

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>240</u>	Skilled (SNF)	<u>240</u>	<u>87,840</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>240</u>	TOTALS	<u>240</u>	<u>87,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>63,224</u>	<u>2,947</u>	<u>8,099</u>	<u>74,270</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,224</u>	<u>2,947</u>	<u>8,099</u>	<u>74,270</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.55%

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

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

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

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

None

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

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

YES NO

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

YES NO

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

Date started 05/28/98

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

YES Date 05/28/98 NO

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

YES NO If YES, enter number of beds certified 240 and days of care provided 7,867

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	438,971	52,769	16,017	507,757		507,757	4,680	512,437			1
2	Food Purchase		378,405		378,405		378,405	487	378,892			2
3	Housekeeping	291,378	70,206		361,584		361,584	(5,332)	356,252			3
4	Laundry	134,924	39,228		174,152		174,152		174,152			4
5	Heat and Other Utilities			340,765	340,765		340,765	4,599	345,364			5
6	Maintenance	83,371		276,593	359,964		359,964	13,800	373,764			6
7	Other (specify):*							3,757	3,757			7
8	TOTAL General Services	948,644	540,608	633,375	2,122,627		2,122,627	21,991	2,144,618			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	3,585,134	191,889	14,043	3,791,066		3,791,066	22,970	3,814,036			10
10a	Therapy	208,576			208,576		208,576	3,365	211,941			10a
11	Activities	166,617	5,169	200	171,986		171,986		171,986			11
12	Social Services	185,365		1,910	187,275		187,275	19,522	206,797			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,710	9,710			15
16	TOTAL Health Care and Programs	4,145,692	197,058	43,153	4,385,903		4,385,903	55,567	4,441,470			16
	C. General Administration											
17	Administrative	124,444		12,000	136,444		136,444	80,871	217,315			17
18	Directors Fees											18
19	Professional Services			578,018	578,018		578,018	(481,746)	96,272			19
20	Dues, Fees, Subscriptions & Promotions			55,981	55,981		55,981	(15,648)	40,333			20
21	Clerical & General Office Expenses	76,316	24,023	864,304	964,643		964,643	(487,416)	477,227			21
22	Employee Benefits & Payroll Taxes			883,723	883,723		883,723	(14,268)	869,455			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,581	6,581		6,581	2,360	8,941			24
25	Other Admin. Staff Transportation			5,368	5,368		5,368	2,442	7,810			25
26	Insurance-Prop.Liab.Malpractice			362,245	362,245		362,245	2,146	364,391			26
27	Other (specify):*							45,341	45,341			27
28	TOTAL General Administration	200,760	24,023	2,768,220	2,993,003		2,993,003	(865,919)	2,127,084			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,295,096	761,689	3,444,748	9,501,533		9,501,533	(788,361)	8,713,172			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr #0042119 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			115,588	115,588		115,588	344,553	460,141			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1	1		1	330,191	330,192			32
33	Real Estate Taxes			308,556	308,556		308,556	6,077	314,633			33
34	Rent-Facility & Grounds			1,164,000	1,164,000		1,164,000	(1,157,263)	6,737			34
35	Rent-Equipment & Vehicles			6,067	6,067		6,067	1,696	7,763			35
36	Other (specify):*											36
37	TOTAL Ownership			1,594,212	1,594,212		1,594,212	(474,746)	1,119,466			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		551,938	646,425	1,198,363		1,198,363	(47,118)	1,151,245			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,760	131,760		131,760		131,760			42
43	Other (specify):*			648	648		648	(648)				43
44	TOTAL Special Cost Centers		551,938	778,833	1,330,771		1,330,771	(47,766)	1,283,005			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,295,096	1,313,627	5,817,793	12,426,516		12,426,516	(1,310,872)	11,115,644			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	22,364	30		9
10	Interest and Other Investment Income	(585,171)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(150)	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	(4,604)	21		18
19	Entertainment				19
20	Contributions	(1,020)	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	(512,141)	21		24
25	Fund Raising, Advertising and Promotional	(13,678)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,590)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(750)	20		28
29	Other-Attach Schedule	(246,752)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,345,492)		\$	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)	34,620		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 34,620		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,310,872)		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						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

South Shore Nsg & Rehab Ctr

ID# 0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Miscellaneous Income	\$ (33)	21	1
2	Jury Duty Income	(17)	10	2
3	Patient Clothing	(830)	10	3
4	COPE Dues	(8,576)	20	4
5	Collections Expense	(8,436)	21	5
6	Prior Period Adjustment - Computer Expense	(6,362)	21	6
7	Annual Report	(250)	20	7
8	Public Relations	(648)	43	8
9	Prior Period and Non-Allowable Legal Fees	(2,440)	19	9
10	Non-Allowable Expense	(180,000)	21	10
11	Building Co. - Trust Fees	(200)	21	11
12	Building Co. - Filing Fees	(250)	21	12
13	Building Co. - Amortization Expense	(38,710)	36	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(246,752)		49

South Shore Nsg & Rehab Ctr

ID# 0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES	Amount	Reference	Sch. V Line
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

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			625		4,592	(489)	(48)					4,680	1
2	Food Purchase	(150)		637									487	2
3	Housekeeping			620		69		(6,021)					(5,332)	3
4	Laundry													4
5	Heat and Other Utilities			3,769		156	674						4,599	5
6	Maintenance			4,762	7,561	20	115	(154)		1,496			13,800	6
7	Other (specify):*				3,162	595							3,757	7
8	TOTAL General Services	(150)		10,413	10,723	5,432	300	(6,223)		1,496			21,991	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(847)				39,373		(15,556)					22,970	10
10a	Therapy					3,365							3,365	10a
11	Activities													11
12	Social Services					19,522							19,522	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					9,710							9,710	15
16	TOTAL Health Care and Programs	(847)				71,970		(15,556)					55,567	16
	C. General Administration													
17	Administrative			2,997	11,174	57,048	9,652						80,871	17
18	Directors Fees													18
19	Professional Services	(2,440)		(348,977)		(130,699)	370						(481,746)	19
20	Fees, Subscriptions & Promotions	(24,274)		8,287		11	328						(15,648)	20
21	Clerical & General Office Expenses	(715,616)	450	36,160	175,344	19,376	11,445	(5)		(14,570)			(487,416)	21
22	Employee Benefits & Payroll Taxes					(13,961)		(307)					(14,268)	22
23	Inservice Training & Education													23
24	Travel and Seminar			2,117		243							2,360	24
25	Other Admin. Staff Transportation			1,800			633			9			2,442	25
26	Insurance-Prop.Liab.Malpractice			1,311		21	783			31			2,146	26
27	Other (specify):*				32,832	9,843	2,666						45,341	27
28	TOTAL General Administration	(742,330)	450	(296,305)	219,350	(58,118)	25,877	(312)		(14,530)			(865,919)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(743,327)	450	(285,892)	230,073	19,284	26,177	(22,091)		(13,034)			(788,361)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	22,364	288,299	16,979		1,167	715			15,029			344,553	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(585,171)	854,527	46,791		8,671	2,197			3,176			330,191	32
33	Real Estate Taxes			5,823		254							6,077	33
34	Rent-Facility & Grounds		(1,164,000)	4,425			2,312						(1,157,263)	34
35	Rent-Equipment & Vehicles			1,474			222						1,696	35
36	Other (specify):*	(38,710)	38,710											36
37	TOTAL Ownership	(601,517)	17,536	75,492		10,092	5,446			18,205			(474,746)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(27,739)	(6,779)		(12,600)			(47,118)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(648)											(648)	43
44	TOTAL Special Cost Centers	(648)					(27,739)	(6,779)		(12,600)			(47,766)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,345,492)	17,986	(210,400)	230,073	29,376	3,884	(28,870)		(7,429)			(1,310,872)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				South Shore Property, 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,164,000	South Shore Property, LLC	100.00%	\$	\$ (1,164,000)	1
2	V	32 Interest	258,103	South Shore Property, LLC	100.00%	1,112,630	854,527	2
3	V	21 Trust Fees		South Shore Property, LLC	100.00%	200	200	3
4	V	21 Filing Fees		South Shore Property, LLC	100.00%	250	250	4
5	V	30 Depreciation Expense		South Shore Property, LLC	100.00%	288,299	288,299	5
6	V	36 Amortization Expense		South Shore Property, LLC	100.00%	38,710	38,710	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,422,103			\$ 1,440,089	\$ * 17,986	14

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/08 Ending: 12/31/08

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. / Extended Care Consulting, LLC	100.00%	\$ 625	\$ 625	15	
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	637	637	16	
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	620	620	17	
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,769	3,769	18	
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,762	4,762	19	
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,997	2,997	20	
21	V	19	Professional Fees	371,270	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	22,293	(348,977)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	8,287	8,287	22	
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	36,160	36,160	23	
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,117	2,117	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,800	1,800	25	
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,311	1,311	26	
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	16,979	16,979	27	
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	46,791	46,791	28	
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	5,823	5,823	29	
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,425	4,425	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,474	1,474	31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 371,270			\$ 160,870	\$ * (210,400)	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 Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	9,194	\$ 9,194	15
16	V	06 Maintenance (Direct)	4,179	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,546	(1,633)	16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,899	2,899	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	263	263	18
19	V	17 Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	11,174	11,174	19
20	V	21 Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	173,922	173,922	20
21	V	21 Office and Clerical (Direct)	52,653	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	54,075	1,422	21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	27,635	27,635	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	5,197	5,197	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		\$ 56,832			\$ 286,905	\$ * 230,073	39

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/08 Ending: 12/31/08

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. / Extended Care Clinical, LLC	100.00%	\$ 69	\$ 69	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	156	156	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	20	20	17	
18	V	19	Professional Fees	132,485	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,786	(130,699)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	11	11	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	299	299	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	243	243	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	21	21	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,167	1,167	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	8,671	8,671	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	254	254	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	4,592	4,592	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	595	595	27	
28	V	10	Nursing Salary	11,383	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	50,756	39,373	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,365	3,365	29	
30	V	12	Social Service Salary	1,909	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	21,431	19,522	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9,710	9,710	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	57,048	57,048	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	19,077	19,077	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9,843	9,843	34	
35	V	22	Employee Benefits	13,961				(13,961)	35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 159,738			\$ 189,114	\$ * 29,376	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/08 Ending: 12/31/08

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%	\$ 5,975	\$ 5,975	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	674	674	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	115	115	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	370	370	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	328	328	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,467	1,467	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	633	633	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	783	783	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	715	715	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	2,197	2,197	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	2,312	2,312	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	222	222	28
29	V	01 Dietary	10,241	Care Centers Health Systems, Inc.	100.00%	3,777	(6,464)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	21 Clerical and General Office		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	43,946	Care Centers Health Systems, Inc.	100.00%	16,207	(27,739)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	9,652	9,652	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	9,978	9,978	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	2,666	2,666	38
39	Total		\$ 54,187			\$ 58,071	\$ *	3,884 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr# 0042119Report Period Beginning: 01/01/08Ending: 12/31/08

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	\$ 543	Xcel Supply, LLC	100.00%	\$ 495	\$ (48)	15
16	V	3 Housekeeping	67,976	Xcel Supply, LLC	100.00%	61,955	(6,021)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance	1,737	Xcel Supply, LLC	100.00%	1,583	(154)	18
19	V	10 Nursing	175,621	Xcel Supply, LLC	100.00%	160,065	(15,556)	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	55	Xcel Supply, LLC	100.00%	50	(5)	23
24	V	22 Employee Benefits	3,471	Xcel Supply, LLC	100.00%	3,164	(307)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	76,526	Xcel Supply, LLC	100.00%	69,748	(6,779)	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		\$ 325,930			\$ 297,060	\$ * (28,870)	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 83,879	\$ 83,879	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	83,879	CCS Employee Benefits Group	100.00%		(83,879)	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			\$ 83,879			\$ 83,879	\$ *	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	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 1,496	\$ 1,496	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	168	168	16
17	V	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%	9	9	17
18	V	26	Insurance		Vent Lease, LLC.	100.00%	31	31	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	4,975	4,975	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	839	839	20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	10,054	10,054	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	2,337	2,337	22
23	V	21	Office and Clerical	14,738	Vent Lease, LLC.	100.00%		(14,738)	23
24	V	39	Ancillary	12,600	Vent Lease, LLC.	100.00%		(12,600)	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		\$ 27,338				\$ 19,909	\$ * (7,429)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sandy Bokor	Relative	Administrative	0.00%	See Attached	1.00	2.00%	Mgmt. Fees	\$ 12,000	17-3	1
2	David Aronin	Shareholder	Administrative	0.83%	See Attached	1.82	3.19%	Alloc. Salary	3,972	17-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.50	4.54%	Alloc. Salary	6,940	17-7	3
4	Eric Rothner	Relative	Administrative	0.00%	See Attached	1.51	3.27%	Alloc. Salary			4
5	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.27	1.61%	Alloc. Salary	234	22-7	5
6	Adam Vales	Relative	Clerical	1.88%	See Attached	0.64	1.60%	Alloc. Salary	1,155	22-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,301		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,635,146	31	\$ 13,778	\$ 74,270	\$ 625	1
2	02	Food	Patient Days	1,635,146	31	13,971	74,270	637	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	74,270	620	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	74,270	3,769	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	74,270	4,762	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	74,270	2,997	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	74,270	22,293	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	74,270	8,287	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	74,270	36,160	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	74,270	2,117	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	74,270	1,800	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	74,270	1,311	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	74,270	16,979	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	74,270	46,791	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	74,270	5,823	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	74,270	4,425	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	74,270	1,474	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 160,870	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Inc/Extended Care Consulting LLC
 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	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	74,270	9,194	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013		2,546	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		74,270	2,899	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015			263	4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	74,270	11,174	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	74,270	173,922	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		54,075	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		74,270	27,635	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			5,197	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					\$ 6,211,280	\$ 5,395,924		\$ 286,905	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

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/Extended Care Clinical
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 74,270	\$ 69	1
2	05	Utilities	Patient Days	1,635,146	31	3,449	74,270	156	2
3	06	Maintenance	Patient Days	1,635,146	31	431	74,270	20	3
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	74,270	1,786	4
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	74,270	11	5
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	74,270	299	6
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	74,270	243	7
8	26	Insurance	Patient Days	1,635,146	31	465	74,270	21	8
9	30	Depreciation	Patient Days	1,635,146	31	25,565	74,270	1,167	9
10	32	Interest	Patient Days	1,635,146	31	191,164	74,270	8,671	10
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	74,270	254	11
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	4,592	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	74,270	595	13
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	39,373	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	3,365	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	19,522	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	74,270	8,055	17
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	57,048	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	19,077	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	74,270	9,843	20
21	10	Nursing Salary	Direct Allocation			401,447	401,447	11,383	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016	1,909	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816		1,655	23
24									24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 189,114	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 200 Howard
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612-5662
 Fax Number (224) 612-5862

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	3,867,056	31	111,096	207,963	5,975	1
2	03	Housekeeping	Gross Billable Income	3,867,056	31		207,963		2
3	05	Heat and Other Utilities	Gross Billable Income	3,867,056	31	12,529	207,963	674	3
4	06	Maintenance	Gross Billable Income	3,867,056	31	2,136	207,963	115	4
5	19	Professional Fees	Gross Billable Income	3,867,056	31	6,873	207,963	370	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,867,056	31	6,095	207,963	328	6
7	21	Clerical and General Office	Gross Billable Income	3,867,056	31	27,280	207,963	1,467	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,867,056	31	11,773	207,963	633	8
9	26	Insurance	Gross Billable Income	3,867,056	31	14,568	207,963	783	9
10	30	Depreciation	Gross Billable Income	3,867,056	31	13,298	207,963	715	10
11	32	Interest	Gross Billable Income	3,867,056	31	40,850	207,963	2,197	11
12	33	Real Estate Taxes	Gross Billable Income	3,867,056	31		207,963		12
13	34	Rent - Building	Gross Billable Income	3,867,056	31	43,000	207,963	2,312	13
14	35	Rent - Equipment	Gross Billable Income	3,867,056	31	4,135	207,963	222	14
15	01	Dietary	Direct Billable Income	279,198	31	102,965	10,241	3,777	15
16	02	Food	Direct Billable Income	4,372	31	1,612			16
17	03	Housekeeping	Direct Billable Income		31				17
18	10	Nursing	Direct Billable Income		31				18
19	21	Clerical and General Office	Direct Billable Income		31				19
20	25	Other Admin. Staff Transport.	Direct Billable Income		31				20
21	39	Ancillary	Direct Billable Income	3,583,486	31	1,321,550	43,946	16,207	21
22	17	Administrative	Gross Billable Income	3,867,056	31	179,474	179,474	9,652	22
23	21	Clerical and General Office	Gross Billable Income	3,867,056	31	185,549	185,549	9,978	23
24	27	Employee Benefits	Gross Billable Income	3,867,056	31	49,573	207,963	2,666	24
25	TOTALS					\$ 2,134,357	\$ 365,023	\$ 58,071	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		495	1
2	3	Housekeeping	Direct Allocation					61,955	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation					1,583	4
5	10	Nursing	Direct Allocation					160,065	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					50	9
10	22	Employee Benefits	Direct Allocation					3,164	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					69,748	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				\$	\$		297,060	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		\$ 83,879	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				\$	\$		\$ 83,879	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	669,310	26	\$ 79,460	\$ 12,600	\$ 1,496	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933	12,600	168	2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473	12,600	9	3
4	26	Insurance	Direct Billing	669,310	26	1,630	12,600	31	4
5	30	Depreciation	Direct Billing	669,310	26	264,263	12,600	4,975	5
6	32	Interest	Direct Billing	669,310	26	44,568	12,600	839	6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	74,270	10,054	7
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	74,270	2,337	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					\$ 672,138	\$	\$ 19,909	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Business Partners LLC		X	Mortgage			\$	16,188,350		\$	1,094,826	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Due to Affiliates										17,804	6								
7												7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related						\$	16,188,350		\$	1,112,630	9								
B. Non-Facility Related*																				
10	Interest Income										(585,171)	10								
11	Interest Income - Bldg. Co.										(258,103)	11								
12	Allocated from CCI/ECC		X								46,791	12								
13	See Supplemental Schedule										14,044	13								
14	TOTAL Non-Facility Related						\$			\$	(782,439)	14								
15	TOTALS (line 9+line14)						\$	16,188,350		\$	330,191	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1						\$	\$			\$	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	Allocated from CC/EC Clinical		X			\$	\$			\$	8,671									
16	Allocated from CC Health Sys.		X								2,197									
17	Allocated from Vent Lease		X								3,176									
18											18									
19											19									
20	TOTAL Non-Facility Related										14,044									

* 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-30-121-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,874.70</u>	\$ <u>1,874.70</u>
2. <u>21-30-121-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,461.14</u>	\$ <u>2,461.14</u>
3. <u>21-30-200-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>253,378.28</u>	\$ <u>253,378.28</u>
4. <u>21-30-200-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>4,198.81</u>	\$ <u>4,198.81</u>
5. <u>21-30-200-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>46,809.26</u>	\$ <u>46,809.26</u>
6. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	\$ <u>122,122.75</u>	\$ <u>2,482.31</u>
7. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>43,667.89</u>	\$ <u>1,322.00</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>474,512.83</u>	\$ <u>312,526.50</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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>101,000</u>	<u>1994</u>	<u>\$ 352,000</u>	1
2	<u>Allocated from CCI/ECC</u>			<u>18,441</u>	2
3	TOTALS	101,000		\$ 370,441	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1998		22,697		20	1,135	1,135	11,700	9
10	Various		1999		22,789		20	1,140	1,140	10,575	10
11	Various		2000		41,526		20	2,076	2,076	18,264	11
12	Various		2001		43,128		20	2,158	2,158	15,968	12
13	Various		2002		37,477		20	3,720	3,720	23,929	13
14	Various		2003		38,966		20	4,716	4,716	25,574	14
15	Various		2004		53,775		20	6,884	6,884	30,933	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

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
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59								59
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61								61
62								62
63								63
64								64
65								65
66								66
67		10,639,989	288,299		313,914	25,615	2,821,951	67
68		102,828	5,431		5,431		35,218	68
69			115,580			(115,580)		69
70		\$ 11,003,175	\$ 409,310		\$ 341,174	\$ (68,136)	\$ 2,994,112	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,003,175	\$ 409,310		\$ 341,174	\$ (68,136)	\$ 2,994,112	1
2	Repair Cut Piping	2005	4,333		20	433	433	1,697	2
3	Door Repairs	2005	2,840		20	568	568	2,178	3
4	Boiler Repair	2005	2,781		20	556	556	2,086	4
5	2 Door Locks	2005	3,691		20	369	369	1,354	5
6	New Compressor	2005	38,047		20	7,609	7,609	27,267	6
7	Boiler Repair	2005	2,703		20	541	541	1,757	7
8	Home Office P/R Painting	2006	2,098		20	210	210	524	8
9	Painting-From Hop	2006	5,876		20	588	588	1,420	9
10	Painting-From Hop	2006	8,498		20	850	850	1,983	10
11	Dep On New Fence	2006	2,080		20	208	208	485	11
12	3 Ton A/C- 1/2 Down 1	2006	6,250		20	1,250	1,250	3,229	12
13	Boiler Repair	2006	4,915		20	983	983	2,539	13
14	3 Ton A/C-1/2 Down 2	2006	6,600		20	1,320	1,320	3,190	14
15	Painting - From Hop	2006	5,994		20	599	599	1,349	15
16	Annie Looking 4 Inv	2006	9,341		20	934	934	2,102	16
17	Painting	2006	1,603		20	160	160	347	17
18	Perenials	2006	2,750		20	183	183	458	18
19	Elevator Repairs	2006	2,722		20	136	136	318	19
20	Painting (Transfer Expense From Home Office)	2007	3,690		20			3,690	20
21	Painting (Transfer Expense From Home Office)	2007	7,695		20	641	641	7,695	21
22	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	2,660	22
23	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	2,545	23
24	Repair Ahu #1 Coil	2007	19,679		20	3,936	3,936	7,216	24
25	Painting (Transfer Expense From Home Office)	2007	3,426		20	571	571	3,426	25
26	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	2,429	26
27	New Telephone System	2007	2,882		20	288	288	504	27
28	Barrier Free Door Closer	2007	4,519		20	452	452	753	28
29	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	2,313	29
30	Final Pymt Of 3 - New Oil Coolers	2007	16,854		20	843	843	1,334	30
31	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	2,198	31
32	Tarkett Vct & Install - 1St Fl Nurs Station	2007	20,299		20	2,030	2,030	3,214	32
33	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	2,082	33
34	TOTAL (lines 1 thru 33)		\$ 11,253,637	\$ 409,310		\$ 375,760	\$ (33,550)	\$ 3,090,454	34

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	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		\$ 11,253,637	\$ 409,310		\$ 375,760	\$ (33,550)	\$ 3,090,454	1
2	Tarkett Vcr & Install, 2Nd Fl Nurs Station	2007	17,256		20	1,726	1,726	2,445	2
3	Booster Heater	2007	3,528		20	706	706	1,000	3
4	Major A/C Work	2007	3,493		20	291	291	412	4
5	Fire Alarm Repair	2007	5,149		20	736	736	858	5
6	Alarm For Air Unit	2008	3,322		20	305	305	305	6
7	New Laundry Exhaust Fan	2008	5,069		20	338	338	338	7
8	3 New Laundry Rooms	2008	14,625		20	853	853	853	8
9	New Chiller Compressor	2008	42,163		20	4,919	4,919	4,919	9
10	New Exhaust System	2008	35,609		20	1,780	1,780	1,780	10
11	2 New Boilers	2008	76,500		20	1,594	1,594	1,594	11
12	Repair To Chiller	2008	8,439		20	211	211	211	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	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 12D, Carried Forward	\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)	\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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
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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)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

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Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,468,790	\$ 409,310		\$ 389,219	\$ (20,091)	\$ 3,105,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240		1998	1998	\$ 9,683,370	\$ 248,292	35	\$ 276,668	\$ 28,376	\$ 2,463,268	4
5			1999	1999	134,000	3,436	35	3,829	393	30,780	5
6			2000	2000	360,000	9,231	35	10,286	1,055	73,462	6
7											7
8											8
Improvement Type**											
9	Land Improvements			1998	462,619	27,340	20	23,131		254,441	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	10,639,989	\$	288,299	\$	313,914	\$	29,824	\$	2,821,951	70

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 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		Allocated from EC/CC Clinical, Inc.	2002	2002	\$ 2,291	\$ 59	39	\$ 59		\$ 370	4
5		Allocated from CCI/ECC - CCI Building		1996	33,943	870	39	870		10,480	5
6		Allocated from CCI/Extended Care Consulting, LLC	2002	2002	20,479	525	39	525		3,304	6
7											7
8											8
		Improvement Type**									
9		Allocated from CCI/Extended Care Consulting, LLC		2002	16,917	1,546	20	1,546		7,745	9
10		Allocated from CCI/Extended Care Consulting, LLC		2003	19,936	1,822	20	1,822		9,127	10
11		Allocated from CCI/Extended Care Consulting, LLC		2005	991	105	20	105		25	11
12		Allocated from CCI/Extended Care Consulting, LLC		2007	207	10	20	10		24	12
13											13
14		Allocated from CCI/ECC- CCI Building		1996	572	-	20	-		572	14
15		Allocated from CCI/ECC- CCI Building		1997	3,259	105	20	105		1,656	15
16											16
17		Allocated from CC/EC Clinical, Inc.		2002	1,892	173	20	173		866	17
18		Allocated from CC/EC Clinical, Inc.		2003	2,230	204	20	204		1,021	18
19		Allocated from CC/EC Clinical, Inc.		2005	111	12	20	12		28	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	102,828	\$	5,431	\$	5,431	\$	35,218	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 495,765	\$ 25,176	\$ 59,805	\$ 34,629	10	\$ 416,455	71
72	Current Year Purchases	16,640	82	7,018	6,936	10	7,018	72
73	Fully Depreciated Assets	2,486,808				10	2,486,808	73
74								74
75	TOTALS	\$ 2,999,213	\$ 25,258	\$ 66,823	\$ 41,565		\$ 2,910,281	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	Facility	2002 CHEVY MALIBU	2005	\$ 5,332	\$	\$ 888	\$ 888	5	\$ 4,000	76
77		Allocated from CCI/ECC	2008	3,281	656	658	2	5	1,276	77
78		Allocated from CC/EC Clinical	2008	38,894	2,417	2,417		5	33,439	78
79		Allocated from CC Health Sys	2008	679	136	136		5	158	79
80	TOTALS			\$ 48,186	\$ 3,209	\$ 4,099	\$ 890		\$ 38,873	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,886,630	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 437,777	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 460,141	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,364	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,054,323	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	Allocated from CCI/ECC				4,425			5
6	Allocated from CC Health Sys.				2,312			6
7	TOTAL				\$ 6,737			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,764 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 265,116	\$		\$ 265,116	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			120,009			120,009	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			260,977			260,977	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				295,981		295,981	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					323	255,957		256,280	13
14	TOTAL			\$		\$ 646,425	\$ 551,938		\$ 1,198,363	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr# 0042119Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 750	\$ 407,022	1
2	Cash-Patient Deposits	89,999	89,999	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,557,666	2,557,666	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	535,870	535,870	6
7	Other Prepaid Expenses	3,656	3,656	7
8	Accounts Receivable (owners or related parties)	1,229,809	4,472,316	8
9	Other(specify): <u>See Attached Schedule</u>	4,889,000	4,889,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,306,750	\$ 12,955,529	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		352,000	13
14	Buildings, at Historical Cost		10,177,369	14
15	Leasehold Improvements, at Historical Cost	511,912	974,531	15
16	Equipment, at Historical Cost	606,295	3,054,987	16
17	Accumulated Depreciation (book methods)	(628,686)	(6,172,083)	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>		65,057	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 489,521	\$ 8,451,861	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,796,271	\$ 21,407,390	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,302,679	\$ 2,302,679	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,860	69,860	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	243,395	243,395	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,621	11,621	31
32	Accrued Real Estate Taxes(Sch.IX-B)	323,730	323,730	32
33	Accrued Interest Payable		89,913	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	470,637	470,637	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,421,922	\$ 3,511,835	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,188,350	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 16,188,350	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,421,922	\$ 19,700,185	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,374,349	\$ 1,707,205	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,796,271	\$ 21,407,390	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,191,685	1
2	Restatements (describe):		2
3	<u>See Attached</u>	(276,389)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,915,296	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	262,051	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	(4,802,998)	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)	\$ (4,540,947)	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)	\$ 6,374,349	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr# 0042119Report Period Beginning: 01/01/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,968,593	1
2	Discounts and Allowances for all Levels	(2,704,826)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,263,767	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,420,936	6
7	Oxygen	33,672	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,454,608	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	257,824	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,133	19
20	Radiology and X-Ray	4,290	20
21	Other Medical Services	100,753	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 385,000	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	585,171	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 585,171	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	21	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,688,567	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,122,627	31
32	Health Care	4,385,903	32
33	General Administration	2,993,003	33
B. Capital Expense			
34	Ownership	1,594,212	34
C. Ancillary Expense			
35	Special Cost Centers	1,199,011	35
36	Provider Participation Fee	131,760	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,426,516	40
41	Income before Income Taxes (line 30 minus line 40)**	262,051	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 262,051	43

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

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

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

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

0042119

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	1,610	1,968	\$ 80,868	\$ 41.09	1
2	Assistant Director of Nursing	1,730	2,340	76,674	32.77	2
3	Registered Nurses	17,921	21,013	551,431	26.24	3
4	Licensed Practical Nurses	62,110	68,046	1,604,620	23.58	4
5	CNAs & Orderlies	115,510	126,201	1,239,266	9.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,756	14,267	208,576	14.62	8
9	Activity Director	1,863	2,110	28,275	13.40	9
10	Activity Assistants	12,503	14,037	138,342	9.86	10
11	Social Service Workers	10,450	11,598	185,365	15.98	11
12	Dietician	1,951	2,169	26,258	12.11	12
13	Food Service Supervisor	2,146	2,436	44,739	18.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,958	5,389	73,904	13.71	15
16	Dishwashers	28,249	31,279	294,070	9.40	16
17	Maintenance Workers	5,737	6,335	83,371	13.16	17
18	Housekeepers	28,425	31,737	291,378	9.18	18
19	Laundry	12,510	14,267	134,924	9.46	19
20	Administrator	1,491	1,909	88,416	46.32	20
21	Assistant Administrator	1,725	2,030	36,028	17.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,992	6,642	76,316	11.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,050	2,336	32,275	13.82	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	331,687	368,109	\$ 5,295,096 *	\$ 14.38	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	331	\$ 16,017	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,660	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	4	200	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>See Attached - Care Centers Allocation</u>		13,293	10-03	47
48					48
49	TOTAL (lines 35 - 48)	335	\$ 59,170		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

Report Period Beginning: 01/01/08 Ending:

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC - \$16,809, IL Assoc. of HCF \$2,640
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,708 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 131,760
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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