

Facility Name & ID Number Washington Heights Nursing Home

0042044 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>228</u>	Skilled (SNF)	<u>228</u>	<u>83,220</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>228</u>	TOTALS	<u>228</u>	<u>83,220</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>57,786</u>	<u>2,659</u>	<u>6,374</u>	<u>66,819</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>57,786</u>	<u>2,659</u>	<u>6,374</u>	<u>66,819</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.29%

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

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

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

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

None

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

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

YES NO

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

YES NO

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

Date started 10/24/1996

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

YES Date 10/24/1996 NO

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

YES NO If YES, enter number of beds certified 228 and days of care provided 6,266

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 Washington Heights Nursing Home # 0042044 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	387,969	95,994	23,532	507,495		507,495	(29,462)	478,033			1
2	Food Purchase		332,148		332,148	(45,990)	286,158	215	286,373			2
3	Housekeeping	261,780	54,063	1,474	317,317		317,317	(3,526)	313,791			3
4	Laundry	66,907	25,975	3,836	96,718		96,718	(13)	96,705			4
5	Heat and Other Utilities			295,651	295,651		295,651	3,554	299,205			5
6	Maintenance	112,100		237,867	349,967		349,967	31,941	381,908			6
7	Other (specify):*							5,214	5,214			7
8	TOTAL General Services	828,756	508,180	562,360	1,899,296	(45,990)	1,853,306	7,923	1,861,229			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,428,122	146,173	3,745	3,578,040		3,578,040	16,738	3,594,778			10
10a	Therapy	192,162		60	192,222		192,222	2,985	195,207			10a
11	Activities	182,663	12,459	2,297	197,419		197,419		197,419			11
12	Social Services	154,338	1,008	1,468	156,814		156,814	8,627	165,441			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,565	5,565			15
16	TOTAL Health Care and Programs	3,957,285	159,640	31,570	4,148,495		4,148,495	33,915	4,182,410			16
	C. General Administration											
17	Administrative	163,474			163,474		163,474	86,068	249,542			17
18	Directors Fees											18
19	Professional Services			483,705	483,705	(9,222)	474,483	(405,367)	69,116			19
20	Dues, Fees, Subscriptions & Promotions			69,169	69,169		69,169	(16,192)	52,977			20
21	Clerical & General Office Expenses	151,993	31,964	806,455	990,412		990,412	(525,791)	464,621			21
22	Employee Benefits & Payroll Taxes			862,389	862,389	45,990	908,379	(1,212)	907,167			22
23	Inservice Training & Education			1,801	1,801		1,801		1,801			23
24	Travel and Seminar			1,619	1,619		1,619	2,995	4,614			24
25	Other Admin. Staff Transportation			3,506	3,506		3,506	2,140	5,646			25
26	Insurance-Prop.Liab.Malpractice			312,987	312,987		312,987	3,925	316,912			26
27	Other (specify):*							39,995	39,995			27
28	TOTAL General Administration	315,467	31,964	2,541,631	2,889,062	36,768	2,925,830	(813,440)	2,112,390			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,101,508	699,784	3,135,561	8,936,853	(9,222)	8,927,631	(771,602)	8,156,029			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 Washington Heights Nursing Home #0042044 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			104,784	104,784		104,784	282,369	387,153		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			59,263	59,263		59,263	421,876	481,139		32
33	Real Estate Taxes			358,964	358,964	9,222	368,186	3,370	371,556		33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,075,564)	4,436		34
35	Rent-Equipment & Vehicles			5,576	5,576		5,576	2,031	7,607		35
36	Other (specify):*							35,452	35,452		36
37	TOTAL Ownership			1,608,587	1,608,587	9,222	1,617,809	(330,466)	1,287,343		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		465,517	389,594	855,111		855,111	(149,037)	706,074		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			124,830	124,830		124,830		124,830		42
43	Other (specify):*							39,628	39,628		43
44	TOTAL Special Cost Centers		465,517	514,424	979,941		979,941	(109,409)	870,532		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,101,508	1,165,301	5,258,572	11,525,381		11,525,381	(1,211,477)	10,313,904		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 Washington Heights Nursing Home

0042044

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	(389)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,754	30		9
10	Interest and Other Investment Income	(236,179)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(130)	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	(24,880)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(500,946)	21		24
25	Fund Raising, Advertising and Promotional	(20,731)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(301,021)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,074,522)		\$	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)	(136,955)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (136,955)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,211,477)		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 C/OPB	\$ (2,713)	20	1
2 Day Care	(7)	19	2
3 Patient Clothing	(141)	10	3
4 Theft Loss	(924)	21	4
5 Collection Expenses	(3,154)	21	5
6 Non-Allowable Expenses	(204,000)	21	6
7 Non-Allowable Legal	(5,687)	19	7
8 Annual Report	(280)	21	8
9 Related Party Interest	(83,753)	21	9
10 Building Co-Bank Charges	(60)	21	10
11 Building Co-Filing Fees	(280)	21	11
12 Out of Period Travel	(52)	25	12
13			13
14			14
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99			99
100			100
101 Total	(301,024)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Heights Nursing Home

0042044

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			280	3,975	(33,709)			(8)				(29,462)	1
2	Food Purchase	(130)		345									215	2
3	Housekeeping			526	53	45			(4,150)				(3,526)	3
4	Laundry								(13)				(13)	4
5	Heat and Other Utilities	(389)		2,510	136	1,297							3,554	5
6	Maintenance			30,761	17	528		635					31,941	6
7	Other (specify):*			4,837	377								5,214	7
8	TOTAL General Services	(519)		39,259	4,558	(31,839)		635	(4,171)				7,923	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(178)			30,894	(4,046)			(9,933)				16,738	10
10a	Therapy				2,985								2,985	10a
11	Activities													11
12	Social Services				8,627								8,627	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				5,565								5,565	15
16	TOTAL Health Care and Programs	(178)			48,071	(4,046)			(9,933)				33,915	16
	C. General Administration													
17	Administrative			11,977	54,245	10,636	9,210						86,068	17
18	Directors Fees													18
19	Professional Services	(5,687)		(278,970)	(121,370)	141	519						(405,367)	19
20	Fees, Subscriptions & Promotions	(24,694)		7,233	33	805	431						(16,192)	20
21	Clerical & General Office Expenses	(734,214)	310	176,313	14,041	17,822	3,157	(3,220)					(525,791)	21
22	Employee Benefits & Payroll Taxes			(888)	(145)				(179)				(1,212)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,224	651		1,120						2,995	24
25	Other Admin. Staff Transportation	(52)		1,584		608							2,140	25
26	Insurance-Prop.Liab.Malpractice			1,605	17	1,170	1,133						3,925	26
27	Other (specify):*			25,410	9,221	4,245	1,119						39,995	27
28	TOTAL General Administration	(764,647)	310	(54,512)	(43,307)	35,427	16,689	(3,220)	(179)				(813,440)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(765,344)	310	(15,253)	9,322	(458)	16,689	(2,585)	(14,283)				(771,602)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	10,754	242,970	20,462	859	915	602	5,807					282,369	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(319,932)	690,833	38,609	3,701	1,525	5,609	1,531					421,876	32
33	Real Estate Taxes			2,995	202	173							3,370	33
34	Rent-Facility & Grounds		(1,080,000)	3,235		1,201							(1,075,564)	34
35	Rent-Equipment & Vehicles			426	6	293	1,306						2,031	35
36	Other (specify):*		35,452										35,452	36
37	TOTAL Ownership	(309,178)	(110,745)	65,727	4,768	4,107	7,517	7,338					(330,466)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(43,307)	(83,226)	(15,925)	(6,579)				(149,037)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*						39,628						39,628	43
44	TOTAL Special Cost Centers					(43,307)	(43,598)	(15,925)	(6,579)				(109,409)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,074,522)	(110,435)	50,474	14,090	(39,658)	(19,392)	(11,172)	(20,862)				(1,211,477)	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		
				Washington Heights Property LLC		

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	\$ 1,080,000	Washington Heights, LLC	100.00%	\$	\$ (1,080,000)	1
2	V	32 Interest Income	59,263	Washington Heights, LLC	100.00%		(59,263)	2
3	V	21 Bank Service Charge		Washington Heights, LLC	100.00%	60	60	3
4	V	21 Filing Fees		Washington Heights, LLC	100.00%	250	250	4
5	V	32 Interest Expenses		Washington Heights, LLC	100.00%	750,096	750,096	5
6	V	30 Depreciation		Washington Heights, LLC	100.00%	242,970	242,970	6
7	V	36 Amortization		Washington Heights, LLC	100.00%	35,452	35,452	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,139,263			\$ 1,028,828	\$ * (110,435)	14

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

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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%	\$ 280	\$ 280	15	
16	V	02	Food		Care Centers, Inc.	100.00%	345	345	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	526	526	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	2,510	2,510	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	4,139	4,139	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	2,507	2,507	20	
21	V	19	Professional Fees	292,203	Care Centers, Inc.	100.00%	13,233	(278,970)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	7,233	7,233	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	20,962	20,962	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	1,224	1,224	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,584	1,584	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	1,605	1,605	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	20,462	20,462	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	38,609	38,609	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,995	2,995	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,235	3,235	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	426	426	31	
32	V	06	Maintenance	3,475	Care Centers, Inc.	100.00%	30,097	26,622	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	4,837	4,837	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	9,470	9,470	34	
35	V	21	Office and Clerical		Care Centers, Inc.	100.00%	155,351	155,351	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	25,410	25,410	36	
37	V	22	Employee Benefits	888	Care Centers, Inc.	100.00%		(888)	37	
38	V								38	
39	Total			\$ 296,566			\$ 347,040	\$ * 50,474	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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%	\$ 53	\$ 53	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	136	136	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	17	17	17	
18	V	19	Professional Fees	123,633	Care Centers Clinical, Inc.	100.00%	2,263	(121,370)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	33	33	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	132	132	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	651	651	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	17	17	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	859	859	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	3,701	3,701	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	202	202	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	6	6	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	3,975	3,975	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	377	377	28	
29	V	10	Nursing Salary	392	Care Centers Clinical, Inc.	100.00%	31,286	30,894	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	2,985	2,985	30	
31	V	12	Social Service Salary	577	Care Centers Clinical, Inc.	100.00%	9,204	8,627	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	5,565	5,565	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	54,245	54,245	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	13,909	13,909	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	9,221	9,221	35	
36	V	22	Employee Benefits	145	Care Centers Clinical, Inc.	100.00%		(145)	36	
37	V								37	
38	V								38	
39	Total			\$ 124,747			\$ 138,837	\$ * 14,090	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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%	\$ 6,474	\$ 6,474	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	45	45	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	1,297	1,297	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	528	528	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	141	141	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	805	805	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,779	2,779	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	608	608	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	1,170	1,170	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	915	915	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	1,525	1,525	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	173	173	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	1,201	1,201	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	293	293	28	
29	V	01	Dietary	59,824	Care Centers Health Systems, Inc.	100.00%	19,641	(40,183)	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	6,024	Care Centers Health Systems, Inc.	100.00%	1,978	(4,046)	32	
33	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33	
34	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34	
35	V	39	Ancillary	64,474	Care Centers Health Systems, Inc.	100.00%	21,167	(43,307)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	10,636	10,636	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	15,043	15,043	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	4,245	4,245	38	
39	Total			\$ 130,322			\$ 90,664	\$ * (39,658)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	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	17 Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 645	\$ 645	15
16	V	19 Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	519	519	16
17	V	20 Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	431	431	17
18	V	21 Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	3,157	3,157	18
19	V	24 Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	1,120	1,120	19
20	V	26 Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	1,133	1,133	20
21	V	30 Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	602	602	21
22	V	32 Interest		Therapy Works Rehabilitation Services, LLC	100.00%	5,609	5,609	22
23	V	35 Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	1,306	1,306	23
24	V	39 Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	15,124	15,124	24
25	V	17 Administrative		Therapy Works Rehabilitation Services, LLC	100.00%	8,565	8,565	25
26	V	27 Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	1,119	1,119	26
27	V	39 Ancillary	373,431	Therapy Works Rehabilitation Services, LLC	100.00%	275,081	(98,350)	27
28	V	43 Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	39,628	39,628	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		\$ 373,431			\$ 354,039	\$ * (19,392)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 635	\$ 635	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	1	1	16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	4,998	4,998	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	418	418	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	809	809	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	1,113	1,113	20
21	V	21	Office and Clerical	3,221	Vent Lease, LLC.	100.00%		(3,221)	21
22	V	39	Ancillary	15,925	Vent Lease, LLC.	100.00%		(15,925)	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			\$ 19,146			\$ 7,974	\$ * (11,172)	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	\$ 100	Xcel Supply, LLC	100.00%	\$ 92	\$ (8)	15
16	V	3 Housekeeping	51,453	Xcel Supply, LLC	100.00%	47,303	(4,150)	16
17	V	4 Laundry	158	Xcel Supply, LLC	100.00%	145	(13)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	123,156	Xcel Supply, LLC	100.00%	113,223	(9,933)	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	2,224	Xcel Supply, LLC	100.00%	2,044	(179)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	81,578	Xcel Supply, LLC	100.00%	74,999	(6,579)	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		\$ 258,668			\$ 237,806	\$ * (20,862)	39

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

Facility Name & ID Number Washington Heights Nursing Home# 0042044Report Period Beginning: 01/01/07Ending: 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 66,216	\$ 66,216	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	66,216	CCS Employee Benefits Group	100.00%		(66,216)	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			\$ 66,216			\$ 66,216	\$ *	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			\$			\$		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

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.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	Eric Rothner	Relative	Administrative	N/A	See Attached	1.37	2.97%		\$		1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.26	4.11%	Alloc. Salary	5,555	17-7	2
3	Adam Vales	Onwer	Clerical	5.70	See Attached	0.41	1.03%	Alloc. Salary	570	22-7	3
4	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.36	1.03%	Alloc. Salary	314	22-7	4
5	David Aronin	Onwer	Administrative	0.89	See Attached	1.65	2.89%	Alloc. Salary	3,853	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,292		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 Washington Heights Nursing Home

0042044

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 Washington Heights Nursing Home

0042044

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	\$ 66,819	\$ 280	1
2	02	Food	Patient Days	1,625,640	33	8,403	66,819	345	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	66,819	526	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	66,819	2,510	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	66,819	4,139	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	66,819	2,507	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	66,819	13,233	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	66,819	7,233	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	66,819	20,962	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	66,819	1,224	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	66,819	1,584	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	66,819	1,605	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	66,819	20,462	13
14	32	Interest	Patient Days	1,625,640	33	939,326	66,819	38,609	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	66,819	2,995	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	66,819	3,235	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	66,819	426	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	7,687	18
19	06	Maintenance	Direct Allocation			456,812	456,812	22,410	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	66,819	4,837	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	9,470	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	155,351	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346		23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	66,819	25,410	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 347,040	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 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

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	\$ 66,819	\$ 53	1
2	05	Utilities	Patient Days	1,625,640	32	3,307	66,819	136	2
3	06	Maintenance	Patient Days	1,625,640	32	410	66,819	17	3
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	66,819	2,263	4
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	66,819	33	5
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	66,819	132	6
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	66,819	651	7
8	26	Insurance	Patient Days	1,625,640	32	409	66,819	17	8
9	30	Depreciation	Patient Days	1,625,640	32	20,909	66,819	859	9
10	32	Interest	Patient Days	1,625,640	32	90,038	66,819	3,701	10
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	66,819	202	11
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	66,819	6	12
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	3,975	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	66,819	377	14
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	30,881	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	2,985	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	8,572	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	66,819	5,472	18
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	54,245	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	13,909	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	66,819	9,221	21
22	10	Nursing Salary	Direct Allocation			13,379	13,379	405	22
23	12	Social Service Salary	Direct Allocation			8,845	8,845	632	23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994		93	24
25	TOTALS					\$ 3,374,561	\$ 2,809,547	\$ 138,837	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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	304,040	6,474	1	
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	304,040	45	2	
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	304,040	1,297	3	
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	304,040	528	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	304,040	141	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	304,040	805	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	304,040	2,779	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	304,040	608	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	304,040	1,170	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	304,040	915	10	
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	304,040	1,525	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	304,040	173	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	304,040	1,201	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	304,040	293	14	
15	01	Dietary	Direct Billable Income	341,879	33	112,243	59,824	19,641	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	6,024	1,978	18	
19	21	Clerical and General Office	Direct Billable Income	487	33	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	64,474	21,167	21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	304,040	10,636	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	304,040	15,043	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	304,040	4,245	24	
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 90,664	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Therapy Works Rehabilitation Services, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 922-0702
 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	17	Administration	Billable Income	4,671,432	16	\$ 9,000	\$ 334,535	\$ 645	1
2	19	Professional Fees	Billable Income	4,671,432	16	7,245	334,535	519	2
3	20	Dues and Subscriptions	Billable Income	4,671,432	16	6,024	334,535	431	3
4	21	Office & Clerical	Billable Income	4,671,432	16	44,084	334,535	3,157	4
5	24	Travel and Seminar	Billable Income	4,671,432	16	15,640	334,535	1,120	5
6	26	Insurance	Billable Income	4,671,432	16	15,816	334,535	1,133	6
7	30	Depreciation	Billable Income	4,671,432	16	8,410	334,535	602	7
8	32	Interest	Billable Income	4,671,432	16	78,317	334,535	5,609	8
9	35	Rent - Equipment	Billable Income	4,671,432	16	18,231	334,535	1,306	9
10	39	Ancillary	Billable Income	4,671,432	16	211,187	334,535	15,124	10
11	17	Administrative	Billable Income	4,671,432	16	119,603	119,603	8,565	11
12	27	Emp. Ben. - Gen. Admin.	Billable Income	4,671,432	16	15,625	334,535	1,119	12
13	39	Ancillary	Billable Income	4,671,432	16	3,841,227	3,841,227	275,081	13
14	43	Emp. Ben. - Other	Billable Income	4,671,432	16	553,364	334,535	39,628	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,943,774	\$ 3,960,830	\$ 354,039	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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	\$ 15,925	\$ 635	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	15,925	1	2
3	30	Depreciation	Direct Billing	892,186	27	280,000	15,925	4,998	3
4	32	Interest	Direct Billing	892,186	27	23,404	15,925	418	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	66,819	809	5
6	32	Interest	Patient Days	1,625,640	33	27,081	66,819	1,113	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	\$	\$ 7,974	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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			\$		\$ 92	1
2	3	Housekeeping	Direct Allocation					47,303	2
3	4	Laundry	Direct Allocation					145	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					113,223	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					2,044	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					74,999	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					\$	\$	237,806	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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, IL 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		\$	\$		\$ 66,216	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				\$	\$		\$ 66,216	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 Washington Heights Nursing Home

0042044

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Business Partners, LLC		X	Mortgage			\$	\$ 9,866,023		\$ 666,343	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	DIAWA		X	Line of Credit						\$ 59,263	6									
7											7									
8	See Supplemental Schedule									\$ 50,975	8									
9	TOTAL Facility Related						\$	\$ 9,866,023		\$ 776,581	9									
B. Non-Facility Related*																				
10	South Shore Partnership	X						\$ 1,236,980		\$ 83,753	10									
11	Interest Income		X							\$ (236,179)	11									
12	Interest Income-Bldg Co.									\$ (59,263)	12									
13	See Supplemental Schedule									\$ (83,753)	13									
14	TOTAL Non-Facility Related						\$	\$ 1,236,980		\$ (295,442)	14									
15	TOTALS (line 9+line14)						\$	\$ 11,103,003		\$ 481,139	15									

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

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

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

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

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

1	2	3	4	5	6	7	8	9	10											
										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																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8	Alloc from Care Centers, Inc		X							\$ 38,609										
9	Alloc from Care Centers Clinical		X							3,701										
10	Alloc from Care Centers Health System		X							1,525										
11	Alloc from Therapy Works		X							5,609										
12	Alloc from Vent Lease		X							1,531										
13																				
14	TOTAL Working Capital									50,975										
B. Non-Facility Related*																				
15	Related Party Interest	X								\$(83,753)										
16																				
17																				
18																				
19																				
20	TOTAL Non-Facility Related									\$(83,753)										

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Washington Heights Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

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) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>25-05-423-001-0000</u>	<u>Long Term Care property</u>	<u>\$ 1,831.34</u>	<u>\$ 1,831.34</u>
2. <u>25-05-423-002-0000</u>	<u>Long Term Care property</u>	<u>\$ 2,083.62</u>	<u>\$ 2,083.62</u>
3. <u>25-05-423-003-0000</u>	<u>Long Term Care property</u>	<u>\$ 2,452.17</u>	<u>\$ 2,452.17</u>
4. <u>25-05-423-004-0000</u>	<u>Long Term Care property</u>	<u>\$ 2,604.70</u>	<u>\$ 2,604.70</u>
5. <u>25-05-423-005-0000</u>	<u>Long Term Care property</u>	<u>\$ 9,221.04</u>	<u>\$ 9,221.04</u>
6. <u>25-05-423-006-0000</u>	<u>Long Term Care property</u>	<u>\$ 41,915.46</u>	<u>\$ 41,915.46</u>
7. <u>25-05-423-007-0000</u>	<u>Long Term Care property</u>	<u>\$ 50,437.78</u>	<u>\$ 50,437.78</u>
8. <u>25-05-423-008-0000</u>	<u>Long Term Care property</u>	<u>\$ 127,733.43</u>	<u>\$ 127,733.43</u>
9. <u>25-05-423-009-0000</u>	<u>Long Term Care property</u>	<u>\$ 103,117.72</u>	<u>\$ 103,117.72</u>
10. <u>See attached</u>	<u>Home Office Allocation</u>	<u>\$ 118,409.42</u>	<u>\$ 3,279.36</u>
	TOTALS	<u>\$ 459,806.68</u>	<u>\$ 344,676.62</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 Washington Heights Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

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 Washington Heights Nursing Home

0042044 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255 B. General Construction Type: Exterior Brick Frame Masonry/Steel 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).

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>85,244</u>	<u>1994</u>	<u>\$ 251,898</u>	1
2	<u>Care Centers Alloc</u>			<u>17,589</u>	2
3	TOTALS	85,244		\$ 269,487	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	21,522		20	1,077	1,077	12,331	9
10	Various			1997	179,381		20	8,971	8,971	93,765	10
11	Various			1998	71,893		20	3,596	3,596	34,252	11
12	Various			1999	54,109		20	2,705	2,705	22,844	12
13	Various			2000	102,147		20	5,618	5,618	43,033	13
14	Various			2001	61,238		20	3,063	3,063	20,978	14
15	Various			2002	93,299		20	8,448	8,448	58,196	15
16	Various			2003	4,294		20	371	371	1,697	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
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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 Washington Heights Nursing Home

0042044

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
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52								52
53								53
54								54
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56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		10,226,094	242,970		254,542	11,572	2,810,000	67
68		96,877	5,165		5,165		31,947	68
69			104,784			(104,784)		69
70		\$ 10,910,854	\$ 352,919		\$ 293,556	\$ (59,363)	\$ 3,129,043	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,910,854	\$ 352,919		\$ 293,556	\$ (59,363)	\$ 3,129,043	1
2	Elevator Doors	2004	3,187		20	159	159	637	2
3	Repair Elevator Door	2004	3,187		20	159	159	611	3
4	New Telephone System	2004	2,929		20	586	586	2,246	4
5	Midwest Mechanical	2004	575		20	58	58	221	5
6	New Telephone System	2004	2,670		20	534	534	2,047	6
7	Roof Repair	2004	1,200		20	120	120	420	7
8	Radio Controlled Doors	2004	4,763		20	476	476	1,627	8
9	Widen Driveway	2004	1,875		20	188	188	625	9
10	Widen Driveway	2004	2,000		20	200	200	667	10
11	Elevator Recall System	2004	2,200		20	110	110	367	11
12	Widen Driveway	2004	1,875		20	188	188	625	12
13	Back Lot Pavement	2004	2,685		20	269	269	895	13
14	Locks On Doors	2004	7,574		20	1,515	1,515	5,050	14
15	Piping & Wiring	2004	1,656		20	166	166	538	15
16	Lab To Remove Debris	2004	2,623		20	262	262	831	16
17	Repair Epdm Roof	2004	700		20	70	70	222	17
18	Fire Alarm System	2004	1,200		20	240	240	760	18
19	Elevator Recall System	2004	1,200		20	60	60	190	19
20	Lighting Maintenance	2004	578		20	58	58	178	20
21	Repair Epdm Roof	2004	650		20	65	65	200	21
22	Plumbing Maintenance	2004	1,300		20	130	130	401	22
23	Smoke Damper	2004	1,448		20	207	207	638	23
24	Zone Valve Thermostat	2004	1,020		20	204	204	629	24
25	Exhaust Fan	2004	1,223		20	245	245	754	25
26	Window Treatment Rods	2004	1,613		20	161	161	497	26
27	Hot Water Heater - Repair	2004	1,579		20	132	132	406	27
28	Hvac	2004	2,811		20	281	281	1,124	28
29	Repairs To Shower Rooms	2004	825		20	83	83	275	29
30	Hvac	2004	1,548		20	155	155	581	30
31	Pneumatic Thermostat And Installation	2004	1,117		20	112	112	391	31
32	Sprinkler Repairs	2004	556		20	28	28	107	32
33	Doors	2004	2,077		20	104	104	355	33
34	TOTAL (lines 1 thru 33)		\$ 10,973,298	\$ 352,919		\$ 300,881	\$ (52,038)	\$ 3,154,158	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,973,298	\$ 352,919		\$ 300,881	\$ (52,038)	\$ 3,154,158	1
2	Generator Repair	2005	5,667		20	1,133	1,133	3,117	2
3	5 Oak Doors	2005	3,440		20	688	688	1,835	3
4	Plumbing For Catch Basin	2005	5,437		20	544	544	1,405	4
5	Hvac Repair	2005	1,519		20	76	76	184	5
6	Plumbing	2005	2,124		20	106	106	239	6
7	Midwest Mech Repairs To Laundry Exhaust	2006	7,125		20	713	713	1,366	7
8	Midwest Mech Repairs To Boiler	2006	2,962		20	296	296	568	8
9	Home Office Pr-Painting	2006	1,241		20	124	124	207	9
10	Home Office Pr-Painting	2006	14,602		20	1,460	1,460	2,312	10
11	Home Office Pr-Painting	2006	7,947		20	795	795	1,192	11
12	Palatine Bldrs	2006	2,741		20	274	274	411	12
13	Inpro.Corp.	2006	3,531		20	353	353	471	13
14	Home Office Pr - Painting	2006	2,070		20	207	207	259	14
15	Vinyl Sheets - Dividers Corners	2006	3,743		20	374	374	468	15
16	Home Office Pr - Painting	2006	12,605		20	1,261	1,261	1,471	16
17	Painting (Transfer Expense From Home Office)	2007	2,443		20	2,443	2,443	2,443	17
18	New Phone System	2007	15,944		20	1,594	1,594	1,594	18
19	Repairs To Catch Basin	2007	3,690		20	369	369	369	19
20	Repairs To Boiler	2007	4,815		20	401	401	401	20
21	New Flooring	2007	9,341		20	571	571	571	21
22	Smoke Detector In Elevator	2007	4,149		20	494	494	494	22
23	2 Boilers	2007	91,000		20	5,688	5,688	5,688	23
24	Repair Heating & A/C Unit	2007	4,551		20	221	221	221	24
25	Painting (Transfer Expense From Home Office)	2007	17,419		20	10,161	10,161	10,161	25
26	Hatco Booster Heater	2007	3,212		20	375	375	375	26
27	Install 2 Halide Floodlights	2007	4,900		20	245	245	245	27
28	Blinds	2007	3,526		20	147	147	147	28
29	Painting (Transfer Payment From Home Office)	2007	3,165		20	1,583	1,583	1,583	29
30	Supply & Install Premium Tile	2007	13,042		20	145	145	145	30
31	New Coils In Make-Up Air Unit	2007	25,734		20	429	429	429	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12C, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	1
2									2
3									3
4									4
5									5
6									6
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8									8
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27									27
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12D, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	1
2									2
3									3
4									4
5									5
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27									27
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12E, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12F, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	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)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12G, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12H, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12I, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	1
2									2
3									3
4									4
5									5
6									6
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8									8
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12J, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	1
2									2
3									3
4									4
5									5
6									6
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12K, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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 12L, Carried Forward		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	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)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	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)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	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)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	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)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	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)		\$ 11,256,983	\$ 352,919		\$ 334,151	\$ (18,768)	\$ 3,194,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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	228		1996	1996	\$ 10,226,094	\$ 242,970	39	\$ 254,542	\$ 11,572	\$ 2,810,000	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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)	\$	10,226,094	\$	242,970	\$	254,542	\$	11,572	\$	2,810,000	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home

0042044

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		Allocated from Care Centers, Inc	2002	2002	\$ 18,304	\$ 469	39	\$ 469		\$ 2,483	4
5		Allocated from Care Centers-Hillside	1996	1996	31,037	796	39	796		8,787	5
6		Allocated from Care Centers Health Systems	2002	2002	1,622	42	39	42		220	6
7		Allocated from Care Centers Clinical	2002	2002	1,896	49	39	49		257	7
8											8
		Improvement Type**									
9		Allocated from Care Centers, Inc		2002	15,120	1,382	20	1,382		6,922	9
10		Allocated from Care Centers, Inc		2003	17,819	1,628	20	1,628		8,158	10
11		Allocated from Care Centers, Inc		2005	885	94	20	94		225	11
12		Allocated from Care Centers, Inc		2007	189	13	20	13		13	12
13											13
14		Allocated from Care Centers-Hillside		1996	523					523	14
15		Allocated from Care Centers-Hillside		1997	2,980	96	20	96		1,418	15
16											16
17		Allocated from Care Centers Health Systems		2002	1,340	122	20	122		613	17
18		Allocated from Care Centers Health Systems		2003	1,579	144	20	144		723	18
19		Allocated from Care Centers Health Systems		2005	78	8	20	8		20	19
20											20
21		Allocated from Care Centers Clinical		2002	1,567	143	20	143		717	21
22		Allocated from Care Centers Clinical		2003	1,846	169	20	169		845	22
23		Allocated from Care Centers Clinical		2005	92	10	20	10		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 Washington Heights Nursing Home

0042044

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)	\$	\$ 96,877		\$ 5,165	\$ 5,165	\$ 31,947	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Washington Heights Nursing Home # 0042044 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	\$ 416,363	\$ 20,778	\$ 46,507	\$ 25,729	10	\$ 333,629	71
72	Current Year Purchases	32,862	234	4,027	3,793	10	4,027	72
73	Fully Depreciated Assets	695,242				10	695,242	73
74								74
75	TOTALS	\$ 1,144,467	\$ 21,012	\$ 50,534	\$ 29,522		\$ 1,032,898	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		Allocated from Care Centers, Inc		\$ 34,531	\$ 2,003	\$ 2,003		5	\$ 28,365	76
77		Allocated from Care Centers Health Systems		866	29	29		5	29	77
78		Allocated from Care Centers Clinical		2,955	437	437		5	558	78
79										79
80	TOTALS			\$ 38,352	\$ 2,469	\$ 2,469			\$ 28,952	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)		\$ 12,709,289	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 376,400	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 387,154	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 10,754	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 4,256,379	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	<u>Alloc from Care Centers, Inc</u>				<u>3,235</u>			5
6	<u>Alloc from Care Centers Health Systems</u>				<u>1,201</u>			6
7	TOTAL				\$ 4,436			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,607 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$		\$ 183,797	\$		\$ 183,797	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			12,196			12,196	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			177,438			177,438	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			238	245,001		245,239	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					15,925	220,516		236,441	13
14	TOTAL			\$		\$ 389,594	\$ 465,517		\$ 855,111	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 Washington Heights Nursing Home# 0042044Report 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	\$ 1,500	\$ 277,649	1
2	Cash-Patient Deposits	57,385	57,385	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,741,625	2,100,092	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	470,666	470,666	6
7	Other Prepaid Expenses	12,382	12,382	7
8	Accounts Receivable (owners or related parties)		15,170	8
9	Other(specify): <u>See Attached Schedule</u>	1,919,209	1,853,006	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,202,767	\$ 4,786,350	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		251,898	13
14	Buildings, at Historical Cost		8,473,923	14
15	Leasehold Improvements, at Historical Cost	751,869	1,186,933	15
16	Equipment, at Historical Cost	515,064	2,500,491	16
17	Accumulated Depreciation (book methods)	(784,414)	(5,533,551)	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>		85,921	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 482,519	\$ 6,965,615	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,685,286	\$ 11,751,965	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,117,785	\$ 2,476,251	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,134	54,134	28
29	Short-Term Notes Payable	1,161,171		29
30	Accrued Salaries Payable	215,420	215,420	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,856	7,856	31
32	Accrued Real Estate Taxes(Sch.IX-B)	358,467	358,467	32
33	Accrued Interest Payable		54,798	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>		98,909	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,914,833	\$ 3,265,835	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,103,003	39
40	Mortgage Payable			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)	\$	\$ 11,103,003	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,914,833	\$ 14,368,838	46
47	TOTAL EQUITY(page 18, line 24)	\$ 770,453	\$ (2,616,873)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,685,286	\$ 11,751,965	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,448,665	1
2	Restatements (describe):		2
3	Retained Earnings Prior Period Adjustment	34,500	3
4	Medicare Settlement	(752)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,482,413	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,608,760)	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	(103,200)	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)	\$ (1,711,960)	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)	\$ 770,453	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home# 0042044Report Period Beginning: 01/01/07Ending: 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	\$ 9,651,499	1
2	Discounts and Allowances for all Levels	(1,931,724)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,719,775	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,597,778	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,597,778	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	244,540	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,744	19
20	Radiology and X-Ray	10,220	20
21	Other Medical Services	72,368	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 362,872	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	236,179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 236,179	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	17	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,916,621	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,899,296	31
32	Health Care	4,148,495	32
33	General Administration	2,889,062	33
B. Capital Expense			
34	Ownership	1,608,587	34
C. Ancillary Expense			
35	Special Cost Centers	855,111	35
36	Provider Participation Fee	124,830	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,525,381	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,608,760)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,608,760)	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 Washington Heights Nursing Home

0042044

Report Period Beginning: 01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,056	2,488	\$ 90,419	\$ 36.34	1
2	Assistant Director of Nursing	2,016	3,178	102,752	32.33	2
3	Registered Nurses	17,508	19,736	540,468	27.38	3
4	Licensed Practical Nurses	53,963	59,222	1,437,813	24.28	4
5	CNAs & Orderlies	111,148	122,066	1,226,262	10.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,134	11,629	192,162	16.52	8
9	Activity Director	1,603	2,014	30,778	15.28	9
10	Activity Assistants	13,727	15,445	151,885	9.83	10
11	Social Service Workers	9,116	8,854	154,338	17.43	11
12	Dietician	2,312	2,122	29,811	14.05	12
13	Food Service Supervisor	1,720	2,498	37,745	15.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,373	5,083	57,668	11.35	15
16	Dishwashers	26,939	29,499	262,745	8.91	16
17	Maintenance Workers	6,105	6,813	112,100	16.45	17
18	Housekeepers	27,540	29,770	261,780	8.79	18
19	Laundry	6,813	7,438	66,907	9.00	19
20	Administrator	2,020	2,437	103,118	42.31	20
21	Assistant Administrator	2,264	2,488	60,356	24.26	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,211	11,556	151,993	13.15	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	1,868	2,124	30,408	14.32	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	313,436	346,460	\$ 5,101,508 *	\$ 14.72	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	544	\$ 23,532	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant	15	1,166	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,579	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	47	2,297	11-03	44
45	Social Service Consultant	33	1,468	12-03	45
46	Other(specify) <u>Therapy Consult</u>	1	60	10a-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	640	\$ 55,102		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 Washington Heights Nursing Home

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

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													
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7													
8													
9													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

