

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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: 0035048

Facility Name: Lake Shore Healthcare & Rehabilitation Ctr

Address: 7200 North Sheridan Road Chicago 60626
 Number City Zip Code

County: Cook

Telephone Number: (773) 973-7200 **Fax #** (773) 973-7724

HFS ID Number: 36-3690679

Date of Initial License for Current Owners: 28th July 1992

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 checked="" 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 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: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2006 to 31-Dec-2006 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) _____ 29th March 2007
 (Date)

(Type or Print Name) Christopher Vicere

(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () _____ Fax # () _____

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr# 0035048 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>313</u>	Skilled (SNF)	<u>313</u>	<u>114,245</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>313</u>	TOTALS	<u>313</u>	<u>114,245</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>36,178</u>	<u>2,023</u>	<u>12,260</u>	<u>50,461</u>	8
9	SNF/PED					9
10	ICF	<u>28,324</u>	<u>1,478</u>	<u>245</u>	<u>30,047</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>64,502</u>	<u>3,501</u>	<u>12,505</u>	<u>80,508</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 70.47%

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)

NoneF. Does the facility maintain a daily midnight census? YesG. 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 1st March 1989

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

YES Date 28th July 1992 NO

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

YES NO If YES, enter number
of beds certified 313 and days of care provided 9,632Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 31st Dec 2006 Fiscal Year: 31st Dec 2006

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr # 0035048 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	114,245	114,245	114,245	342,735		342,735		342,735			1
2	Food Purchase		457,607		457,607	(37,548)	420,059	(191)	419,868			2
3	Housekeeping	310,345	183,596		493,941		493,941		493,941			3
4	Laundry	224,858	58,321	1,160	284,339		284,339		284,339			4
5	Heat and Other Utilities			427,693	427,693		427,693		427,693			5
6	Maintenance	166,881	76,263	307,462	550,606		550,606	3,900	554,506			6
7	Other (specify):*											7
8	TOTAL General Services	816,329	890,032	850,560	2,556,921	(37,548)	2,519,373	3,709	2,523,082			8
	B. Health Care and Programs											
9	Medical Director			55,500	55,500		55,500		55,500			9
10	Nursing and Medical Records	4,736,732	503,756	381,174	5,621,662		5,621,662		5,621,662			10
10a	Therapy			9,810	9,810		9,810		9,810			10a
11	Activities	179,913	74,255		254,168		254,168		254,168			11
12	Social Services	169,630	5,382		175,012		175,012		175,012			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* *Dental Service**			6,972	6,972		6,972		6,972			15
16	TOTAL Health Care and Programs	5,086,275	583,393	453,456	6,123,124		6,123,124		6,123,124			16
	C. General Administration											
17	Administrative	195,932		499,548	695,480		695,480	(282,842)	412,638			17
18	Directors Fees											18
19	Professional Services			34,792	34,792		34,792	25,702	60,494			19
20	Dues, Fees, Subscriptions & Promotions			84,986	84,986		84,986	(60,672)	24,314			20
21	Clerical & General Office Expenses	182,199	62,113	71,679	315,991		315,991	108,022	424,013			21
22	Employee Benefits & Payroll Taxes			1,109,342	1,109,342	37,548	1,146,890	17,232	1,164,122			22
23	Inservice Training & Education			4,464	4,464		4,464	3,969	8,433			23
24	Travel and Seminar			6,412	6,412		6,412	6,423	12,835			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			19,088	19,088		19,088		19,088			26
27	Other (specify):* *Payroll Taxes (Sch VII)							35,624	35,624			27
28	TOTAL General Administration	378,131	62,113	1,830,311	2,270,555	37,548	2,308,103	(146,542)	2,161,561			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,280,735	1,535,538	3,134,327	10,950,600		10,950,600	(142,833)	10,807,767			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			65,250	65,250		65,250	360,130	425,380			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,096	43,096		43,096	249,203	292,299			32
33	Real Estate Taxes			402,783	402,783		402,783		402,783			33
34	Rent-Facility & Grounds			844,676	844,676		844,676	(840,000)	4,676			34
35	Rent-Equipment & Vehicles			2,180	2,180		2,180		2,180			35
36	Other (specify):*											36
37	TOTAL Ownership			1,357,985	1,357,985		1,357,985	(230,667)	1,127,318			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		923,600	1,071,211	1,994,811		1,994,811		1,994,811			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,368	171,368		171,368		171,368			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		923,600	1,242,579	2,166,179		2,166,179		2,166,179			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,280,735	2,459,138	5,734,891	14,474,764		14,474,764	(373,500)	14,101,264			45

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr

0035048

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

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				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	(58,773)	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	(191)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,987)	24		19
20	Contributions	(5,067)	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	(1,268)	21		24
25	Fund Raising, Advertising and Promotional	(108,443)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,200)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule ** Page 5A attached **	3,900	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (173,029)		\$	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)	(200,471)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (200,471)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (373,500)		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

BHF USE ONLY						
48		49		50		51
						52

Lake Shore Healthcare & Rehabilitation Ctr

ID# 0035048

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance Expenses (incurred in 2006)	\$ (2,558)	6 1
2	Deferred Maintenance Exps (allocated for 2006)	6,458	6 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			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	3,900	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr

0035048

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(191)	0	0	0	0	0	0	0	0	0	0	(191)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	3,900	0	0	0	0	0	0	0	0	0	0	3,900	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	3,709	0	0	0	0	0	0	0	0	0	0	3,709	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(282,842)	0	0	0	0	0	0	0	0	0	(282,842)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,702	0	0	0	0	0	0	0	0	0	25,702	19
20	Fees, Subscriptions & Promotions	(113,510)	52,838	0	0	0	0	0	0	0	0	0	(60,672)	20
21	Clerical & General Office Expenses	(2,468)	109,290	1,200	0	0	0	0	0	0	0	0	108,022	21
22	Employee Benefits & Payroll Taxes	0	17,232	0	0	0	0	0	0	0	0	0	17,232	22
23	Inservice Training & Education	0	3,969	0	0	0	0	0	0	0	0	0	3,969	23
24	Travel and Seminar	(1,987)	8,410	0	0	0	0	0	0	0	0	0	6,423	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	35,624	0	0	0	0	0	0	0	0	0	35,624	27
28	TOTAL General Administration	(117,965)	(29,777)	1,200	0	(146,542)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(114,256)	(29,777)	1,200	0	(142,833)	29							

STATE OF ILLINOIS

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr

0035048

Report Period Beginning:

1-Jan-2006 Ending:

Summary B
31-Dec-2006

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	(58,773)	1,217	417,686	0	0	0	0	0	0	0	0	360,130	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(28,953)	278,156	0	0	0	0	0	0	0	0	249,203	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(840,000)	0	0	0	0	0	0	0	0	(840,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(58,773)	(27,736)	(144,158)	0	(230,667)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(173,029)	(57,513)	(142,958)	0	(373,500)	45							

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

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	17 Management Fee Income	\$ 499,548	Lancaster, Ltd.	100.00%	\$	\$ (499,548)	1
2	V	17 Officers' Salary		Lancaster, Ltd.	100.00%	96,197	96,197	2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	25,702	25,702	3
4	V	21 Clerical Expenditures		Lancaster, Ltd.	100.00%	109,290	109,290	4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	17,232	17,232	5
6	V	24 Seminars and Travel		Lancaster, Ltd.	100.00%	8,410	8,410	6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	120,509	120,509	7
8	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	51,719	51,719	8
9	V	32 Interest	30,984	Lancaster, Ltd.	100.00%	2,031	(28,953)	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	1,217	1,217	10
11	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	1,119	1,119	11
12	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	35,624	35,624	12
13	V	23 Education and Inservice		Lancaster, Ltd.	100.00%	3,969	3,969	13
14	Total		\$ 530,532			\$ 473,019	\$ * (57,513)	14

* 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	34 Rental Income	\$ 840,000	Lake Shore Associates		\$	(840,000)	15
16	V	30 Depreciation		Lake Shore Associates		417,686	417,686	16
17	V	32 Interest	12,112	Lake Shore Associates		290,268	278,156	17
18	V	21 State Replacement Tax		Lake Shore Associates		1,200	1,200	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		\$ 852,112			\$ 709,154	\$ * (142,958)	39

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr # 0035048 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	Christopher Vicere	VP-Finance	Administrative		See attached	13	27.08	Lancaster	\$ 48,155	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	13	27.08	Lancaster	48,042	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 96,197		13

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr # 0035048 Report Period Beginning: 1-Jan-2006 Ending: -Dec-2006

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 Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road,
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773) 604-4416
 Fax Number (773) 478-1192

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	17	Christopher Vicere	Hours Worked	48	7	\$ 177,802	\$ 177,802	13	\$ 48,155	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,454		13	2,560	2
3	17	Cheryl Morris	Hours Worked	48	7	177,385	177,385	13	48,042	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,436		13	2,556	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,146,620	7	110,443		499,548	25,702	13
14	21	Clerical Expenses	Management Fees	2,146,620	7	469,632	428,989	499,548	109,290	14
15	22	Employee Benefits	Management Fees	2,146,620	7	74,046		499,548	17,232	15
16	24	Seminars & Travel	Management Fees	2,146,620	7	36,138		499,548	8,410	16
17	17	Administrative Consulting	Management Fees	2,146,620	7	517,841	471,840	499,548	120,509	17
18	20	Marketing and Fees	Management Fees	2,146,620	7	222,241	180,200	499,548	51,719	18
19	32	Interest	Management Fees	2,146,620	7	8,729		499,548	2,031	19
20	30	Depreciation	Management Fees	2,146,620	7	5,231		499,548	1,217	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,146,620	7	4,809		499,548	1,119	21
22	27	Payroll Taxes	Management Fees	2,146,620	7	131,096		499,548	30,508	22
23	23	Education & Inservice	Management Fees	2,146,620	7	17,054		499,548	3,969	23
24	32	*Direct Interest*								24
25	TOTALS					\$ 1,971,337	\$ 1,436,216		\$ 473,019	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	JP Morgan Chase Bank		X	Commercial Loan	\$30,000.00	5/1/02	\$ 7,200,000	\$ 5,970,000		4.8900%	\$ 290,268	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	JP Morgan Chase Bank		X	Working Capital							2,031	6								
7												7								
8												8								
9	TOTAL Facility Related				\$30,000.00		\$ 7,200,000	\$ 5,970,000			\$ 292,299	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 7,200,000	\$ 5,970,000			\$ 292,299	15								

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 406,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 402,783	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (3,717)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 406,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 402,783	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	427,029	8
	2002	431,817	9
	2003	390,059	10
	2004	398,723	11
	2005	402,783	12
** Accrual is based on 2005 actual Taxes, adjusted for inflation**			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehabilitation Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 35048

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604 - 4416 FAX #: (773) 478 - 1192

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>11-29-320-035-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>26,612.28</u>	\$ <u>26,612.28</u>
2. <u>11-29-320-036-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>87,209.86</u>	\$ <u>87,209.86</u>
3. <u>11-29-320-037-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>87,687.62</u>	\$ <u>87,687.62</u>
4. <u>11-29-320-038-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>87,687.62</u>	\$ <u>87,687.62</u>
5. <u>11-29-320-039-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>87,498.56</u>	\$ <u>87,498.56</u>
6. <u>11-29-320-040-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>26,087.15</u>	\$ <u>26,087.15</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>402,783.09</u>	\$ <u>402,783.09</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,769 B. General Construction Type: Exterior Brick 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			1992	\$ 740,000	1
2					2
3	TOTALS			\$ 740,000	3

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr

0035048

Report Period Beginning:

1-Jan-2006 Ending: 31-Dec-2006

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	313		1992		\$ 11,667,460	\$ 370,396	40	\$ 291,687	\$ (78,709)	\$ 4,229,462	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1989		24,908		10			24,908	9
10	Various		1990		80,814		10			80,814	10
11	Various		1991		28,469	3,277	20	1,112	(2,165)	23,785	11
12	Various		1992		12,856	408	20	643	235	9,286	12
13	Various		1993		68,862	1,789	20	3,444	1,655	46,489	13
14	Various		1994		5,698	146	20	286	140	3,665	14
15	Various		1995		76,433	1,767	20	3,822	2,055	44,754	15
16	Fire Alarm System		1996		54,450	1,396	20	2,723	1,327	29,953	16
17	Seamco Stone Deck		1996		7,989	205	20	399	194	4,123	17
18	Roof Exhauster		1996		2,700	69	20	135	66	1,372	18
19	Front Sign		1996		12,020	710	20	601	(109)	6,160	19
20	Water Heating System		1997		38,800	995	20	1,940	945	19,077	20
21	Fluorescent Conversion		1997		25,353	650	20	1,268	618	12,363	21
22	Elevator Improvement		1998		55,364	1,420	20	1,420		12,248	22
23	Electronic Alzheimer Doors		1998		11,800	303	20	303		2,512	23
24	Elevator Interiors		1999		34,422	883	20	883		6,512	24
25	Parking Lot Resurface		1999		20,240	1,195	20	1,195		10,828	25
26	Patio Stone Decking		1999		6,465	382	20	382		3,555	26
27	Electric Panel Board		2002		5,000	128	10	500	372	2,167	27
28	Parking Lot Fence		2003		19,707	759	10	1,314	555	4,763	28
29	Hand Rail System		2005		5,968	153	10	597	444	1,045	29
30	Wood Flooring		2005		4,248	109	10	425	316	744	30
31	Concrete Patio Porch		2005		8,603	221	10	860	639	1,434	31
32	Piping For Hot Water System		2005		11,900	305	10	1,190	885	1,884	32
33	Eclipse Gas Booster		2005		9,000	231	10	900	669	1,425	33
34	Wallguards		2005		2,519	65	10	252	187	378	34
35	Electrical Sub Panel		2005		3,370	86	10	337	251	477	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Concrete Work at Drain	2005	\$ 1,595	\$ 41	10	\$ 160	\$ 119	\$ 213	37
38	Heaters in Outdoor Patio	2005	2,850	73	10	285	212	333	38
39	Junction Box - Fire Panel	2005	780	20	10	78	58	91	39
40	Electricals for 12 Bedrooms	2005	1,600	41	10	160	119	187	40
41	Electricals for 6 Bedrooms	2005	800	21	10	80	59	87	41
42	Switches & Lights for 34 Rooms	2006	2,805	69	10	281	212	281	42
43	Install 28 Wall Sconces	2006	3,150	71	10	289	218	289	43
44	Line & Outlets - Garden Room	2006	3,580	73	10	298	225	298	44
45	Drilling Elevator Hole	2006	29,392	598	10	2,449	1,851	2,449	45
46	Overhaul & Install Elevator	2006	47,986	976	10	3,999	3,023	3,999	46
47	3 New Doors	2006	450	7	10	30	23	30	47
48	Custom Size Fire Door	2006	1,511	24	10	101	77	101	48
49	2 Stainless Steel Doors for Walk-in Freezer	2006	4,620	64	10	270	206	270	49
50	Renovation of 1st Floor & building new Town Square	2006	368,254	8,275	10	8,275		8,275	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,774,791	\$ 398,401		\$ 335,373	\$ (63,028)	\$ 4,603,086	70

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr # 0035048 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	\$ 602,280	\$ 29,403	\$ 39,075	\$ 9,672	5	\$ 77,071	71
72	Current Year Purchases	237,978	47,597	44,379	(3,218)	5	44,379	72
73	Fully Depreciated Assets	1,865,619	7,535	5,336	(2,199)	5	1,865,619	73
74	**Lancaster Allocation**		1,217	1,217		5	8,675	74
75	TOTALS	\$ 2,705,877	\$ 85,752	\$ 90,007	\$ 4,255		\$ 1,995,744	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	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)	\$ 16,220,668	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 484,153	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 425,380	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (58,773)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,598,830	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ** N/A -- Related Party Lease **

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5			<u>** Off-site Public Storage Space **</u>		<u>4,676</u>			5
6								6
7	TOTAL				\$ <u>4,676</u>			7

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: \$ 2,180 Description: Rental for Photocopying Machine @\$305 per month effective 6/25/06

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____/2007 \$ _____

13. _____/2008 \$ _____

14. _____/2009 \$ _____

* 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.

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	39-3	hrs	\$		\$ 272,458	\$		\$ 272,458	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			74,924			74,924	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			379,756			379,756	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation *Ventilation Therapy*	39-3	hrs			344,073	71,623		415,696	8
9	Pharmacy	39-2	# of prescripts				508,006		508,006	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **Medical Supplies**	39-2					152,714		152,714	
	Speciality Beds	39-2					191,257		191,257	13
14	TOTAL			\$		\$ 1,071,211	\$ 923,600		\$ 1,994,811	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.

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr # 0035048 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-2006 (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	\$ 72,588	\$ 72,588	1
2	Cash-Patient Deposits	95,935	95,935	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	5,711,846	5,711,846	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	81,758	81,758	6
7	Other Prepaid Expenses	2,094	2,094	7
8	Accounts Receivable (owners or related parties)	25,805	25,805	8
9	Other(specify): **Refundable Deposits**	3,995	3,995	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,994,021	\$ 5,994,021	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		740,000	13
14	Buildings, at Historical Cost		11,667,460	14
15	Leasehold Improvements, at Historical Cost	700,683	1,072,937	15
16	Equipment, at Historical Cost	1,252,508	2,715,860	16
17	Accumulated Depreciation (book methods)	(1,320,572)	(7,995,450)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		217,904	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(217,904)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 632,619	\$ 8,200,807	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,626,640	\$ 14,194,828	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 522,235	\$ 522,419	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	93,286	93,286	28
29	Short-Term Notes Payable	4,817,197	4,493,174	29
30	Accrued Salaries Payable	804,500	804,500	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,821	29,821	31
32	Accrued Real Estate Taxes(Sch.IX-B)	406,500	406,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,673,539	\$ 6,349,700	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,970,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,970,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,673,539	\$ 12,319,700	46
47	TOTAL EQUITY(page 18, line 24)	\$ 188,438	\$ 2,110,465	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,861,977	\$ 14,430,165	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,031,793	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,031,793	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(658,355)	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) ** Treasury Stock **	(185,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (843,355)	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)	\$ 188,438	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,175,862	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,175,862	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(515,397)	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	(2,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ** Treasury Stock **	(550,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (3,065,397)	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)	\$ 2,110,465	24 *

* This must agree with page 17, line 47.

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	\$ 13,769,846	1
2	Discounts and Allowances for all Levels	(2,801,106)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,968,740	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,076,268	6
7	Oxygen	141,401	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,217,669	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	429,408	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,284	19
20	Radiology and X-Ray	12,295	20
21	Other Medical Services	169,007	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 616,994	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	**Vending Commissions **	13,006	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,006	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,816,409	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,556,921	31
32	Health Care	6,123,124	32
33	General Administration	2,270,555	33
B. Capital Expense			
34	Ownership	1,357,985	34
C. Ancillary Expense			
35	Special Cost Centers	1,994,811	35
36	Provider Participation Fee	171,368	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,474,764	40
41	Income before Income Taxes (line 30 minus line 40)**	(658,355)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (658,355)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. **Cash Basis Taxpayer

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

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

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr

0035048

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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	2,037	2,126	\$ 83,659	\$ 39.35	1
2	Assistant Director of Nursing	2,005	2,268	83,458	36.80	2
3	Registered Nurses	68,919	73,955	1,928,456	26.08	3
4	Licensed Practical Nurses	16,461	17,565	409,728	23.33	4
5	CNAs & Orderlies	175,428	188,993	2,134,722	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,869	6,329	86,586	13.68	9
10	Activity Assistants	7,256	7,645	93,327	12.21	10
11	Social Service Workers	11,982	13,100	169,630	12.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,737	41,646	439,248	10.55	15
16	Dishwashers					16
17	Maintenance Workers	11,446	12,540	166,881	13.31	17
18	Housekeepers	28,875	32,132	310,345	9.66	18
19	Laundry	21,671	24,079	224,858	9.34	19
20	Administrator	1,997	2,180	96,800	44.40	20
21	Assistant Administrator	3,693	4,078	99,132	24.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,429	11,361	182,199	16.04	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	6,781	7,849	96,709	12.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	413,586	447,846	\$ 6,605,738 *	\$ 14.75	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	1,460	\$ 46,680	1-3	35
36	Medical Director	1,235	55,500	9-3	36
37	Medical Records Consultant	117	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	328	6,560	10-3	39
40	Physical Therapy Consultant	281	9,810	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,421	\$ 122,774		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,016	\$ 144,384	10-3	50
51	Licensed Practical Nurses	5,924	226,006	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	11,940	\$ 370,390		53

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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Painting and Decorating	Aug-2001	\$ 674	3	\$ 224	\$ 113							
2	Painting and Decorating	Dec-2001	1,199	3	400	199							
3	Painting and Decorating	Jul-2002	113	3	37	37	19						
4	Painting and Decorating	Aug-2002	1,252	3	417	417	209						
5	Painting and Decorating	Nov-2002	229	3	76	76	38						
6	Painting and Decorating	Jan-Mar '03	664	3	111	221	221	111					
7	Painting and Decorating	Jul-Sept '03	1,012	3	168	338	338	168					
8	Painting and Decorating	Oct-Dec '03	1,401	3	234	467	467	233					
9	Painting and Decorating	Jan-Jul '04	1,320	3		220	440	440	220				
10	Painting and Decorating	Aug-Oct'04	1,507	3		251	502	502	252				
11	Painting and Decorating	Nov-Dec '04	2,768	3		461	923	923	461				
12	Painting and Decorating	Jan-Jun '05	8,457	3			1,410	2,819	2,819	1,409			
13	Painting and Decorating	Jul-Dec '05	2,504	3			417	835	835	417			
14	Painting and Decorating	Jan-Jun '06	980	3				164	326	326	164		
15	Painting and Decorating	Jul-Dec '06	1,578	3				263	526	526	263		
16													
17													
18													
19													
20	TOTALS		\$ 25,658		\$ 1,667	\$ 2,800	\$ 4,984	\$ 6,458	\$ 5,439	\$ 2,678	\$ 427	\$	\$

