	2002	9,448		20	472	472	1,346	3
4	Lobby Air Conditioning And Compressor	2002	7,594		20	380	380	1,082	4
5	Insulated Glass	2002	3,275		20	164	164	467	5
6	Door Replacement	2002	4,490		20	225	225	639	6
7	Pumps	2002	3,721		20	186	186	529	7
8	Piping, Ball Valve, And Fittings	2002	5,491		20	275	275	783	8
9	Hot Water Heater	2002	2,000		20	100	100	285	9
10	Windows And Doors	2003	27,230		20	1,362	1,362	2,888	10
11	Heating & Cooling Chassis	2003	7,142		20	357	357	758	11
12	Door Alarm	2003	1,515		20	76	76	161	12
13	Tiling	2003	2,328		20	116	116	247	13
14	A/C Condensor	2005	1,750		20	88	88	88	14
15	Concrete	2005	1,575		20	79	79	79	15
16	Replace Ball Valves	2005	2,836		20	142	142	142	16
17	Replace Compressor	2005	4,350		20	218	218	218	17
18	Circulating Pump	2005	2,464		20	123	123	123	18
19	Compressor Installation	2005	1,760		20	88	88	88	19
20	Glass Insulating Units	2005	2,112		20	106	106	106	20
21	Fire Alarm Repair	2005	1,600		20	80	80	80	21
22	Call System	2005	5,307		20	265	265	265	22
23	Call System	2005	938		20	47	47	47	23
24	Blue Prints	2005	3,347		20	167	167	167	24
25	Hvac Repairs	2005	951		20	48	48	48	25
26	Paint Rooms	2005	10,000		20	500	500	500	26
27	5Th Floor Rehab	2005	14,518		20	726	726	726	27
28	Passenger Elevator	2005	21,900		20	1,095	1,095	1,095	28
29	Paint Rooms	2005	10,000		20	500	500	500	29
30	Modernize 3 Elevators	2005	197,100		20	9,855	9,855	9,855	30
31	Alarm Repair	2005	3,652		20	183	183	183	31
32	Paint 5Th Floor	2005	6,000		20	300	300	300	32
33	Blinds For 5Th Floor	2005	4,810		20	241	241	241	33
34	TOTAL (lines 1 thru 33)		\$ 20,367,274	\$ 531,966		\$ 540,341	\$ 8,375	\$ 4,824,508	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 20,367,274	\$ 531,966		\$ 540,341	\$ 8,375	\$ 4,824,508	1
2	Handrails / Bumpers 5Th Floor	2005	7,433		20	372	372	372	2
3	Overbed Light	2005	128		20	6	6	6	3
4	Overbed Light	2005	7,157		20	358	358	358	4
5	Permits For Elevator Modernization	2005	2,517		20	126	126	126	5
6	Locks	2005	1,112		20	56	56	56	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)		\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	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		\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
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21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425		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)	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425		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)	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	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		\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425	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)	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425		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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
1		\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425	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)	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425		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)	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
1		\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425	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)	\$ 20,385,621	\$ 531,966		\$ 541,258	\$ 9,292	\$ 4,825,425	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	485		1996	1974	\$ 19,609,780	\$ 524,499	39	\$ 502,815	\$ (21,684)	\$ 4,734,840	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Hot Water Heaters			2004	22,404	1,120	20	1,120		1,960	9
10	Vertical Pumps			2004	5,860	293	20	293		501	10
11	New Conduit			2004	3,160	158	20	158		270	11
12	Plumbing			2004	15,337	767	20	767		1,310	12
13	Compressor			2004	11,023	551	20	551		850	13
14	Elevator Door			2004	38,820	1,941	20	1,941		2,507	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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)	\$	\$ 19,706,384		\$ 507,645	\$ (21,684)	\$ 4,742,238	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	Allocation from 2201 Main LLC		2002	2002	\$ 13,601	\$ 349	39	\$ 349	\$	\$ 1,148	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Allocation from 2201 Main LLC			2002	11,235	562	20	562		1,966	9
10	Allocation from 2201 Main LLC			2003	13,240	662	20	662		1,655	10
11	Allocation from 2201 Main LLC			2005	658	15	20	15		15	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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)	\$	\$		\$	\$	\$	70
		38,734	1,588		1,588		4,784	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Center # 0042325 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 975,760	\$ 14,116	\$ 104,544	\$ 90,428	10	\$ 707,444	71
72	Current Year Purchases	63,244	275	5,614	5,339	10	5,614	72
73	Fully Depreciated Assets	1,455,000				10	1,455,000	73
74								74
75	TOTALS	\$ 2,494,004	\$ 14,391	\$ 110,158	\$ 95,767		\$ 2,168,058	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		Care Centers Allocation		\$ 18,950	\$ 1,388	\$ 1,388		5	\$ 14,350	76
77										77
78										78
79										79
80	TOTALS			\$ 18,950	\$ 1,388	\$ 1,388			\$ 14,350	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)		\$ 23,028,446	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 547,745	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 652,804	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 105,059	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 7,007,833	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Off Site Storage				2,949			5
6	Allocated from Care Centers				6,468			6
7	TOTAL				\$ 9,417			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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 20,716 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	Resident Transport.	GMAC Van	\$	11,823	17
18	Administration	Jaquar		1,509	18
19					19
20					20
21	TOTAL		\$	13,332	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 69,024	\$		\$ 69,024	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			161			161	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			84,048			84,048	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				81,466		81,466	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						90,442		90,442	13
14	TOTAL			\$		\$ 153,233	\$ 171,908		\$ 325,141	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 Westshire Nursing & Rehab Center# 0042325Report Period Beginning: 01/01/05

Ending:

12/31/05**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,081	\$ 6,384	1
2	Cash-Patient Deposits	124,601	124,601	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,355,055	1,485,055	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	211,023	211,023	6
7	Other Prepaid Expenses	20,415	82,616	7
8	Accounts Receivable (owners or related parties)	410,952	410,952	8
9	Other(specify): <u>See Attached Schedule</u>	241,592	1,495,548	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,365,719	\$ 3,816,179	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		120,000	13
14	Buildings, at Historical Cost		19,609,780	14
15	Leasehold Improvements, at Historical Cost	377,062	473,666	15
16	Equipment, at Historical Cost	1,343,790	1,343,790	16
17	Accumulated Depreciation (book methods)	(1,028,075)	(5,770,313)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		175,705	23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 692,777	\$ 15,952,628	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,058,496	\$ 19,768,807	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,274,121	\$ 1,310,108	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	105,287	105,287	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,129	204,129	30
	Accrued Taxes Payable (excluding real estate taxes)	8,959	8,959	31
32	Accrued Real Estate Taxes(Sch.IX-B)		792,500	32
33	Accrued Interest Payable		130,014	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	3,811	135,776	36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,596,307	\$ 2,686,773	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,083,691	4,083,691	39
40	Mortgage Payable		19,874,694	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,083,691	\$ 23,958,385	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,679,998	\$ 26,645,158	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,621,502)	\$ (6,876,351)	47
	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,058,496	\$ 19,768,807	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (867,207)	1
2	Restatements (describe):		2
3	Post Closing Entries	965,614	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 98,407	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,719,909)	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)	\$ (2,719,909)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,621,502)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center# 0042325Report Period Beginning: 01/01/05Ending: 12/31/05**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,367,923	1
2	Discounts and Allowances for all Levels	(466,278)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,901,645	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	466,638	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 466,638	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	142	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,361	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,416	19
20	Radiology and X-Ray	1,320	20
21	Other Medical Services	1,657	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 84,896	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	14,442	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,442	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,467,621	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,492,590	31
32	Health Care	4,590,776	32
33	General Administration	3,467,043	33
B. Capital Expense			
34	Ownership	3,046,442	34
C. Ancillary Expense			
35	Special Cost Centers	325,141	35
36	Provider Participation Fee	265,538	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,187,530	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,719,909)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,719,909)	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 Westshire Nursing & Rehab Center

0042325

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,010	2,426	\$ 78,607	\$ 32.40	1
2	Assistant Director of Nursing	1,833	2,291	66,073	28.84	2
3	Registered Nurses	23,551	26,315	679,017	25.80	3
4	Licensed Practical Nurses	42,570	48,159	1,056,403	21.94	4
5	CNAs & Orderlies	131,895	142,999	1,527,995	10.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,031	11,231	198,695	17.69	8
9	Activity Director	1,790	2,891	46,287	16.01	9
10	Activity Assistants	15,031	16,513	157,923	9.56	10
11	Social Service Workers	21,077	23,926	355,691	14.87	11
12	Dietician	2,441	2,720	49,205	18.09	12
13	Food Service Supervisor	2,773	3,325	79,540	23.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,155	6,931	85,502	12.34	15
16	Dishwashers	36,344	39,574	349,342	8.83	16
17	Maintenance Workers	24,119	26,710	307,205	11.50	17
18	Housekeepers	34,050	36,974	343,849	9.30	18
19	Laundry	14,504	15,918	169,638	10.66	19
20	Administrator	2,235	2,977	162,423	54.56	20
21	Assistant Administrator	924	983	16,544	16.83	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,507	11,187	183,902	16.44	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	4,397	4,874	70,029	14.37	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,645	3,056	37,449	12.25	33
34	TOTAL (lines 1 - 33)	389,882	431,980	\$ 6,021,319 *	\$ 13.94	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	48	\$ 2,413	01-03	35
36	Medical Director	15	13,500	09-03	36
37	Medical Records Consultant	monthly	4,463	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	5,789	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	49	2,450	11-03	44
45	Social Service Consultant	17	924	12-03	45
46	Other(specify) <u>Therapy Consult</u>	1	48	10A-03	46
47	<u>Psycho-Social</u>	weekly	750	12-03	47
48	<u>CCI - see attached</u>		12,291	various	48
49	TOTAL (lines 35 - 48)	130	\$ 42,628		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	111	\$ 5,621	10-03	50
51	Licensed Practical Nurses	1,242	45,019	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,353	\$ 50,640		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

Report Period Beginning: 01/01/05 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 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	Painting / Decorating	6/00	\$ 3,547	3	\$ 1,182	\$ 592							
2	Painting / Decorating	6/03	3,249	3		541	1,083	1,083	542				
3	Painting / Decorating	6/04	22,452	3			7,484	3,742	3,742	7,484			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 29,248		\$ 1,182	\$ 1,133	\$ 8,567	\$ 4,825	\$ 4,284	\$ 7,484	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Center

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,517 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. \$ 265,538
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 34,456 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 142
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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