

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0042325

Facility Name: Westshire Nursing & Rehab Ctr

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

County: Cook

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

HFS ID Number: 364096965001

Date of Initial License for Current Owners: 9/1/1996

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____
	(Type or Print Name) _____ (Date) _____
Paid Preparer	(Title) _____
	(Signed) _____ (Date) _____
Paid Preparer	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325 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>74</u>	Skilled (SNF)	<u>74</u>	<u>27,010</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>411</u>	Intermediate (ICF)	<u>411</u>	<u>150,015</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>485</u>	TOTALS	<u>485</u>	<u>177,025</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>23,041</u>	<u>1,917</u>	<u>2,052</u>	<u>27,010</u>	8
9	SNF/PED					9
10	ICF	<u>91,133</u>			<u>91,133</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>114,174</u>	<u>1,917</u>	<u>2,052</u>	<u>118,143</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.74%

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

0 (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 09/01/96

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

YES Date 09/01/96 NO

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

YES NO If YES, enter number of beds certified 33 and days of care provided 1,862

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 Westshire Nursing & Rehab Ctr # 0042325 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	591,605	64,662	251	656,518		656,518	(212)	656,306		1
2	Food Purchase		484,509		484,509		484,509	532	485,041		2
3	Housekeeping	355,156	87,369		442,525		442,525	(5,222)	437,303		3
4	Laundry	133,809	49,494		183,303		183,303	(311)	182,992		4
5	Heat and Other Utilities			325,510	325,510		325,510	5,010	330,520		5
6	Maintenance	351,798		189,484	541,282		541,282	71,316	612,598		6
7	Other (specify):*							4,119	4,119		7
8	TOTAL General Services	1,432,368	686,034	515,245	2,633,647		2,633,647	75,232	2,708,879		8
	B. Health Care and Programs										
9	Medical Director			19,500	19,500		19,500		19,500		9
10	Nursing and Medical Records	3,713,590	104,343	42,918	3,860,851		3,860,851	45,974	3,906,825		10
10a	Therapy	225,732		60	225,792		225,792	5,281	231,073		10a
11	Activities	196,482	28,003	2,425	226,910		226,910		226,910		11
12	Social Services	453,960	1,147	15,854	470,961		470,961	15,163	486,124		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							9,680	9,680		15
16	TOTAL Health Care and Programs	4,589,764	133,493	80,757	4,804,014		4,804,014	76,098	4,880,112		16
	C. General Administration										
17	Administrative	199,650			199,650		199,650	120,703	320,353		17
18	Directors Fees										18
19	Professional Services			24,278	24,278	(1,250)	23,028	113,570	136,598		19
20	Dues, Fees, Subscriptions & Promotions			66,990	66,990		66,990	(7,192)	59,798		20
21	Clerical & General Office Expenses	157,032	38,384	507,056	702,472		702,472	(136,021)	566,451		21
22	Employee Benefits & Payroll Taxes			1,039,963	1,039,963		1,039,963	(37,721)	1,002,242		22
23	Inservice Training & Education			5,014	5,014		5,014		5,014		23
24	Travel and Seminar			2,511	2,511		2,511	3,034	5,545		24
25	Other Admin. Staff Transportation			4,550	4,550		4,550	2,956	7,506		25
26	Insurance-Prop.Liab.Malpractice			222,615	222,615		222,615	23,308	245,923		26
27	Other (specify):*							62,447	62,447		27
28	TOTAL General Administration	356,682	38,384	1,872,977	2,268,043	(1,250)	2,266,793	145,084	2,411,877		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,378,814	857,911	2,468,979	9,705,704	(1,250)	9,704,454	296,414	10,000,868		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr #0042325 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			117,685	117,685		117,685	567,984	685,669		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			142,262	142,262		142,262	1,286,374	1,428,636		32
33	Real Estate Taxes					1,250	1,250	724,606	725,856		33
34	Rent-Facility & Grounds			2,520,000	2,520,000		2,520,000	(2,513,972)	6,028		34
35	Rent-Equipment & Vehicles			13,659	13,659		13,659	960	14,619		35
36	Other (specify):*							95,628	95,628		36
37	TOTAL Ownership			2,793,606	2,793,606	1,250	2,794,856	161,580	2,956,436		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		221,972	43,124	265,096		265,096	(63,927)	201,169		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			265,538	265,538		265,538		265,538		42
43	Other (specify):*							3,644	3,644		43
44	TOTAL Special Cost Centers		221,972	308,662	530,634		530,634	(60,283)	470,351		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,378,814	1,079,883	5,571,247	13,029,944		13,029,944	397,711	13,427,655		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(39,830)	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(79)	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	(16,273)	21		18
19	Entertainment				19
20	Contributions	(1,750)	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	(404,671)	21		24
25	Fund Raising, Advertising and Promotional	(18,291)	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	(156,564)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (637,461)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,035,172		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,035,172		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 397,711		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

HW 0042325
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Rental Income	\$ (1,720)	21	1
2 Miscellaneous Income	(68,742)	21	2
3 Jury Duty Income	(72)	10	3
4 Patient Clothing	(610)	10	4
5 Travel Expenses	0	21	5
6 Collection Expense	(87)	21	6
7 PPA - Professional Fees	(4,544)	19	7
8 PPA - Employee Benefits	(36,916)	24	8
9 PPA - Pharmacy	(34,241)	19	9
10 Annual Report	(250)	20	10
11 Prior Year Seminar	(386)	24	11
12 Amortization of Deferred Maintenance	7,484	06	12
13 Prior Year Legal Fees	(33,505)	19	13
14 Capitalized R&M	(2,682)	06	14
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101 Total	(156,564)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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			496	7,032	(7,740)							(212)	1
2	Food Purchase	(79)		611									532	2
3	Housekeeping			931	94	12			(6,259)				(5,222)	3
4	Laundry								(311)				(311)	4
5	Heat and Other Utilities			4,439	240	331							5,010	5
6	Maintenance	4,802	39,851	26,002	30	135		547	(51)				71,316	6
7	Other (specify):*			3,452	667								4,119	7
8	TOTAL General Services	4,723	39,851	35,931	8,063	(7,262)		547	(6,621)				75,232	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(682)			54,627	(1,625)			(6,346)				45,974	10
10a	Therapy				5,281								5,281	10a
11	Activities													11
12	Social Services				15,163								15,163	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				9,680								9,680	15
16	TOTAL Health Care and Programs	(682)			84,751	(1,625)			(6,346)				76,098	16
	C. General Administration													
17	Administrative			21,188	95,957	2,711	847						120,703	17
18	Directors Fees													18
19	Professional Services	(38,049)		263,152	(111,617)	36	48						113,570	19
20	Fees, Subscriptions & Promotions	(20,291)		12,795	59	205	40						(7,192)	20
21	Clerical & General Office Expenses	(471,885)		311,890	24,839	4,543	290	(5,698)					(136,021)	21
22	Employee Benefits & Payroll Taxes	(36,816)		(691)					(214)				(37,721)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(386)		2,165	1,152		103						3,034	24
25	Other Admin. Staff Transportation			2,801		155							2,956	25
26	Insurance-Prop.Liab.Malpractice		20,037	2,839	30	298	104						23,308	26
27	Other (specify):*			44,950	16,312	1,082	103						62,447	27
28	TOTAL General Administration	(567,427)	20,037	661,089	26,732	9,030	1,535	(5,698)	(214)				145,084	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(563,386)	59,888	697,020	119,546	143	1,535	(5,151)	(13,181)				296,414	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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	(39,830)	564,072	36,197	1,520	233	55	5,737					567,984	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3)	1,208,298	68,298	6,547	389	516	2,329					1,286,374	32
33	Real Estate Taxes		718,906	5,298	358	44							724,606	33
34	Rent-Facility & Grounds		(2,520,000)	5,722		306							(2,513,972)	34
35	Rent-Equipment & Vehicles			754	11	75	120						960	35
36	Other (specify):*		95,628										95,628	36
37	TOTAL Ownership	(39,833)	66,904	116,269	8,436	1,047	691	8,066					161,580	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(34,242)				(6,178)	(6,157)	(13,720)	(3,630)				(63,927)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*						3,644						3,644	43
44	TOTAL Special Cost Centers	(34,242)				(6,178)	(2,513)	(13,720)	(3,630)				(60,283)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(637,461)	126,792	813,289	127,982	(4,988)	(287)	(10,805)	(16,811)				397,711	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		
				Westshire Health Care Properties, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 2,520,000	Westshire Health Care Properties, LLC	100.00%	\$	\$ (2,520,000)	1
2	V	32 Interest	7,079			1,215,377	1,208,298	2
3	V	06 Repairs & Maintenance				39,851	39,851	3
4	V	30 Depreciation				564,072	564,072	4
5	V	33 Real Estate Taxes				718,906	718,906	5
6	V	26 Property & Liability Insurance				20,037	20,037	6
7	V	36 MIP Expense				95,628	95,628	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,527,079			\$ 2,653,871	\$ * 126,792	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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%	\$ 496	\$ 496	15	
16	V	02	Food		Care Centers, Inc.	100.00%	611	611	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	931	931	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	4,439	4,439	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	7,321	7,321	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	4,435	4,435	20	
21	V	19	Professional Fees	(239,743)	Care Centers, Inc.	100.00%	23,409	263,152	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	12,795	12,795	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	37,081	37,081	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	2,165	2,165	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	2,801	2,801	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	2,839	2,839	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	36,197	36,197	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	68,298	68,298	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	5,298	5,298	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,722	5,722	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	754	754	31	
32	V	06	Maintenance	4,607	Care Centers, Inc.	100.00%	23,288	18,681	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	3,452	3,452	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	16,753	16,753	34	
35	V	21	Office and Clerical		Care Centers, Inc.	100.00%	274,809	274,809	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	44,950	44,950	36	
37	V	22	Employee Benefits	691	Care Centers, Inc.	100.00%		(691)	37	
38	V								38	
39	Total			\$ (234,445)			\$ 578,844	\$ * 813,289	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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%	\$ 94	\$ 94	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	240	240	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	30	30	17	
18	V	19	Professional Fees	115,620	Care Centers Clinical, Inc.	100.00%	4,003	(111,617)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	59	59	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	234	234	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	1,152	1,152	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	30	30	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	1,520	1,520	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	6,547	6,547	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	358	358	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	11	11	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	7,032	7,032	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	667	667	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	54,627	54,627	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	5,281	5,281	30	
31	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	15,163	15,163	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	9,680	9,680	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	95,957	95,957	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	24,605	24,605	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	16,312	16,312	35	
36	V	22	Employee Benefits		Care Centers Clinical, Inc.	100.00%			36	
37	V								37	
38	V								38	
39	Total			\$ 115,620			\$ 243,602	\$ * 127,982	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,650	\$ 1,650	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%	12	12	16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	331	331	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	135	135	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	36	36	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	205	205	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	708	708	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	155	155	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	298	298	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	233	233	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	389	389	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	44	44	26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	306	306	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	75	75	28
29	V	01 Dietary	13,979	Care Centers Health Systems, Inc.	100.00%	4,589	(9,390)	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	2,420	Care Centers Health Systems, Inc.	100.00%	795	(1,625)	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	9,198	Care Centers Health Systems, Inc.	100.00%	3,020	(6,178)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	2,711	2,711	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	3,835	3,835	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,082	1,082	38
39	Total		\$ 25,597			\$ 20,609	\$ * (4,988)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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	17	Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 59	\$ 59	15	
16	V	19	Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	48	48	16	
17	V	20	Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	40	40	17	
18	V	21	Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	290	290	18	
19	V	24	Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	103	103	19	
20	V	26	Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	104	104	20	
21	V	30	Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	55	55	21	
22	V	32	Interest		Therapy Works Rehabilitation Services, LLC	100.00%	516	516	22	
23	V	35	Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	120	120	23	
24	V	39	Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	1,391	1,391	24	
25	V	17	Administrative		Therapy Works Rehabilitation Services, LLC	100.00%	788	788	25	
26	V	27	Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	103	103	26	
27	V	39	Ancillary	32,844	Therapy Works Rehabilitation Services, LLC	100.00%	25,296	(7,548)	27	
28	V	43	Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	3,644	3,644	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			\$ 32,844			\$ 32,557	\$ *	(287)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 547	\$ 547	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	1	1	16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	4,306	4,306	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	360	360	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	1,431	1,431	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	1,969	1,969	20
21	V	21	Office and Clerical	5,699	Vent Lease, LLC.	100.00%		(5,699)	21
22	V	39	Ancillary	13,720	Vent Lease, LLC.	100.00%		(13,720)	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		\$ 19,419				\$ 8,614	\$ * (10,805)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	77,608	Xcel Supply, LLC	100.00%	71,349	(6,259)	16
17	V	4 Laundry	3,854	Xcel Supply, LLC	100.00%	3,543	(311)	17
18	V	6 Repairs & Maintenance	635	Xcel Supply, LLC	100.00%	584	(51)	18
19	V	10 Nursing	78,684	Xcel Supply, LLC	100.00%	72,338	(6,346)	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	2,651	Xcel Supply, LLC	100.00%	2,437	(214)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	45,003	Xcel Supply, LLC	100.00%	41,373	(3,630)	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		\$ 208,435			\$ 191,624	\$ * (16,811)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 179,134	\$ 179,134	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	179,134	CCS Employee Benefits Group	100.00%		(179,134)	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			\$ 179,134			\$ 179,134	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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	Owner	Administrative	9.60%	See Attached	2.42	5.24%		\$	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	4.00	7.27%	Alloc. Salary	9,826	17-7	2
3	David Aronin	Owner	Administrative	0.82%	See Attached	2.92	5.12%	Alloc. Salary	6,816	17-7	3
4	Steve Miretzky	Owner	Admin. / Clerical	0.41%	See Attached	2.91	7.27%	Alloc. Salary	8,065	21-7	4
5	Adam Vales	Owner	Clerical	2.48%	See Attached	1.11	2.77%	Alloc. Salary	1,542	22-7	5
6	Kim Rudolph	Owner	Clerical	2.48%	See Attached	0.97	2.77%	Alloc. Salary	848	22-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,097		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 Westshire Nursing & Rehab Ctr# 0042325

Report Period Beginning:

01/01/07Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Care 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

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	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 118,200	\$ 496	1
2	2	Food	Patient Days	1,625,640	33	8,403	118,200	611	2
3	3	Housekeeping	Patient Days	1,625,640	33	12,807	118,200	931	3
4	5	Utilities	Patient Days	1,625,640	33	61,054	118,200	4,439	4
5	6	Maintenance	Patient Days	1,625,640	33	100,693	118,200	7,321	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	118,200	4,435	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	118,200	23,409	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	118,200	12,795	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	118,200	37,081	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	118,200	2,165	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	118,200	2,801	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	118,200	2,839	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	118,200	36,197	13
14	32	Interest	Patient Days	1,625,640	33	939,326	118,200	68,298	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	118,200	5,298	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	118,200	5,722	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	118,200	754	17
18	6	Maintenance	Patient Days	1,625,640	33	187,019	118,200	13,598	18
19	6	Maintenance	Direct Allocation			456,812	456,812	9,690	19
20	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	118,200	3,452	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	118,200	16,753	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	118,200	274,809	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	118,200	44,950	24
25	TOTALS					\$ 8,891,187	\$ 5,143,113	\$ 578,844	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	3	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 118,200	\$ 94	1	
2	5	Utilities	Patient Days	1,625,640	32	3,307	118,200	240	2	
3	6	Maintenance	Patient Days	1,625,640	32	410	118,200	30	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	118,200	4,003	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	118,200	59	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	118,200	234	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	118,200	1,152	7	
8	26	Insurance	Patient Days	1,625,640	32	409	118,200	30	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	118,200	1,520	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	118,200	6,547	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	118,200	358	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	118,200	11	12	
13	1	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	118,200	7,032	13
14	7	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	118,200	667	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	118,200	54,627	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	118,200	5,281	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	118,200	15,163	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	118,200	9,680	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	118,200	95,957	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	118,200	24,605	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	118,200	16,312	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		22	
23	12	Social Service Salary	Direct Allocation			8,845	8,845		23	
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			24	
25	TOTALS					\$ 3,374,560	\$ 2,809,548	\$ 243,602	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	1	Dietary	Gross Billable Income	4,431,674	33	94,358	77,510	1,650	1
2	3	Housekeeping	Gross Billable Income	4,431,674	33	663	77,510	12	2
3	5	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	77,510	331	3
4	6	Maintenance	Gross Billable Income	4,431,674	33	7,696	77,510	135	4
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	77,510	36	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	77,510	205	6
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	77,510	708	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	77,510	155	8
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	77,510	298	9
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	77,510	233	10
11	32	Insurance	Gross Billable Income	4,431,674	33	22,225	77,510	389	11
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	77,510	44	12
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	77,510	306	13
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	77,510	75	14
15	1	Dietary	Direct Billable Income	341,879	33	112,243	13,979	4,589	15
16	2	Food	Direct Billable Income	25	33	8			16
17	3	Housekeeping	Direct Billable Income	29	33	10			17
18	10	Nursing	Direct Billable Income	69,616	33	22,856	2,420	795	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	9,198	3,020	21
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	2,711	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	3,835	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	77,510	1,082	24
25	TOTALS					\$ 2,152,813	\$ 374,301	\$ 20,609	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	\$ 30,764	\$ 59	1
2	19	Professional Fees	Billable Income	4,671,432	16	7,245	30,764	48	2
3	20	Dues and Subscriptions	Billable Income	4,671,432	16	6,024	30,764	40	3
4	21	Office & Clerical	Billable Income	4,671,432	16	44,084	30,764	290	4
5	24	Travel and Seminar	Billable Income	4,671,432	16	15,640	30,764	103	5
6	26	Insurance	Billable Income	4,671,432	16	15,816	30,764	104	6
7	30	Depreciation	Billable Income	4,671,432	16	8,410	30,764	55	7
8	32	Interest	Billable Income	4,671,432	16	78,317	30,764	516	8
9	35	Rent - Equipment	Billable Income	4,671,432	16	18,231	30,764	120	9
10	39	Ancillary	Billable Income	4,671,432	16	211,187	30,764	1,391	10
11	17	Administrative	Billable Income	4,671,432	16	119,603	119,603	788	11
12	27	Emp. Ben. - Gen. Admin.	Billable Income	4,671,432	16	15,625	30,764	103	12
13	39	Ancillary	Billable Income	4,671,432	16	3,841,227	3,841,227	25,296	13
14	43	Emp. Ben. - Other	Billable Income	4,671,432	16	553,364	30,764	3,644	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,943,773	\$ 3,960,830	\$ 32,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	6	Repairs	Direct Billing	892,186	27	\$ 35,557	\$ 13,720	\$ 547	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	13,720	1	2
3	30	Depreciation	Direct Billing	892,186	27	280,000	13,720	4,306	3
4	32	Interest	Direct Billing	892,186	27	23,404	13,720	360	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	118,200	1,431	5
6	32	Interest	Patient Days	1,625,640	33	27,081	118,200	1,969	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					\$ 385,763	\$	\$ 8,614	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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			\$		\$	1	
2	3	Housekeeping	Direct Allocation					71,349	2	
3	4	Laundry	Direct Allocation					3,543	3	
4	6	Repairs & Maintenance	Direct Allocation					584	4	
5	10	Nursing	Direct Allocation					72,338	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					2,437	10	
11	24	Seminars & Education	Direct Allocation						11	
12	39	Ancillary	Direct Allocation					41,373	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					\$		\$	191,624	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 179,134	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				\$	\$		\$ 179,134	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 Westshire Nursing & Rehab Ctr

0042325

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	HUD		X	Mortgage			\$	\$ 20,407,088		\$ 1,215,377	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	First Bank		X	Line of Credit				931,183		142,262	6									
7	Shareholder Loan	X						3,355,296			7									
8	See Supplemental Schedule										8									
9	TOTAL Facility Related						\$	\$ 24,693,567		\$ 1,357,639	9									
B. Non-Facility Related*																				
10	Interest Income		X							(7,082)	10									
11	Allocate Care Centers, Inc.		X							68,298	11									
12	Allocate CC Clinical, Inc.		X							6,547	12									
13	See Supplemental Schedule									3,234	13									
14	TOTAL Non-Facility Related						\$	\$		\$ 70,997	14									
15	TOTALS (line 9+line14)						\$	\$ 24,693,567		\$ 1,428,636	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 95,628 Line # 36

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

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

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

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15	Allocate CC Health Sys.		X				\$	\$			\$	389	15
16	Allocate Therapy Works		X									516	16
17	Allocate Vent Lease LLC		X									2,329	17
18													18
19													19
20	TOTAL Non-Facility Related											3,234	20

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Westshire Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042325

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>16-29-202-004-0000</u>	<u>Long Term Care Property</u>	<u>\$ 100,886.36</u>	<u>\$ 100,886.36</u>
2. <u>16-29-202-005-0000</u>	<u>Long Term Care Property</u>	<u>\$ 100,886.36</u>	<u>\$ 100,886.36</u>
3. <u>16-29-202-006-0000</u>	<u>Long Term Care Property</u>	<u>\$ 201,772.92</u>	<u>\$ 201,772.92</u>
4. <u>16-29-202-007-0000</u>	<u>Long Term Care Property</u>	<u>\$ 114,787.51</u>	<u>\$ 114,787.51</u>
5. <u>16-29-202-008-0000</u>	<u>Long Term Care Property</u>	<u>\$ 201,673.05</u>	<u>\$ 201,673.05</u>
6. <u>See Attached</u>	<u>Care Centers, Inc. Allocation</u>	<u>\$ 46,662.50</u>	<u>\$ 3,392.82</u>
7. <u>See Attached</u>	<u>Care Centers Clinical, Inc.</u>	<u>\$ 4,834.42</u>	<u>\$ 351.51</u>
8. <u>See Attached</u>	<u>Care Centers Health Sys. Alloc.</u>	<u>\$ 2,476.87</u>	<u>\$ 43.32</u>
9. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	<u>\$ 24,152.48</u>	<u>\$ 1,756.12</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
	TOTALS	<u>\$ 798,132.47</u>	<u>\$ 725,549.97</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 Westshire Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042325

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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 Westshire Nursing & Rehab Ctr

0042325 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1996</u>	<u>\$ 120,000</u>	1
2	<u>Allocate Care Centers, Inc.</u>			<u>29,332</u>	2
3	TOTALS			\$ 149,332	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	3,490		20	89	89	995	9
10	Various			1997	58,633		20	1,503	1,503	15,849	10
11	Various			1998	73,844		20	1,893	1,893	18,067	11
12	Various			1999	19,521		20	501	501	4,276	12
13	Various			2000	37,266		20	1,355	1,355	10,219	13
14	Various			2001	53,553		20	1,947	1,947	12,738	14
15	Various			2002	40,664		20	1,043	1,043	5,778	15
16	Various			2003	38,215		20	980	980	4,450	16
17											17
18											18
19											19
20											20
21											21
22											22
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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 Westshire Nursing & Rehab Ctr

0042325

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
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54								54
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		20,280,051	553,909		542,820	(11,089)	5,814,550	67
68		164,376	8,657		8,657		54,441	68
69			117,685			(117,685)		69
70		\$ 20,769,613	\$ 680,251		\$ 560,788	\$ (119,463)	\$ 5,941,363	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 20,769,613	\$ 680,251		\$ 560,788	\$ (119,463)	\$ 5,941,363	1
2	Blue Prints	2005	3,347		20	167	167	460	2
3	Paint Rooms	2005	10,000		20	500	500	1,208	3
4	Painting 5Th Floor	2005	6,000		20	300	300	650	4
5	Blinds 5Th Floor	2005	4,810		20	241	241	521	5
6	Handrails/Bumpers 5Th Floor	2005	7,433		20	372	372	805	6
7	Call System	2005	5,307		20	354	354	1,032	7
8	Ptac'S	2005	14,518		20	2,904	2,904	7,017	8
9	Alarm Repair	2005	3,652		20	730	730	1,643	9
10	Permits For Modernization	2005	2,517		20	503	503	1,091	10
11	A/C Condensor	2005	1,750		20	88	88	219	11
12	Concrete	2005	1,575		20	79	79	184	12
13	Replace Ball Valves	2005	2,836		20	142	142	366	13
14	Replace Compressor	2005	4,350		20	218	218	526	14
15	Circulating Pump	2005	2,464		20	123	123	298	15
16	Compressor Installation	2005	1,760		20	88	88	220	16
17	Glass Insulating Units	2005	2,112		20	106	106	264	17
18	Fire Alarm Repair	2005	1,600		20	80	80	173	18
19	Call System	2005	938		20	47	47	133	19
20	Hvac Repairs	2005	951		20	48	48	127	20
21	Overbed Light	2005	128		20	6	6	14	21
22	Locks	2005	1,112		20	56	56	116	22
23	Bath And Shower Room Remodeling	2006	15,000		20	1,001	1,001	1,500	23
24	Bright Electric	2006	5,518		20	368	368	552	24
25	Hvac For Elevator	2006	9,277		20	619	619	928	25
26	Bathroom Renovation	2006	27,377		20	1,826	1,826	2,738	26
27	Circuit Breaker	2006	3,500		20	233	233	350	27
28	S. Electronic	2006	1,564		20	104	104	156	28
29	Monitoring System	2006	1,170		20	78	78	117	29
30	Duct System	2007	33,500		20	1,256	1,256	1,256	30
31	Painting (Transfer Expense From Home Office)	2007	5,560		20	3,243	3,243	3,243	31
32	Dairy Cooling System	2007	10,125		20	211	211	211	32
33	New Water Main Pipes	2007	113,300		20	2,360	2,360	2,360	33
34	TOTAL (lines 1 thru 33)		\$ 21,074,664	\$ 680,251		\$ 579,239	\$ (101,012)	\$ 5,971,841	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 12B, Carried Forward		\$ 21,074,664	\$ 680,251		\$ 579,239	\$ (101,012)	\$ 5,971,841	1
2	New Furnace	2007	130		20	5	5	5	2
3	Ac Unit	2007	12,022		20	334	334	334	3
4	Fire Alarm System Install	2007	86,574		20	2,061	2,061	2,061	4
5	Voice Evacuation System	2007	25,900		20	617	617	617	5
6	Install Cabling & Electrical	2007	2,682		20	134	134	134	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	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)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	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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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	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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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	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)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	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)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	1
2									2
3									3
4									4
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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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)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,201,972	\$ 680,251		\$ 582,390	\$ (97,861)	\$ 5,974,992	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		
	Bed* ^s	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	485		1996	1974	\$ 19,609,780	\$ 502,815	39	\$ 502,795	\$ (20)	\$ 5,719,585	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Hot Water Heaters		2004	2004	22,404	1,120	20	2,240	1,120	4,201	9
10	Vertical Pumps		2004	2004	5,860	293	20	150	(143)	1,087	10
11	New Conduit		2004	2004	3,160	158	20	81	(77)	586	11
12	Plumbing		2004	2004	15,337	767	20	393	(374)	2,844	12
13	Compressor		2004	2004	11,023	551	20	283	(268)	952	13
14	Elevator Door		2004	2004	38,820	1,941	20	995	(946)	6,389	14
15	Remodel Patient Room		2005	2005	10,000	1,000	20	500	(500)	2,250	15
16	Overbed Lights		2005	2005	7,157	716	20	358	(358)	1,551	16
17	Passenger Elevator 3		2005	2005	21,900	1,095	20	1,095		2,646	17
18	Modernize 3 Elevators		2005	2005	197,100	9,855	20	9,855		22,174	18
19	5th Floor Rehab (Nurses Station)		2006	2006	15,480	1,548	20	774	(774)	2,967	19
20	5th Floor Rehab (Drawings)		2006	2006	6,605	661	20	330	(331)	1,266	20
21	Remove & Replace Doors		2006	2006	5,836	584	20	292	(292)	1,070	21
22	5th Floor Rehab (Remodel of Bathrooms)		2006	2006	76,000	7,600	20	3,800	(3,800)	12,033	22
23	5th Floor Rehab (Drawings)		2006	2006	16,763	1,676	20	838	(838)	2,654	23
24	Elevator Wiring, HVAC Wiring, Elevator Recall System		2006	2006	56,300	5,630	20	2,815	(2,815)	11,260	24
25	5th Floor Rehab (Overbed Lights)		2006	2006	6,940	1,388	20	1,388		2,660	25
26	Butterfly Valves for Chiller		2006	2006	2,739	548	20	548		867	26
27	5th Floor Rehab (Cubicle Curtains)		2006	2006	8,787	1,757	20	1,757		2,636	27
28	6th Floor Rehab (Cubicle Curtains)		2006	2006	9,981	1,996	20	1,996		2,662	28
29	Fire Panel		2007	2007	5,947	496	20	496		496	29
30	Tiling		2007	2007	12,500	694	20	694		694	30
31	Fire Panel		2007	2007	67,578	7,241	20	7,241		7,241	31
32	Repair Shower Room		2007	2007	11,200	747	20	373	(374)	747	32
33	Compressor		2007	2007	6,250	260	20	130	(130)	260	33
34	Accessories for AC Unit		2007	2007	8,092	225	20	225		225	34
35	Patio Fence		2007	2007	4,800	160	20	80	(80)	160	35
36	Replace Doors and Build Frames		2007	2007	7,100	178	20	89	(89)	178	36

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Doors	2007	\$ 3,442	\$ 29	20	\$ 29	\$	\$ 29	37
38 New Furnace	2007	5,170	180	20	180		180	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
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54								54
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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)		\$ 20,280,051	\$ 553,909		\$ 542,820	\$ (11,089)	\$ 5,814,550	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Beds*	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	Allocate Care Centers, Inc. 2201 Main LLC	2002	2002	\$ 32,378	\$ 830	39	\$ 830	\$	\$ 4,393	4
5	Allocate Care Centers, Inc. - CCI Building		1996	54,902	1,408	39	1,408		15,544	5
6	Allocate Care Centers Clinical, Inc.	2002	2002	3,355	86	39	86		455	6
7	Allocate Care Centers Health Systems, Inc.	2002	2002	413	11	39	11		56	7
8										8
	Improvement Type**									
9	Allocate Care Centers, Inc. 2201 Main LLC		2002	26,747	2,444	20	2,444		12,245	9
10	Allocate Care Centers, Inc. 2201 Main LLC		2003	31,520	2,881	20	2,881		14,431	10
11	Allocate Care Centers, Inc. 2201 Main LLC		2005	1,566	166	20	166		398	11
12										12
13	Allocate Care Centers, Inc.		2007	334	22	20	22		334	13
14										14
15	Allocate Care Centers, Inc. - CCI Building		1996	926	-	20	-		926	15
16	Allocate Care Centers, Inc. - CCI Building		1997	5,272	171	20	171		2,509	16
17										17
18	Allocate Care Centers Clinical, Inc.		2002	2,771	253	20	253		1,269	18
19	Allocate Care Centers Clinical, Inc.		2003	3,266	298	20	298		1,495	19
20	Allocate Care Centers Clinical, Inc.		2005	162	17	20	17		41	20
21										21
22	Allocate Care Centers Health Systems, Inc.		2002	342	31	20	31		156	22
23	Allocate Care Centers Health Systems, Inc.		2003	402	37	20	37		184	23
24	Allocate Care Centers Health Systems, Inc.		2005	20	2	20	2		5	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		
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62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	164,376	\$	8,657	\$	8,657	\$	54,441	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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	\$ 442,958	\$ 35,710	\$ 71,790	\$ 36,080	10	\$ 345,529	71
72	Current Year Purchases	34,998	5,215	27,166	21,951	10	33,100	72
73	Fully Depreciated Assets	2,389,230				10	2,389,230	73
74								74
75	TOTALS	\$ 2,867,186	\$ 40,925	\$ 98,956	\$ 58,031		\$ 2,767,859	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		Allocate Care Centers, Inc.	2007	\$ 61,083	\$ 3,544	\$ 3,544	\$	5	\$ 50,177	76
77		Allocate Care Centers Clinical, In	2007	5,227	772	772		5	988	77
78		Allocate Care Centers Health Sys.	2007	221	7	7		5	7	78
79										79
80	TOTALS			\$ 66,531	\$ 4,323	\$ 4,323	\$		\$ 51,172	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)		\$ 24,285,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 725,499	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 685,669	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (39,830)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 8,794,023	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>Allocate Care Centers, Inc.</u>				<u>5,722</u>			5
6	<u>Allocate Care Centers Health Sys.</u>				<u>306</u>			6
7	TOTAL				\$ 6,028			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: \$ 10,470 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	<u>Resident Transport</u>	<u>GMAC Vac</u>	\$ <u>829.85</u>	\$ <u>4,149</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 829.85	\$ 4,149	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	\$		\$ 4,653	\$		\$ 4,653	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,152			4,152	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			24,039			24,039	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				128,632		128,632	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					10,280	93,340		103,620	13
14	TOTAL			\$		\$ 43,124	\$ 221,972		\$ 265,096	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 Report 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	\$ (233,873)	\$ (27,679)	1
2	Cash-Patient Deposits	87,623	87,623	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,846,850	1,846,850	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,547	59,547	6
7	Other Prepaid Expenses	25,400	50,959	7
8	Accounts Receivable (owners or related parties)	293,519	125,567	8
9	Other(specify): <u>See Attached Schedule</u>	640	1,795,619	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,079,706	\$ 3,938,486	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		120,000	13
14	Buildings, at Historical Cost		19,609,780	14
15	Leasehold Improvements, at Historical Cost	707,293	1,343,171	15
16	Equipment, at Historical Cost	1,146,084	1,222,700	16
17	Accumulated Depreciation (book methods)	(1,155,997)	(7,008,033)	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>		167,271	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 697,380	\$ 15,454,889	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,777,086	\$ 19,393,375	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 947,533	\$ 1,073,099	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	95,092	95,092	28
29	Short-Term Notes Payable	931,183	931,183	29
30	Accrued Salaries Payable	252,006	252,006	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,859	11,859	31
32	Accrued Real Estate Taxes(Sch.IX-B)		756,000	32
33	Accrued Interest Payable		100,845	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	8,794	8,794	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,246,467	\$ 3,228,878	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	3,355,296	3,355,296	39
40	Mortgage Payable		20,407,088	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)	\$ 3,355,296	\$ 23,762,384	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,601,763	\$ 26,991,262	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,824,677)	\$ (7,597,887)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,777,086	\$ 19,393,375	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,106,979)	1
2	Restatements (describe):		2
3	<u>Union Dues</u>	(601)	3
4	<u>Rounding</u>	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,107,578)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	282,901	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 282,901	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,824,677)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr# 0042325Report 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	\$ 13,258,010	1
2	Discounts and Allowances for all Levels	(193,998)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,064,012	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,716	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 70,716	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	98,490	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,996	19
20	Radiology and X-Ray	3,583	20
21	Other Medical Services	13,481	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 127,550	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	50,564	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 50,564	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,312,845	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,633,647	31
32	Health Care	4,804,014	32
33	General Administration	2,268,043	33
B. Capital Expense			
34	Ownership	2,793,606	34
C. Ancillary Expense			
35	Special Cost Centers	265,096	35
36	Provider Participation Fee	265,538	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,029,944	40
41	Income before Income Taxes (line 30 minus line 40)**	282,901	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 282,901	43

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

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

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

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	1,622	1,707	\$ 74,073	\$ 43.39	1
2	Assistant Director of Nursing	3,933	4,810	139,719	29.05	2
3	Registered Nurses	21,859	23,588	637,553	27.03	3
4	Licensed Practical Nurses	49,734	53,590	1,411,468	26.34	4
5	CNAs & Orderlies	110,745	121,986	1,415,475	11.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,507	15,115	225,732	14.93	8
9	Activity Director	1,963	2,237	37,757	16.88	9
10	Activity Assistants	13,701	15,238	158,725	10.42	10
11	Social Service Workers	28,800	30,902	453,960	14.69	11
12	Dietician	1,955	2,163	33,610	15.54	12
13	Food Service Supervisor	1,957	2,278	76,994	33.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,019	5,816	75,032	12.90	15
16	Dishwashers	36,921	40,699	405,969	9.97	16
17	Maintenance Workers	27,540	29,604	351,798	11.88	17
18	Housekeepers	32,917	35,606	355,156	9.97	18
19	Laundry	9,934	11,220	133,809	11.93	19
20	Administrator	1,531	1,680	70,732	42.10	20
21	Assistant Administrator	4,158	4,508	128,918	28.60	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,187	9,847	157,032	15.95	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	1,929	2,204	35,302	16.02	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	378,912	414,798	\$ 6,378,814 *	\$ 15.38	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	5	\$ 251	01-03	35
36	Medical Director	23	19,500	09-03	36
37	Medical Records Consultant	Monthly	4,434	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,980	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,425	11-03	44
45	Social Service Consultant	367	15,854	12-03	45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	1	60	10a-03	47
48	<u>Psychiatric Consultant</u>	170	7,984	10-03	48
49	TOTAL (lines 35 - 48)	615	\$ 55,488		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 575	10-03	50
51	Licensed Practical Nurses	645	24,945	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	661	\$ 25,520		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	Painting / Decorating	6/03	\$ 3,547	3	\$ 1,083	\$ 1,083	\$ 542	\$	\$	\$	\$	\$	\$
2	Painting / Decorating	6/04	22,452		7,484	3,742	3,742	7,484					
3													
4													
5													
6													
7													
8													
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16													
17													
18													
19													
20	TOTALS		\$ 25,999		\$ 8,567	\$ 4,825	\$ 4,284	\$ 7,484	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Association of HCF \$6,660
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,696 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 265,538
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 100% ln 14
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? No
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT