

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>240</u>	Skilled (SNF)	<u>240</u>	<u>87,600</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>240</u>	TOTALS	<u>240</u>	<u>87,600</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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>61,559</u>	<u>3,793</u>	<u>10,849</u>	<u>76,201</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>61,559</u>	<u>3,793</u>	<u>10,849</u>	<u>76,201</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.99%

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

36 (Do not include bed-hold days in Section B.)

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

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

None

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

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

YES NO

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

YES NO

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

Date started 05/28/1998

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

YES Date 05/28/1998 NO

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

YES NO If YES, enter number of beds certified 240 and days of care provided 7,328

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	401,522	80,227	17,232	498,981		498,981	(13,319)	485,662		1
2	Food Purchase		343,706		343,706		343,706	225	343,931		2
3	Housekeeping	282,860	52,126		334,986		334,986	(2,225)	332,761		3
4	Laundry	138,868	36,848	2,070	177,786		177,786	(14)	177,772		4
5	Heat and Other Utilities			329,120	329,120		329,120	4,361	333,481		5
6	Maintenance	73,928		189,163	263,091		263,091	27,200	290,291		6
7	Other (specify):*							4,488	4,488		7
8	TOTAL General Services	897,178	512,907	537,585	1,947,670		1,947,670	20,716	1,968,386		8
	B. Health Care and Programs										
9	Medical Director			20,500	20,500		20,500		20,500		9
10	Nursing and Medical Records	3,415,323	187,776	4,656	3,607,755		3,607,755	19,190	3,626,945		10
10a	Therapy	208,466		1,872	210,338		210,338	3,403	213,741		10a
11	Activities	174,178	3,443	2,400	180,021		180,021		180,021		11
12	Social Services	171,716		1,779	173,495		173,495	9,826	183,321		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							6,312	6,312		15
16	TOTAL Health Care and Programs	3,969,683	191,219	31,207	4,192,109		4,192,109	38,731	4,230,840		16
	C. General Administration										
17	Administrative	136,961		12,000	148,961		148,961	86,515	235,476		17
18	Directors Fees										18
19	Professional Services			532,563	532,563	(4,173)	528,390	(438,500)	89,890		19
20	Dues, Fees, Subscriptions & Promotions			55,359	55,359		55,359	(9,885)	45,474		20
21	Clerical & General Office Expenses	71,276	18,335	558,312	647,923		647,923	(215,994)	431,929		21
22	Employee Benefits & Payroll Taxes			849,432	849,432		849,432	(5,866)	843,566		22
23	Inservice Training & Education			5,184	5,184		5,184		5,184		23
24	Travel and Seminar			570	570		570	2,107	2,677		24
25	Other Admin. Staff Transportation			1,303	1,303		1,303	2,435	3,738		25
26	Insurance-Prop.Liab.Malpractice			291,274	291,274		291,274	3,061	294,335		26
27	Other (specify):*							47,849	47,849		27
28	TOTAL General Administration	208,237	18,335	2,305,997	2,532,569	(4,173)	2,528,396	(528,278)	2,000,118		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,075,098	722,461	2,874,789	8,672,348	(4,173)	8,668,175	(468,831)	8,199,344		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr #0042119 Report Period Beginning: 01/01/07 Ending: 12/31/07

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			115,749	115,749		115,749	353,793	469,542		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							37,129	37,129		32
33	Real Estate Taxes			283,410	283,410	4,173	287,583	3,824	291,407		33
34	Rent-Facility & Grounds			1,164,000	1,164,000		1,164,000	(1,159,068)	4,932		34
35	Rent-Equipment & Vehicles			6,923	6,923		6,923	797	7,720		35
36	Other (specify):*										36
37	TOTAL Ownership			1,570,082	1,570,082	4,173	1,574,255	(763,525)	810,730		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		495,458	566,526	1,061,984		1,061,984	(55,631)	1,006,353		39
40	Barber and Beauty Shops			243	243		243		243		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			131,400	131,400		131,400		131,400		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		495,458	698,169	1,193,627		1,193,627	(55,631)	1,137,996		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,075,098	1,217,919	5,143,040	11,436,057		11,436,057	(1,287,987)	10,148,070		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	37,906	30		9
10	Interest and Other Investment Income	(893,063)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(9,179)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(252,000)	21		24
25	Fund Raising, Advertising and Promotional	(15,314)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,642)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(583)	20		28
29	Other-Attach Schedule	(227,893)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,365,937)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	77,950		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 77,950		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,287,987)		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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Other Income	\$ (670)	21	1
2 Jury Duty	(10)	21	2
3 Patient Clothing	(1,140)	10	3
4 Non-Allowable Expense	(180,000)	21	4
5 Collection Expense	(900)	21	5
6 C/PPE Dues	(2,855)	20	6
7 Annual Report	(250)	20	7
8 Out of Period Union Reimbursement	(750)	10	8
9 Administrative Expenses- Building Co.	(400)	20	9
10 Travel Fees- Building Co.	(150)	21	10
11 Printing Fees- Building Co.	(300)	21	11
12 2006 Legal Fees	(2,065)	19	12
13 Amortization- Building Co.	(58,710)	31	13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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99			99
100			100
101 Total	(227,893)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

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			320	4,532	(18,152)		(19)					(13,319)	1
2	Food Purchase	(169)		394									225	2
3	Housekeeping			600	61	47		(2,933)					(2,225)	3
4	Laundry							(14)					(14)	4
5	Heat and Other Utilities			2,861	155	1,345							4,361	5
6	Maintenance			26,678	19	547	185	(229)					27,200	6
7	Other (specify):*			4,058	430								4,488	7
8	TOTAL General Services	(169)		34,911	5,197	(16,213)	185	(3,195)					20,716	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,890)			35,209			(14,129)					19,190	10
10a	Therapy				3,403								3,403	10a
11	Activities													11
12	Social Services				9,826								9,826	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,312								6,312	15
16	TOTAL Health Care and Programs	(1,890)			54,750			(14,129)					38,731	16
	C. General Administration													
17	Administrative			13,653	61,835	11,027							86,515	17
18	Directors Fees													18
19	Professional Services	(2,065)		(309,020)	(127,561)	146							(438,500)	19
20	Fees, Subscriptions & Promotions	(19,402)	400	8,245	38	834							(9,885)	20
21	Clerical & General Office Expenses	(448,544)	450	201,616	16,006	18,150	(3,672)						(215,994)	21
22	Employee Benefits & Payroll Taxes			(5,750)	(116)			0					(5,866)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,395	742			(30)					2,107	24
25	Other Admin. Staff Transportation			1,805		630							2,435	25
26	Insurance-Prop.Liab.Malpractice			1,829	19	1,213							3,061	26
27	Other (specify):*			32,937	10,511	4,401							47,849	27
28	TOTAL General Administration	(470,011)	850	(53,290)	(38,526)	36,401	(3,672)	(30)					(528,278)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(472,070)	850	(18,379)	21,421	20,188	(3,487)	(17,354)					(468,831)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	37,906	288,253	23,325	980	948	2,381						353,793	30
31	Amortization of Pre-Op. & Org.	(38,710)	38,710											31
32	Interest	(893,063)	878,990	44,011	4,219	1,581	1,391						37,129	32
33	Real Estate Taxes			3,414	231	179							3,824	33
34	Rent-Facility & Grounds		(1,164,000)	3,687		1,245							(1,159,068)	34
35	Rent-Equipment & Vehicles			486	7	304							797	35
36	Other (specify):*													36
37	TOTAL Ownership	(893,867)	41,953	74,923	5,437	4,257	3,772						(763,525)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(47,284)	(4,650)	(3,697)					(55,631)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers					(47,284)	(4,650)	(3,697)					(55,631)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,365,937)	42,803	56,544	26,858	(22,839)	(4,365)	(21,051)					(1,287,987)	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
See Attached		See Attached		See Attached		
				South Shore Properties, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,164,000	South Shore Property	100.00%	\$	\$ (1,164,000)	1
2	V	32 Interest Income	265,930	South Shore Property	100.00%		(265,930)	2
3	V	20 Misc. Administrative Expense		South Shore Property	100.00%	400	400	3
4	V	30 Depreciation Expense		South Shore Property	100.00%	288,253	288,253	4
5	V	31 Amortization		South Shore Property	100.00%	38,710	38,710	5
6	V	32 Interest Expense		South Shore Property	100.00%	1,144,920	1,144,920	6
7	V	21 Trust Fees		South Shore Property	100.00%	150	150	7
8	V	21 Filing Fees		South Shore Property	100.00%	300	300	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,429,930			\$ 1,472,733	\$ * 42,803	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary		Care Centers, Inc.	100.00%	\$ 320	\$ 320	15	
16	V	02	Food		Care Centers, Inc.	100.00%	394	394	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	600	600	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	2,861	2,861	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	4,718	4,718	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	2,858	2,858	20	
21	V	19	Professional Fees	324,105	Care Centers, Inc.	100.00%	15,085	(309,020)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	8,245	8,245	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	23,895	23,895	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	1,395	1,395	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,805	1,805	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	1,829	1,829	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	23,325	23,325	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	44,011	44,011	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,414	3,414	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,687	3,687	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	486	486	31	
32	V	06	Maintenance	3,541	Care Centers, Inc.	100.00%	25,501	21,960	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	4,058	4,058	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	10,795	10,795	34	
35	V	21	Office and Clerical	34,791	Care Centers, Inc.	100.00%	212,512	177,721	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	32,937	32,937	36	
37	V	22	Employee Benefits	5,750	Care Centers, Inc.	100.00%		(5,750)	37	
38	V								38	
39	Total			\$ 368,187			\$ 424,731	\$ * 56,544	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 61	\$ 61	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	155	155	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	19	19	17	
18	V	19	Professional Fees	130,140	Care Centers Clinical, Inc.	100.00%	2,579	(127,561)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	38	38	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	151	151	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	742	742	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	19	19	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	980	980	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	4,219	4,219	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	231	231	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	7	7	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	4,532	4,532	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	430	430	28	
29	V	10	Nursing Salary	196	Care Centers Clinical, Inc.	100.00%	35,405	35,209	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	3,403	3,403	30	
31	V	12	Social Service Salary	577	Care Centers Clinical, Inc.	100.00%	10,403	9,826	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	6,312	6,312	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	61,835	61,835	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	15,855	15,855	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	10,511	10,511	35	
36	V	22	Employee Benefits	116	Care Centers Clinical, Inc.	100.00%		(116)	36	
37	V								37	
38	V								38	
39	Total			\$ 131,029			\$ 157,887	\$ * 26,858	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 6,711	\$ 6,711	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	47	47	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	1,345	1,345	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	547	547	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	146	146	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	834	834	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,881	2,881	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	630	630	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	1,213	1,213	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	948	948	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	1,581	1,581	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	179	179	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	1,245	1,245	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	304	304	28	
29	V	01	Dietary	37,016	Care Centers Health Systems, Inc.	100.00%	12,153	(24,863)	29	
30	V	02	Food		Care Centers Health Systems, Inc.	100.00%			30	
31	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%			31	
32	V	10	Nursing		Care Centers Health Systems, Inc.	100.00%			32	
33	V	21	Clerical and General Office	487	Care Centers Health Systems, Inc.	100.00%	160	(327)	33	
34	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34	
35	V	39	Ancillary	70,395	Care Centers Health Systems, Inc.	100.00%	23,111	(47,284)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	11,027	11,027	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	15,596	15,596	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	4,401	4,401	38	
39	Total			\$ 107,898			\$ 85,059	\$ * (22,839)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 185	\$ 185	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	1,459	1,459	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	122	122	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	922	922	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	1,269	1,269	20
21	V	21	Office and Clerical	3,672	Vent Lease, LLC.	100.00%		(3,672)	21
22	V	39	Ancillary	4,650	Vent Lease, LLC.	100.00%		(4,650)	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		\$ 8,322				\$ 3,957	\$ * (4,365)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$ 232	Xcel Supply, LLC	100.00%	\$ 213	\$ (19)	15
16	V	3 Housekeeping	36,365	Xcel Supply, LLC	100.00%	33,432	(2,933)	16
17	V	4 Laundry	175	Xcel Supply, LLC	100.00%	161	(14)	17
18	V	6 Repairs & Maintenance	2,839	Xcel Supply, LLC	100.00%	2,610	(229)	18
19	V	10 Nursing	175,190	Xcel Supply, LLC	100.00%	161,061	(14,129)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	4,776	Xcel Supply, LLC	100.00%	4,776	0	24
25	V	24 Seminars & Education	373	Xcel Supply, LLC	100.00%	343	(30)	25
26	V	39 Ancillary	45,839	Xcel Supply, LLC	100.00%	42,142	(3,697)	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		\$ 265,789			\$ 244,739	\$ * (21,051)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefit Group, Inc.	100.00%	\$ 86,379	\$ 86,379	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	86,379	CCS Employee Benefit Group, Inc.	100.00%		(86,379)	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			\$ 86,379			\$ 86,379	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Sandy Bokor	Relative	Administrative		See Attached	1.00	2.00%	Mgmt Fees.	\$ 12,000	17-3	1
2	David Aronin	Shareholder	Administrative	1.00%	See Attached	1.88	3.30%	Alloc. Salary	4,392	17-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	2.58	4.69%	Alloc. Salary	6,332	17-7	3
4	Eric Rothner	Relative	Administrative		See Attached	1.56	3.38%			17-7	4
5	Kim Rudolph	Relative	Clerical		See Attached	0.47	1.34%	Alloc. Salary	409	22-7	5
6	Adam Vales	Relative	Clerical	1.88%	See Attached	0.53	1.33%	Alloc. Salary	743	22-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,876		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 76,168	\$ 320	1
2	02	Food	Patient Days	1,625,640	33	8,403	76,168	394	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	76,168	600	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	76,168	2,861	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	76,168	4,718	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	76,168	2,858	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	76,168	15,085	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	76,168	8,245	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	76,168	23,895	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	76,168	1,395	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	76,168	1,805	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	76,168	1,829	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	76,168	23,325	13
14	32	Interest	Patient Days	1,625,640	33	939,326	76,168	44,011	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	76,168	3,414	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	76,168	3,687	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	76,168	486	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	8,763	18
19	06	Maintenance	Direct Allocation			456,812	456,812	16,738	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	76,168	4,058	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	10,795	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	177,087	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	35,425	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	76,168	32,937	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 424,731	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Center Clinical, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 76,168	\$ 61	1	
2	05	Utilities	Patient Days	1,625,640	32	3,307	76,168	155	2	
3	06	Maintenance	Patient Days	1,625,640	32	410	76,168	19	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	76,168	2,579	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	76,168	38	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	76,168	151	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	76,168	742	7	
8	26	Insurance	Patient Days	1,625,640	32	409	76,168	19	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	76,168	980	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	76,168	4,219	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	76,168	231	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	76,168	7	12	
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	76,168	4,532	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	76,168	430	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	76,168	35,202	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	76,168	3,403	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	76,168	9,771	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	76,168	6,238	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	76,168	61,835	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	76,168	15,855	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	76,168	10,511	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		203	22
23	12	Social Service Salary	Direct Allocation			8,845	8,845		632	23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			74	24
25	TOTALS					\$ 3,374,561	\$ 2,809,547		\$ 157,887	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Health Systems, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	4,431,674	33	94,358	315,214	6,711	1
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	315,214	47	2
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	315,214	1,345	3
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	315,214	547	4
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	315,214	146	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	315,214	834	6
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	315,214	2,881	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	315,214	630	8
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	315,214	1,213	9
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	315,214	948	10
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	315,214	1,581	11
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	315,214	179	12
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	315,214	1,245	13
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	315,214	304	14
15	01	Dietary	Direct Billable Income	341,879	33	112,243	37,016	12,153	15
16	02	Food	Direct Billable Income	25	33	8			16
17	03	Housekeeping	Direct Billable Income	29	33	10			17
18	10	Nursing	Direct Billable Income	69,616	33	22,856			18
19	21	Clerical and General Office	Direct Billable Income	487	33	160	487	160	19
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298	70,395	23,111	21
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	11,027	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	15,596	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	315,214	4,401	24
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 85,059	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Repairs	Direct Billing	892,186	27	\$ 35,557	\$	4,650	\$ 185	1
2	21	Office and Clerical	Direct Billing	892,186	27	44		4,650		2
3	30	Depreciation	Direct Billing	892,186	27	280,000		4,650	1,459	3
4	32	Interest	Direct Billing	892,186	27	23,404		4,650	122	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677		76,168	922	5
6	32	Interest	Patient Days	1,625,640	33	27,081		76,168	1,269	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 385,762	\$		\$ 3,957	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$		\$ 213	1
2	3	Housekeeping	Direct Allocation					33,432	2
3	4	Laundry	Direct Allocation					161	3
4	6	Repairs & Maintenance	Direct Allocation					2,610	4
5	10	Nursing	Direct Allocation					161,061	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					4,391	10
11	24	Seminars & Education	Direct Allocation					343	11
12	39	Ancillary	Direct Allocation					42,142	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$		\$ 244,353	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 86,379	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 86,379	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Business Partners LLC		X	Mortgage- Building Co.			\$	\$ 16,701,768			\$ 1,128,024	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
Working Capital																	
6	Due from Affiliates										16,896	6					
7												7					
8	See Supplemental Schedule											8					
9	TOTAL Facility Related						\$	\$ 16,701,768			\$ 1,144,920	9					
B. Non-Facility Related*																	
10	Interest Income		X								(893,063)	10					
11	Interest Income (Bldg Co.)		X								(265,930)	11					
12												12					
13	See Supplemental Schedule										51,202	13					
14	TOTAL Non-Facility Related						\$	\$			(1,107,791)	14					
15	TOTALS (line 9+line14)						\$	\$ 16,701,768			\$ 37,129	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

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

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

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

	1	2	3	4	5	6		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							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15	Care Centers, Inc.		X				\$	\$			\$	44,011	15						
16	Care Centers Clinical, Inc.		X									4,219	16						
17	Care Centers Health Systems, Inc.		X									1,581	17						
18	Vent Lease, LLC.		X									1,391	18						
19													19						
20	TOTAL Non-Facility Related																		

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

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

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.		\$ 356,341	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.)		\$ 315,877	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (40,464)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 327,698	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.)		\$ 4,173	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.		\$ 291,407	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	334,103	8
	2003	327,938	9
	2004	335,944	10
	2005	339,365	11
	2006	312,053	12
<u>2007 Accrual \$312,053 x 1.05= \$327,698</u>			
<u>Allocation From Care Centers \$3,824</u>			

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$ _____
14	PLUS APPEAL COST FROM LINE 5	\$ _____
15	LESS REFUND FROM LINE 6	\$ _____
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 South Shore Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-30-200-001-0000</u>	<u>Long Term Care Property</u>	<u>\$ 256,112.47</u>	<u>\$ 256,112.47</u>
2. <u>21-30-200-002-0000</u>	<u>Long Term Care Property</u>	<u>\$ 4,244.09</u>	<u>\$ 4,244.09</u>
3. <u>21-30-200-008-0000</u>	<u>Long Term Care Property</u>	<u>\$ 47,314.36</u>	<u>\$ 47,314.36</u>
4. <u>21-30-121-008-0000</u>	<u>Long Term Care Property</u>	<u>\$ 1,894.93</u>	<u>\$ 1,894.93</u>
5. <u>21-30-121-009-0000</u>	<u>Long Term Care Property</u>	<u>\$ 2,487.40</u>	<u>\$ 2,487.40</u>
6. <u>See Attached</u>	<u>Care Centers, Inc.</u>	<u>\$ 46,662.50</u>	<u>\$ 2,186.33</u>
7. <u>See Attached</u>	<u>Care Centers Building, LLC</u>	<u>\$ 24,152.48</u>	<u>\$ 1,131.64</u>
8. <u>See Attached</u>	<u>Care Centers Health Systems, LLC</u>	<u>\$ 2,476.87</u>	<u>\$ 176.17</u>
9. <u>See Attached</u>	<u>Care Centers Clinical, Inc.</u>	<u>\$ 4,834.42</u>	<u>\$ 226.51</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
	TOTALS	<u>\$ 390,179.52</u>	<u>\$ 315,773.90</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 96,000 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories 3

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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>101,000</u>	<u>1994</u>	<u>\$ 352,000</u>	1
2	<u>Allocation from Care Centers</u>			<u>19,929</u>	2
3	TOTALS	101,000		\$ 371,929	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1998		22,697		20	1,135	1,135	10,563	9
10	Various		1999		22,789		20	1,140	1,140	9,435	10
11	Various		2000		41,526		20	2,076	2,076	16,187	11
12	Various		2001		43,128		20	2,158	2,158	13,812	12
13	Various		2002		37,477		20	3,720	3,720	20,211	13
14	Various		2003		38,966		20	4,750	4,750	20,857	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
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61								61
62								62
63								63
64								64
65								65
66								66
67		10,639,989	288,254		313,914	25,660	2,798,820	67
68		109,956	5,854		5,854		36,258	68
69			115,749			(115,749)		69
70		\$ 10,956,528	\$ 409,857		\$ 334,747	\$ (75,110)	\$ 2,926,143	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,956,528	\$ 409,857		\$ 334,747	\$ (75,110)	\$ 2,926,143	1
2	Repair Dietary Door	2004	1,100		20	220	220	843	2
3	Pop Up Spray Heads	2004	654		20	65	65	251	3
4	Damper Motor	2004	1,635		20	327	327	1,226	4
5	New Damper	2004	1,763		20	353	353	1,322	5
6	Fire Alarm Repair	2004	1,009		20	202	202	757	6
7	Fire Damper Repair	2004	1,631		20	326	326	1,223	7
8	Door Delay Lock	2004	2,247		20	225	225	824	8
9	Nustep	2004	3,530		20	353	353	1,265	9
10	Door Opener	2004	2,040		20	408	408	1,462	10
11	Wiring	2004	695		20	70	70	243	11
12	T-Stat	2004	1,050		20	105	105	368	12
13	Paint Job	2004	3,550		20	355	355	1,183	13
14	Lawn Cleanup	2004	7,000		20	700	700	2,333	14
15	Carpet Strips	2004	1,359		20	136	136	453	15
16	Repair Booster Heater	2004	1,052		20	105	105	351	16
17	Generator Service	2004	601		20	120	120	401	17
18	New Camera System	2004	7,002		20	700	700	2,276	18
19	Replace Spray Heads	2004	520		20	52	52	169	19
20	Security Power Supply	2004	540		20	108	108	351	20
21	Generator Maint	2004	1,293		20	259	259	840	21
22	Wrist Band Transm	2004	999		20	200	200	650	22
23	4 Mag Locks	2004	3,692		20	369	369	1,169	23
24	Lab & Wiring 2Nd Fl	2004	595		20	119	119	377	24
25	Lab & Wiring Sys Buzzing	2004	760		20	152	152	481	25
26	Elevator Hatch Doors	2004	2,651		20	530	530	2,121	26
27	Pump Drain	2004	1,667		20	167	167	528	27
28	Floor Treatment	2004	810		20	41	41	138	28
29	Paint	2004	2,330		20	117	117	447	29
30	Repair Cut Piping	2005	4,333		20	433	433	1,264	30
31	Door Repairs	2005	2,840		20	568	568	1,610	31
32	Boiler Repair	2005	2,781		20	556	556	1,530	32
33	2 Door Locks	2005	3,691		20	369	369	984	33
34	TOTAL (lines 1 thru 33)		\$ 11,023,948	\$ 409,857		\$ 343,557	\$ (66,300)	\$ 2,955,583	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,023,948	\$ 409,857		\$ 343,557	\$ (66,300)	\$ 2,955,583	1
2	New Compressor	2005	38,047		20	7,609	7,609	19,658	2
3	Boiler Repair	2005	2,703		20	541	541	1,216	3
4	Home Office P/R Painting	2006	2,098		20	210	210	315	4
5	Painting-From Hop	2006	5,876		20	588	588	832	5
6	Painting-From Hop	2006	8,498		20	850	850	1,133	6
7	Dep On New Fence	2006	2,080		20	208	208	277	7
8	3 Ton A/C- 1/2 Down 1	2006	6,250		20	1,250	1,250	1,979	8
9	Boiler Repair	2006	4,915		20	983	983	1,556	9
10	3 Ton A/C-1/2 Down 2	2006	6,600		20	1,320	1,320	1,870	10
11	Painting - From Hop	2006	5,994		20	599	599	749	11
12	Annie Looking 4 Inv	2006	9,341		20	934	934	1,168	12
13	Painting	2006	1,603		20	160	160	187	13
14	Elevator Repairs	2006	2,722		20	136	136	272	14
15	Perennials	2006	2,750		20	138	138	199	15
16	Painting (Transfer Expense From Home Office)	2007	3,690		20	3,690	3,690	3,690	16
17	Painting (Transfer Expense From Home Office)	2007	7,695		20	7,054	7,054	7,054	17
18	Replace Laundry Boiler	2007	9,716		20	1,272	1,272	1,272	18
19	Replace Laundry Boiler	2007	9,716		20	1,157	1,157	1,157	19
20	Repair Ahu #1 Coil	2007	19,679		20	3,280	3,280	3,280	20
21	Painting (Transfer Expense From Home Office)	2007	3,426		20	2,855	2,855	2,855	21
22	Replace Laundry Boiler	2007	9,716		20	1,041	1,041	1,041	22
23	New Telephone System	2007	2,882		20	216	216	216	23
24	Barrier Free Door Closer	2007	4,519		20	301	301	301	24
25	Replace Laundry Boiler	2007	9,716		20	925	925	925	25
26	Final Pymt Of 3 - New Oil Coolers	2007	16,854		20	492	492	492	26
27	Replace Laundry Boiler	2007	9,716		20	810	810	810	27
28	Tarkett Vct & Install - 1St Fl Nurs Station	2007	20,299		20	1,184	1,184	1,184	28
29	Replace Laundry Boiler	2007	9,716		20	694	694	694	29
30	Tarkett Vcr & Install, 2Nd Fl Nurs Station	2007	17,256		20	719	719	719	30
31	Booster Heater	2007	3,528		20	294	294	294	31
32	Major A/C Work	2007	3,493		20	121	121	121	32
33	Fire Alarm Repair	2007	5,149		20	123	123	123	33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
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4									4
5									5
6									6
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10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Report Period Beginning:

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Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
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8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

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01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,290,191	\$ 409,857		\$ 385,311	\$ (24,546)	\$ 3,013,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07 Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240		1998	1998	\$ 9,683,370	\$ 248,292	35	\$ 276,668	\$ 28,376	\$ 2,463,268	4
5			1999	1999	134,000	3,436	35	3,829	393	30,780	5
6			2000	2000	360,000	9,231	35	10,286	1,055	73,462	6
7											7
8											8
Improvement Type**											
9	Land Improvements			1998	462,619	27,295	20	23,131	(4,164)	231,310	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	10,639,989	\$	288,254	\$	313,914	\$	25,660	\$	2,798,820	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed* ^s	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	2201 Main LLC Allocation	2002	2002	\$ 20,865	\$ 535		\$ 535	\$	\$ 2,831	4
5	Care Centers Health Systems	2002	2002	1,681	43		43		228	5
6	Care Centers Clinical	2002	2002	2,162	55		55		293	6
7	Hillside (Storage and Training)	1996	1996	35,379	907		907		10,017	7
8										8
	Improvement Type**									
9	Care Centers Health Systems		2002	1,389	127	20	127		636	9
10	Care Centers Health Systems		2003	1,637	150	20	150		749	10
11	Care Centers Health Systems		2005	81	9	20	9		21	11
12										12
13	Care Centers Clinical		2002	1,786	163	20	163		818	13
14	Care Centers Clinical		2003	2,104	192	20	192		963	14
15	Care Centers Clinical		2005	105	11	20	11		27	15
16										16
17	2201 Main LLC Allocation		2002	17,236	1,575	20	1,575		7,891	17
18	2202 Main LLC Allocation		2003	20,312	1,856	20	1,856		9,299	18
19	2203 Main LLC Allocation		2005	1,009	107	20	107		257	19
20										20
21	Care Centers Inc.		2007	216	14	20	14		14	21
22										22
23	Hillside (Storage and Training)		1996	597	-	20	-		597	23
24	Hillside (Storage and Training)		1997	3,397	110	20	110		1,617	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	109,956	\$	5,854	\$	5,854	\$	36,258	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 486,402	\$ 18,709	\$ 69,211	\$ 50,502	10	\$ 368,469	71
72	Current Year Purchases	33,457	258	11,256	10,998	10	11,256	72
73	Fully Depreciated Assets	2,469,423				10	2,469,423	73
74								74
75	TOTALS	\$ 2,989,282	\$ 18,967	\$ 80,467	\$ 61,500		\$ 2,849,148	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		2002 CHEVY MALIBU	2005	\$ 5,332	\$	\$ 952	\$ 952	5	\$ 3,111	76
77	Care Centers Health Sys.	Allocation	2007	898	30	30		5	30	77
78	Care Centers Clinical	Allocation	2007	3,368	498	498		5	636	78
79	Care Centers, Inc	Allocation	2007	39,362	2,284	2,284		5	32,334	79
80	TOTALS			\$ 48,960	\$ 2,812	\$ 3,764	\$ 952		\$ 36,111	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)		\$ 14,700,362	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 431,636	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 469,542	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 37,906	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 5,898,481	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Care Centers				4,932			5
6								6
7	TOTAL				\$ 4,932			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,720 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 229,503	\$		\$ 229,503	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			73,183			73,183	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			253,834			253,834	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				287,884		287,884	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					10,006	207,574		217,580	13
14	TOTAL			\$		\$ 566,526	\$ 495,458		\$ 1,061,984	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr# 0042119Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 750	\$ 141,754	1
2	Cash-Patient Deposits	81,780	330,780	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,502,972	2,542,972	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	379,615	379,615	6
7	Other Prepaid Expenses	12,735	12,735	7
8	Accounts Receivable (owners or related parties)	10,565,482	14,000,380	8
9	Other(specify): <u>See Attached Schedule</u>	477,045	477,045	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 14,020,379	\$ 17,885,281	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		352,000	13
14	Buildings, at Historical Cost		10,177,369	14
15	Leasehold Improvements, at Historical Cost	323,435	786,054	15
16	Equipment, at Historical Cost	590,902	3,039,594	16
17	Accumulated Depreciation (book methods)	(512,854)	(5,767,952)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		103,767	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 401,483	\$ 8,690,832	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,421,862	\$ 26,576,113	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,624,631	\$ 2,624,631	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	72,757	72,757	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	194,315	194,315	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,098	9,098	31
32	Accrued Real Estate Taxes(Sch.IX-B)	327,698	327,698	32
33	Accrued Interest Payable		92,764	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,678	1,678	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,230,177	\$ 3,322,941	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,701,768	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 16,701,768	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,230,177	\$ 20,024,709	46
47	TOTAL EQUITY (page 18, line 24)	\$ 11,191,685	\$ 6,551,404	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,421,862	\$ 26,576,113	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,309,354	1
2	Restatements (describe):		2
3	<u>See Attached</u>	(28,056)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,281,298	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,090,387	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	(180,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 910,387	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)	\$ 11,191,685	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/07

Ending: 12/31/07

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,404,379	1
2	Discounts and Allowances for all Levels	(2,402,757)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,001,622	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,268,076	6
7	Oxygen	27,638	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,295,714	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	246,057	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,090	19
20	Radiology and X-Ray	6,170	20
21	Other Medical Services	44,955	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 335,272	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	893,063	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 893,063	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	773	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 773	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,526,444	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,947,670	31
32	Health Care	4,192,109	32
33	General Administration	2,532,569	33
B. Capital Expense			
34	Ownership	1,570,082	34
C. Ancillary Expense			
35	Special Cost Centers	1,062,227	35
36	Provider Participation Fee	131,400	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,436,057	40
41	Income before Income Taxes (line 30 minus line 40)**	1,090,387	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,090,387	43

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

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

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

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,758	1,926	\$ 84,229	\$ 43.73	1
2	Assistant Director of Nursing	1,347	1,674	51,106	30.53	2
3	Registered Nurses	21,426	24,364	591,077	24.26	3
4	Licensed Practical Nurses	58,426	62,830	1,420,561	22.61	4
5	CNAs & Orderlies	117,863	128,822	1,235,876	9.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,247	15,890	208,466	13.12	8
9	Activity Director	1,874	2,072	26,966	13.01	9
10	Activity Assistants	14,116	15,702	147,212	9.38	10
11	Social Service Workers	10,614	11,374	171,716	15.10	11
12	Dietician					12
13	Food Service Supervisor	3,804	4,073	63,424	15.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,439	5,976	68,099	11.40	15
16	Dishwashers	27,748	29,973	269,999	9.01	16
17	Maintenance Workers	6,285	6,636	73,928	11.14	17
18	Housekeepers	29,282	31,825	282,860	8.89	18
19	Laundry	13,428	14,890	138,868	9.33	19
20	Administrator	1,950	2,231	102,154	45.79	20
21	Assistant Administrator	1,854	2,125	34,807	16.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,211	6,465	71,276	11.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,105	2,392	32,474	13.58	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	339,777	371,240	\$ 5,075,098 *	\$ 13.67	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	402	\$ 17,232	01-03	35
36	Medical Director	Monthly	20,500	09-03	36
37	Medical Records Consultant	Monthly	944	10-03	37
38	Nurse Consultant		100	10-03	38
39	Pharmacist Consultant	Monthly	3,416	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,400	11-03	44
45	Social Service Consultant	22	1,202	12-03	45
46	Other(specify) <u>Therapy Consultant</u>		1,872	10a-03	46
47	<u>Social Service Consultant</u>	See Attached	577	12-03	47
48	<u>Medical Records Consultant</u>	See Attached	196	10-03	48
49	TOTAL (lines 35 - 48)	472	\$ 48,439		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/07

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Timothy Drummond	Administrator	0	\$ 18,090	Workers' Compensation Insurance	\$ 121,463	IDPH License Fee	\$ 1,824	
Kay Ross	Administrator	0	84,064	Unemployment Compensation Insurance	94,514	Advertising: Employee Recruitment	4,611	
Niquitta D. Berry	Asst. Admin.	0	1,668	FICA Taxes	382,774	Health Care Worker Background Check		
Roland Carey	Asst. Admin.	0	33,139	Employee Health Insurance	183,842	(Indicate # of checks performed <u>376</u>)	5,833	
				Employee Meals		Patient Background Checks	240	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	14,812	
				Chicago Head Tax	7,584	Licenses & Fees	9,037	
				Employee Physicals	1,640	Advertising & Promotion	15,314	
				Pension Expense	29	Yellow Page Advertising	583	
				Union Pension	40,444	See Supplemental Schedule	9,117	
				Other Employee Welfare	7,557	Less: Public Relations Expense	()	
				Holiday Expense	3,719	Non-allowable advertising	(15,314)	
						Yellow page advertising	(583)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 843,566			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Description				Description				
Amount				Line #				
Amount				Amount				
Management Fees- Sandy Bokor								
\$ 12,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL				
				\$				
\$ 12,000								
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee				Description				
Type				Amount				
Amount				Amount				
FR & R				Out-of-State Travel				
Accounting				\$				
\$ 9,000								
Care Centers, Inc								
Home Office Expense								
454,244								
Personnel Planners								
Unemployment Consult.								
3,453								
ADP				In-State Travel				
Payroll Services								
11,512								
eHealth Data Solutions								
Data Processing								
2,650								
National Datacare Corp.								
Data Processing								
2,903								
Care Centers, Inc				Seminar Expense				
Other Professional Fees				570				
9,850				Care Centers Allocation				
Universal International				2,107				
Risk Mgmnt Consulting								
2,700								
Blymas Inc								
Tax Credit Services								
502								
Prospect Resources								
Natural Gas Procurement								
1,200								
HFG								
Line of Credit/Audit								
6,193								
See Supplemental Schedule				Entertainment Expense				
28,355				()				
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL (agree to Sch. V, line 24, col. 8)				
				\$				
\$ 532,562				\$ 2,677				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number South Shore Nsg & Rehab Ctr

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$13,104; IL Assoc of HC \$3,120
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,801 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 131,400
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT