

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr# 0035048 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

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>39,737</u>	<u>2,716</u>	<u>15,164</u>	<u>57,617</u>	8
9	SNF/PED					9
10	ICF	<u>20,078</u>	<u>1,379</u>	<u>543</u>	<u>22,000</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>59,815</u>	<u>4,095</u>	<u>15,707</u>	<u>79,617</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.69%

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 13,123Medicare 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 2007 Fiscal Year: 31st Dec 2007

* 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-2007 Ending: 31-Dec-2007

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	470,145	88,956	47,025	606,126		606,126		606,126		1
2	Food Purchase		545,048		545,048	(43,645)	501,403	(267)	501,136		2
3	Housekeeping	348,822	200,930		549,752		549,752		549,752		3
4	Laundry	200,247	54,443	429	255,119		255,119		255,119		4
5	Heat and Other Utilities			486,463	486,463		486,463		486,463		5
6	Maintenance	163,158	91,744	303,845	558,747		558,747	1,125	559,872		6
7	Other (specify):*										7
8	TOTAL General Services	1,182,372	981,121	837,762	3,001,255	(43,645)	2,957,610	858	2,958,468		8
	B. Health Care and Programs										
9	Medical Director			60,000	60,000		60,000		60,000		9
10	Nursing and Medical Records	5,067,435	583,487	278,086	5,929,008		5,929,008		5,929,008		10
10a	Therapy			10,877	10,877		10,877		10,877		10a
11	Activities	228,141	111,145		339,286		339,286		339,286		11
12	Social Services	101,365	3,226		104,591		104,591		104,591		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	5,396,941	697,858	355,935	6,450,734		6,450,734		6,450,734		16
	C. General Administration										
17	Administrative	223,715		394,380	618,095		618,095	(158,536)	459,559		17
18	Directors Fees										18
19	Professional Services			29,057	29,057		29,057	14,139	43,196		19
20	Dues, Fees, Subscriptions & Promotions			89,821	89,821		89,821	(41,175)	48,646		20
21	Clerical & General Office Expenses	245,238	62,299	180,589	488,126		488,126	16,389	504,515		21
22	Employee Benefits & Payroll Taxes			1,187,739	1,187,739	43,645	1,231,384	35,971	1,267,355		22
23	Inservice Training & Education			430	430		430	2,854	3,284		23
24	Travel and Seminar			3,569	3,569		3,569	5,903	9,472		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			19,144	19,144		19,144		19,144		26
27	Other (specify):* *Payroll Taxes (Sch VII)							30,394	30,394		27
28	TOTAL General Administration	468,953	62,299	1,904,729	2,435,981	43,645	2,479,626	(94,061)	2,385,565		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,048,266	1,741,278	3,098,426	11,887,970		11,887,970	(93,203)	11,794,767		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				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			78,427	78,427	78,427	378,477	456,904				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			138,918	138,918	138,918	112,737	251,655				32
33	Real Estate Taxes			346,258	346,258	346,258		346,258				33
34	Rent-Facility & Grounds			848,477	848,477	848,477	(840,000)	8,477				34
35	Rent-Equipment & Vehicles			3,659	3,659	3,659		3,659				35
36	Other (specify):*											36
37	TOTAL Ownership			1,415,739	1,415,739	1,415,739	(348,786)	1,066,953				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		932,437	1,534,541	2,466,978	2,466,978		2,466,978				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,367	171,367	171,367		171,367				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		932,437	1,705,908	2,638,345	2,638,345		2,638,345				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,048,266	2,673,715	6,220,073	15,942,054	15,942,054	(441,989)	15,500,065				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-2007

Ending: 31-Dec-2007

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(65,203)	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	(267)	2		13
14	Non-Care Related Interest	(12,443)	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	(1,676)	24		19
20	Contributions	(4,708)	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	(105,176)	21		24
25	Fund Raising, Advertising and Promotional	(97,160)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(275)	20		28
29	Other-Attach Schedule	915	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (286,993)		\$	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)	(154,996)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (154,996)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (441,989)		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-2007

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance Expenses (incurred in 2007)	\$ (5,428)	6 1
2	Deferred Maintenance Exps (allocated for 2007)	6,343	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	915	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr

0035048

Report Period Beginning:

1-Jan-2007

Ending:

31-Dec-2007

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	(267)	0	0	0	0	0	0	0	0	0	0	(267)	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	915	0	210	0	0	0	0	0	0	0	0	1,125	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	648	0	210	0	858	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	(158,536)	0	0	0	0	0	0	0	0	0	(158,536)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,224	2,915	0	0	0	0	0	0	0	0	14,139	19
20	Fees, Subscriptions & Promotions	(102,143)	60,968	0	0	0	0	0	0	0	0	0	(41,175)	20
21	Clerical & General Office Expenses	(106,176)	121,565	1,000	0	0	0	0	0	0	0	0	16,389	21
22	Employee Benefits & Payroll Taxes	0	35,971	0	0	0	0	0	0	0	0	0	35,971	22
23	Inservice Training & Education	0	2,854	0	0	0	0	0	0	0	0	0	2,854	23
24	Travel and Seminar	(1,676)	7,579	0	0	0	0	0	0	0	0	0	5,903	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	30,394	0	0	0	0	0	0	0	0	0	30,394	27
28	TOTAL General Administration	(209,995)	112,019	3,915	0	(94,061)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(209,347)	112,019	4,125	0	(93,203)	29							

STATE OF ILLINOIS

Facility Name & ID Number Lake Shore Healthcare & Rehabilitation Ctr

0035048

Report Period Beginning:

1-Jan-2007 Ending:

Summary B
31-Dec-2007

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	(65,203)	1,421	442,259	0	0	0	0	0	0	0	0	378,477	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,443)	(109,557)	234,737	0	0	0	0	0	0	0	0	112,737	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	(77,646)	(108,136)	(163,004)	0	(348,786)	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)	(286,993)	3,883	(158,879)	0	(441,989)	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	\$ 394,380	Lancaster, Ltd.	100.00%	\$	\$ (394,380)	1
2	V	17 Officers Salary		Lancaster, Ltd.	100.00%	106,482	106,482	2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	11,224	11,224	3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	121,565	121,565	4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	35,971	35,971	5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	7,579	7,579	6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	129,362	129,362	7
8	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	59,295	59,295	8
9	V	32 Interest	115,220	Lancaster, Ltd.	100.00%	5,663	(109,557)	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	1,421	1,421	10
11	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	1,673	1,673	11
12	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	30,394	30,394	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	2,854	2,854	13
14	Total		\$ 509,600			\$ 513,483	\$ * 3,883	14

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

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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		442,259	442,259	16
17	V	32 Interest	23,698	Lake Shore Associates		258,435	234,737	17
18	V	21 State Replacement Tax		Lake Shore Associates		1,000	1,000	18
19	V	6 Repairs & Maintenance		Lake Shore Associates		210	210	19
20	V	19 Accounting Fees		Lake Shore Associates		2,915	2,915	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		\$ 863,698			\$ 704,819	\$ * (158,879)	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-2007 Ending: 31-Dec-2007

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	10.42	Lancaster	\$ 53,241	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	13	10.42	Lancaster	53,241	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	\$ 106,482		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-2007 Ending: -Dec-2007

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	\$ 196,583	\$ 196,583	13	\$ 53,241	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,894		13	2,680	2
3	17	Cheryl Morris	Hours Worked	48	7	196,583	196,583	13	53,241	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,894		13	2,680	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	1,694,700	7	48,231		394,380	11,224	13
14	21	Clerical Expenses	Management Fees	1,694,700	7	522,379	452,822	394,380	121,565	14
15	22	Employee Benefits	Management Fees	1,694,700	7	154,573		394,380	35,971	15
16	24	Seminars & Travel	Management Fees	1,694,700	7	32,569		394,380	7,579	16
17	17	Administrative Consulting	Management Fees	1,694,700	7	555,885	555,885	394,380	129,362	17
18	20	Marketing and Fees	Management Fees	1,694,700	7	254,796	183,072	394,380	59,295	18
19	32	Interest	Management Fees	1,694,700	7	24,333		394,380	5,663	19
20	30	Depreciation	Management Fees	1,694,700	7	6,106		394,380	1,421	20
21	20	Dues, Fees and Subscriptions	Management Fees	1,694,700	7	7,190		394,380	1,673	21
22	27	Payroll Taxes	Management Fees	1,694,700	7	107,574		394,380	25,034	22
23	23	Education & Inservice	Management Fees	1,694,700	7	12,265		394,380	2,854	23
24	32	*Direct Interest*								24
25	TOTALS					\$ 2,138,857	\$ 1,584,945		\$ 513,483	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	\$ 5,610,000		4.5500%	\$ 258,435	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	JP Morgan Chase Bank		X	Working Capital							5,663	6								
7												7								
8												8								
9	TOTAL Facility Related				\$30,000.00		\$ 7,200,000	\$ 5,610,000			\$ 264,098	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	\$ 5,610,000			\$ 264,098	15								

Less : Interest Income (12,443)

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

251,655

Per Page 4 line 32

* 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 2006 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.)		\$ 356,758	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (49,742)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 396,000	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.		\$ 346,258	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	431,817	8
	2003	390,059	9
	2004	398,723	10
	2005	402,783	11
	2006	356,758	12
** Accrual is based on 2006 actual Taxes, adjusted for inflation**			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehabilitation Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035048

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 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax 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>23,991.55</u>	\$ <u>23,991.55</u>
2. <u>11-29-320-036-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>77,022.74</u>	\$ <u>77,022.74</u>
3. <u>11-29-320-037-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>77,476.96</u>	\$ <u>77,476.96</u>
4. <u>11-29-320-038-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>77,476.96</u>	\$ <u>77,476.96</u>
5. <u>11-29-320-039-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>77,297.22</u>	\$ <u>77,297.22</u>
6. <u>11-29-320-040-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>23,492.37</u>	\$ <u>23,492.37</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>356,757.80</u>	\$ <u>356,757.80</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

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-2007 Ending: 31-Dec-2007

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)	\$ 4,521,149	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	3,276	20	1,112	(2,164)	24,897	11
12	Various		1992		12,856	408	20	643	235	9,929	12
13	Various		1993		68,862	1,789	20	3,444	1,655	49,933	13
14	Various		1994		5,698	146	20	286	140	3,951	14
15	Various		1995		76,433	1,767	20	3,822	2,055	48,576	15
16	Fire Alarm System		1996		54,450	1,396	20	2,723	1,327	32,676	16
17	Seamco Stone Deck		1996		7,989	205	20	399	194	4,522	17
18	Roof Exhauster		1996		2,700	69	20	135	66	1,507	18
19	Front Sign		1996		12,020	710	20	601	(109)	6,761	19
20	Water Heating System		1997		38,800	995	20	1,940	945	21,017	20
21	Fluorescent Conversion		1997		25,353	650	20	1,268	618	13,631	21
22	Elevator Improvement		1998		55,364	1,420	20	1,420		13,668	22
23	Electronic Alzheimer Doors		1998		11,800	303	20	303		2,815	23
24	Elevator Interiors		1999		34,422	883	20	883		7,395	24
25	Parking Lot Resurface		1999		20,240	1,195	20	1,195		12,023	25
26	Patio Stone Decking		1999		6,465	382	20	382		3,937	26
27	Electric Panel Board		2002		5,000	128	10	500	372	2,667	27
28	Parking Lot Fence		2003		19,707	683	10	1,314	631	6,077	28
29	Hand Rail System		2005		5,968	153	10	597	444	1,642	29
30	Wood Flooring		2005		4,248	109	10	425	316	1,169	30
31	Concrete Patio Porch		2005		8,603	221	10	860	639	2,294	31
32	Piping For Hot Water System		2005		11,900	305	10	1,190	885	3,074	32
33	Eclipse Gas Booster		2005		9,000	231	10	900	669	2,325	33
34	Wallguards		2005		2,519	65	10	252	187	630	34
35	Electrical Sub Panel		2005		3,370	86	10	337	251	814	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	\$ 373	37
38	Heaters in Outdoor Patio	2005	2,850	73	10	285	212	618	38
39	Junction Box - Fire Panel	2005	780	20	10	78	58	169	39
40	Electricals for 12 Bedrooms	2005	1,600	41	10	160	119	347	40
41	Electricals for 6 Bedrooms	2005	800	21	10	80	59	167	41
42	Switches & Lights for 34 Rooms	2006	2,805	72	10	281	209	562	42
43	Install 28 Wall Sconces	2006	3,150	81	10	315	234	604	43
44	Line & Outlets - Garden Room	2006	3,580	92	10	358	266	656	44
45	Drilling Elevator Hole	2006	29,392	754	10	2,939	2,185	5,388	45
46	Overhaul & Install Elevator	2006	47,986	1,230	10	4,799	3,569	8,798	46
47	3 New Doors	2006	450	12	10	45	33	75	47
48	Custom Size Fire Door	2006	1,511	39	10	151	112	252	48
49	2 Stainless Steel Doors for Walk-in Freezer	2006	4,620	118	10	462	344	732	49
50	Renovation of 1st Floor & building new Town Square	2006	368,254	9,442	10	9,442		17,717	50
51	Lawn Pond	2007	4,853	162	20	162		162	51
52	Iron Works Fence	2007	4,194	210	20	163	(47)	163	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)		\$ 12,783,838	\$ 400,379		\$ 338,498	\$ (61,881)	\$ 4,941,584	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-2007 Ending: 31-Dec-2007

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	\$ 881,847	\$ 95,108	\$ 97,287	\$ 2,179		\$ 267,800	71
72	Current Year Purchases	96,432	19,285	12,225	(7,060)		12,225	72
73	Fully Depreciated Assets	1,824,030	5,915	7,474	1,559		1,824,030	73
74			1,420	1,420			10,095	74
75	TOTALS	\$ 2,802,309	\$ 121,728	\$ 118,406	\$ (3,322)		\$ 2,114,150	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)		\$ 16,326,147	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 522,107	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 456,904	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (65,203)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 7,055,734	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	<u>** Off-site Public Storage Space **</u>		<u>8,477</u>			4
5							5
6							6
7	TOTAL			\$ <u>8,477</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: \$ 3,659 Description: Rental for Photocopying Machine @\$304.90 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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

* 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	\$		\$ 561,774	\$		\$ 561,774	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			100,912			100,912	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			736,305			736,305	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation *Ventilation Therapy*	39-3	hrs			135,550	71,472		207,022	8
9	Pharmacy	39-2	# of prescripts				554,449		554,449	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** **Speciality Beds**	39-2 39-2					130,467 176,049		130,467 176,049	13
14	TOTAL			\$		\$ 1,534,541	\$ 932,437		\$ 2,466,978	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-2007 Ending: 31-Dec-2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-2007 (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	\$ 83,148	\$ 583,233	1
2	Cash-Patient Deposits	77,210	77,210	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	5,537,066	5,537,066	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,877	88,877	6
7	Other Prepaid Expenses	4,967	4,967	7
8	Accounts Receivable (owners or related parties)	5,138	90,417	8
9	Other(specify): **Refundable Deposits**	2,297	2,297	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,798,703	\$ 6,384,067	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	709,731	1,081,985	15
16	Equipment, at Historical Cost	1,340,291	2,803,643	16
17	Accumulated Depreciation (book methods)	(1,398,998)	(8,516,134)	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)	\$ 651,024	\$ 7,776,954	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,449,727	\$ 14,161,021	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 657,669	\$ 657,669	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	77,333	77,333	28
29	Short-Term Notes Payable	4,591,838	4,951,838	29
30	Accrued Salaries Payable	853,112	853,112	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,660	30,660	31
32	Accrued Real Estate Taxes(Sch.IX-B)	396,000	396,000	32
33	Accrued Interest Payable		20,388	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)	\$ 6,606,612	\$ 6,987,000	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		5,250,000	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)	\$	\$ 5,250,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,606,612	\$ 12,237,000	46
47	TOTAL EQUITY(page 18, line 24)	\$ (156,885)	\$ 1,924,021	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,449,727	\$ 14,161,021	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 138,101	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 138,101	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(109,986)	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)	\$ (294,986)	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)	\$ (156,885)	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Totals on Cosolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,425,128	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,425,128	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	48,893	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 **	(550,000)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (501,107)	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)	\$ 1,924,021	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	\$ 16,080,695	1
2	Discounts and Allowances for all Levels	(4,300,982)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,779,713	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,223,654	6
7	Oxygen	93,516	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,317,170	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	587,139	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,119	19
20	Radiology and X-Ray	19,180	20
21	Other Medical Services	104,304	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 718,742	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,443	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,443	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	**Vending Commissions **	4,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,832,068	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,001,255	31
32	Health Care	6,450,734	32
33	General Administration	2,435,981	33
B. Capital Expense			
34	Ownership	1,415,739	34
C. Ancillary Expense			
35	Special Cost Centers	2,466,978	35
36	Provider Participation Fee	171,367	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,942,054	40
41	Income before Income Taxes (line 30 minus line 40)**	(109,986)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (109,986)	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. **Offset on Page 5 & 9

****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-2007

Ending:

31-Dec-2007

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	2,206	\$ 94,293	\$ 42.74	1
2	Assistant Director of Nursing	2,414	2,767	96,729	34.96	2
3	Registered Nurses	72,294	78,356	2,051,639	26.18	3
4	Licensed Practical Nurses	21,814	23,030	535,316	23.24	4
5	CNAs & Orderlies	179,341	193,604	2,182,224	11.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,512	6,146	84,198	13.70	9
10	Activity Assistants	10,998	12,187	143,943	11.81	10
11	Social Service Workers	6,757	7,803	101,365	12.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,453	42,656	470,145	11.02	15
16	Dishwashers					16
17	Maintenance Workers	10,773	12,124	163,158	13.46	17
18	Housekeepers	31,934	35,866	348,822	9.73	18
19	Laundry	18,062	20,377	200,247	9.83	19
20	Administrator	1,965	2,194	100,813	45.95	20
21	Assistant Administrator	3,767	4,428	122,902	27.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,369	14,450	245,238	16.97	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	7,695	8,571	107,234	12.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	428,185	466,765	\$ 7,048,266 *	\$ 15.10	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		\$ 47,025	1-3	35
36	Medical Director		60,000	9-3	36
37	Medical Records Consultant		4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant		10,877	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)		\$ 122,126		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	9,916	\$ 238,636	10-3	50
51	Licensed Practical Nurses	957	35,226	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10,873	\$ 273,862		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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	Painting and Decorating	Jan-Jul '04	\$ 1,320	3	\$ 220	\$ 440	\$ 440	\$ 220	\$	\$	\$	\$	\$
2	Painting and Decorating	Aug-Oct '04	1,507	3	251	502	502	252					
3	Painting and Decorating	Nov-Dec '04	2,768	3	461	923	923	461					
4	Painting and Decorating	Jan-Jun '05	8,457	3		1,410	2,819	2,819	1,409				
5	Painting and Decorating	Jul-Dec '05	2,504	3		417	835	835	417				
6	Painting and Decorating	Jan-Jun '06	980	3			164	326	326	164			
7	Painting and Decorating	Jul-Dec '06	1,578	3			263	526	526	263			
8	Painting and Decorating	Jan-Jun '07	3,728	3				621	1,243	1,243	621		
9	Painting and Decorating	Jul-Dec '07	1,700	3				283	567	567	283		
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 24,542		\$ 932	\$ 3,692	\$ 5,946	\$ 6,343	\$ 4,488	\$ 2,237	\$ 904	\$	\$

