

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325 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>74</u>	Skilled (SNF)	<u>74</u>	<u>27,084</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>411</u>	Intermediate (ICF)	<u>411</u>	<u>150,426</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>485</u>	TOTALS	<u>485</u>	<u>177,510</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>24,118</u>	<u>1,034</u>	<u>1,932</u>	<u>27,084</u>	8
9	SNF/PED					9
10	ICF	<u>94,367</u>			<u>94,367</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>118,485</u>	<u>1,034</u>	<u>1,932</u>	<u>121,451</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.42%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 09/01/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/1996 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 33 and days of care provided 1,932

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 Report Period Beginning: 01/01/08 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	602,894	67,425	75	670,394		670,394	4,458	674,852		1
2	Food Purchase		550,176		550,176		550,176	992	551,168		2
3	Housekeeping	361,613	90,974		452,587		452,587	(4,345)	448,242		3
4	Laundry	127,520	53,222		180,742		180,742	(430)	180,312		4
5	Heat and Other Utilities			357,564	357,564		357,564	6,578	364,142		5
6	Maintenance	390,731		247,443	638,174		638,174	46,309	684,483		6
7	Other (specify):*							5,999	5,999		7
8	TOTAL General Services	1,482,758	761,797	605,082	2,849,637		2,849,637	59,561	2,909,198		8
	B. Health Care and Programs										
9	Medical Director			18,300	18,300		18,300		18,300		9
10	Nursing and Medical Records	3,874,233	135,866	15,438	4,025,537		4,025,537	56,583	4,082,120		10
10a	Therapy	205,914			205,914		205,914	5,501	211,415		10a
11	Activities	186,396	20,606	200	207,202		207,202		207,202		11
12	Social Services	509,288	2,601	13,547	525,436		525,436	31,957	557,393		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							13,904	13,904		15
16	TOTAL Health Care and Programs	4,775,831	159,073	47,485	4,982,389		4,982,389	107,945	5,090,334		16
	C. General Administration										
17	Administrative	150,235			150,235		150,235	119,930	270,165		17
18	Directors Fees										18
19	Professional Services			686,844	686,844	(36,794)	650,050	(536,453)	113,597		19
20	Dues, Fees, Subscriptions & Promotions			54,056	54,056		54,056	(5,798)	48,258		20
21	Clerical & General Office Expenses	209,998	45,901	398,976	654,875		654,875	60,578	715,453		21
22	Employee Benefits & Payroll Taxes			1,028,472	1,028,472		1,028,472	(5,332)	1,023,140		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,069	6,069		6,069	3,961	10,030		24
25	Other Admin. Staff Transportation			14,120	14,120		14,120	3,107	17,227		25
26	Insurance-Prop.Liab.Malpractice			266,053	266,053		266,053	22,380	288,433		26
27	Other (specify):*							63,931	63,931		27
28	TOTAL General Administration	360,233	45,901	2,454,590	2,860,724	(36,794)	2,823,930	(273,696)	2,550,234		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,618,822	966,771	3,107,157	10,692,750	(36,794)	10,655,956	(106,190)	10,549,766		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr #0042325 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			82,654	82,654		82,654	562,227	644,881		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			38,463	38,463		38,463	1,293,444	1,331,907		32
33	Real Estate Taxes					36,794	36,794	798,678	835,472		33
34	Rent-Facility & Grounds			2,520,000	2,520,000		2,520,000	(2,512,229)	7,771		34
35	Rent-Equipment & Vehicles			11,609	11,609		11,609	2,635	14,244		35
36	Other (specify):*							101,487	101,487		36
37	TOTAL Ownership			2,652,726	2,652,726	36,794	2,689,520	246,242	2,935,762		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		157,780	66,333	224,113		224,113	(36,714)	187,399		39
40	Barber and Beauty Shops			18	18		18		18		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			266,265	266,265		266,265		266,265		42
43	Other (specify):*							4,641	4,641		43
44	TOTAL Special Cost Centers		157,780	332,616	490,396		490,396	(32,073)	458,323		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,618,822	1,124,551	6,092,499	13,835,872		13,835,872	107,979	13,943,851		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning: 01/01/08

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	(76,725)	30		9
10	Interest and Other Investment Income	(3,321)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(21,580)	21		18
19	Entertainment				19
20	Contributions	(500)	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	(252,592)	21		24
25	Fund Raising, Advertising and Promotional	(16,352)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(17,101)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (388,217)		\$	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)	496,196		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 496,196		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 107,979		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

Westshire Nursing & Rehab Ctr

ID# 0042325

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	PY Reclass Ventlease	\$ (3,440)	39	1
2	PY Liability Insurance	(92)	26	2
3	Rental Income	(19,303)	21	3
4	Jury Duty	(34)	10	4
5	Misc. Income	(370)	21	5
6	Patient Clothing	(563)	10	6
7	Charitable Donations	(1,750)	20	7
8	Theft Loss	(59)	21	8
9	Collection Expense	(93)	21	9
10	Public Relations	(648)	20	10
11	Annual Fee	(250)	20	11
12	Non-Allowable Legal	(3,293)	19	12
13	Accrued Legal Expenses	12,794	19	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	(17,101)		49

Westshire Nursing & Rehab Ctr

ID# 0042325

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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 Westshire Nursing & Rehab Ctr

0042325

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			1,023		7,514	(4,079)						4,458	1
2	Food Purchase	(47)		1,039									992	2
3	Housekeeping			1,015		112		(5,472)					(4,345)	3
4	Laundry							(430)					(430)	4
5	Heat and Other Utilities			6,166		256	156						6,578	5
6	Maintenance		21,452	7,788	15,036	32	27	(206)		2,180			46,309	6
7	Other (specify):*				5,026	973							5,999	7
8	TOTAL General Services	(47)	21,452	17,031	20,062	8,887	(3,896)	(6,108)		2,180			59,561	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(597)				64,417		(7,237)					56,583	10
10a	Therapy					5,501							5,501	10a
11	Activities													11
12	Social Services					31,957							31,957	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					13,904							13,904	15
16	TOTAL Health Care and Programs	(597)				115,779		(7,237)					107,945	16
	C. General Administration													
17	Administrative			4,902	18,280	93,351	2,227				1,170		119,930	17
18	Directors Fees													18
19	Professional Services	9,501		(281,762)		(264,820)	85				543		(536,453)	19
20	Fees, Subscriptions & Promotions	(19,500)		13,561		18	76				47		(5,798)	20
21	Clerical & General Office Expenses	(293,997)		59,186	284,570	31,709	2,642	(94)		(23,856)	418		60,578	21
22	Employee Benefits & Payroll Taxes				(5,068)			(264)					(5,332)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,461		396					104		3,961	24
25	Other Admin. Staff Transportation			2,948			146			13			3,107	25
26	Insurance-Prop.Liab.Malpractice	(92)	19,938	2,142		35	181			45	131		22,380	26
27	Other (specify):*				47,075	16,103	615				138		63,931	27
28	TOTAL General Administration	(304,088)	19,938	(195,562)	344,857	(123,208)	5,972	(359)		(23,798)	2,551		(273,696)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(304,731)	41,390	(178,531)	364,919	1,458	2,076	(13,704)		(21,618)	2,551		(106,190)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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	(76,725)	585,126	27,993		1,901	165			23,690	77		562,227	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,321)	1,199,820	76,613		14,194	507			5,045	586		1,293,444	32
33	Real Estate Taxes		788,736	9,526		416							798,678	33
34	Rent-Facility & Grounds		(2,520,000)	7,237			534						(2,512,229)	34
35	Rent-Equipment & Vehicles			2,414			51				170		2,635	35
36	Other (specify):*		101,487										101,487	36
37	TOTAL Ownership	(80,046)	155,169	123,783		16,511	1,257			28,735	833		246,242	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(3,440)					(377)	(6,816)		(18,360)	(7,721)		(36,714)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*										4,641		4,641	43
44	TOTAL Special Cost Centers	(3,440)					(377)	(6,816)		(18,360)	(3,080)		(32,073)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(388,217)	196,559	(54,748)	364,919	17,969	2,956	(20,520)		(11,243)	304		107,979	45

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

Ending:

12/31/08

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Westshire Health Care Properties, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 2,520,000	Westshire Health Care Properties, LLC	100.00%	\$	\$ (2,520,000)	1
2	V	32 Interest	3,882			1,203,702	1,199,820	2
3	V	06 Repairs & Maintenance				21,452	21,452	3
4	V	30 Depreciation				585,126	585,126	4
5	V	33 Real Estate Taxes				788,736	788,736	5
6	V	26 Property & Liability Insurance				19,938	19,938	6
7	V	36 MIP Expense				101,487	101,487	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,523,882			\$ 2,720,441	\$ * 196,559	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 Report Period Beginning: 01/01/08 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%	\$ 1,023	\$ 1,023	15	
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,039	1,039	16	
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,015	1,015	17	
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	6,166	6,166	18	
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	7,788	7,788	19	
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,902	4,902	20	
21	V	19	Professional Fees	318,247	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	36,485	(281,762)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	13,561	13,561	22	
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	59,186	59,186	23	
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,461	3,461	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,948	2,948	25	
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,142	2,142	26	
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	27,993	27,993	27	
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	76,613	76,613	28	
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	9,526	9,526	29	
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	7,237	7,237	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,414	2,414	31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 318,247			\$ 263,499	\$ * (54,748)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 Report Period Beginning: 01/01/08 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	06 Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	15,036	\$	15,036	15
16	V	06 Maintenance (Direct)	2,282	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,282			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,731		4,731	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	295		295	18
19	V	17 Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	18,280		18,280	19
20	V	21 Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	284,462		284,462	20
21	V	21 Office and Clerical (Direct)	15,282	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	15,390		108	21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	45,196		45,196	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,879		1,879	23
24	V	22 Emp. Ben. - Gen. Admin. (Direct)	5,068	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%			(5,068)	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		\$ 22,632			\$ 387,551	\$ *	364,919	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 Report Period Beginning: 01/01/08 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%	\$ 112	\$ 112	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	256	256	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	32	32	17	
18	V	19	Professional Fees	267,731	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	2,911	(264,820)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	18	18	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	489	489	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	396	396	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	35	35	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,901	1,901	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	14,194	14,194	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	416	416	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7,514	7,514	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	973	973	27	
28	V	10	Nursing Salary	5,605	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	70,022	64,417	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	5,501	5,501	29	
30	V	12	Social Service Salary	2,169	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	34,126	31,957	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	13,904	13,904	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	93,351	93,351	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	31,220	31,220	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	16,103	16,103	34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 275,505			\$ 293,474	\$ * 17,969	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 Report Period Beginning: 01/01/08 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%	\$ 1,379	\$ 1,379	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%	156	156	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	27	27	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	85	85	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	76	76	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	339	339	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	146	146	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	181	181	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	165	165	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	507	507	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%	534	534	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	51	51	28
29	V	01 Dietary	8,647	Care Centers Health Systems, Inc.	100.00%	3,189	(5,458)	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	597	Care Centers Health Systems, Inc.	100.00%	220	(377)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	2,227	2,227	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,303	2,303	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	615	615	38
39	Total		\$ 9,244			\$ 12,200	\$ *	2,956 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr# 0042325Report 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	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	61,780	Xcel Supply, LLC	100.00%	56,308	(5,472)	16
17	V	4 Laundry	4,849	Xcel Supply, LLC	100.00%	4,420	(430)	17
18	V	6 Repairs & Maintenance	2,325	Xcel Supply, LLC	100.00%	2,119	(206)	18
19	V	10 Nursing	81,707	Xcel Supply, LLC	100.00%	74,470	(7,237)	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	1,066	Xcel Supply, LLC	100.00%	972	(94)	23
24	V	22 Employee Benefits	2,982	Xcel Supply, LLC	100.00%	2,718	(264)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	76,953	Xcel Supply, LLC	100.00%	70,137	(6,816)	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		\$ 231,663			\$ 211,143	\$ * (20,520)	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%	\$ 173,057	\$ 173,057	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	173,057	CCS Employee Benefits Group	100.00%		(173,057)	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			\$ 173,057			\$ 173,057	\$ *	39

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr# 0042325Report 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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 2,180	\$ 2,180	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	245	245	16
17	V	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%	13	13	17
18	V	26	Insurance		Vent Lease, LLC.	100.00%	45	45	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	7,249	7,249	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	1,223	1,223	20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	16,441	16,441	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	3,822	3,822	22
23	V	21	Office and Clerical	24,101	Vent Lease, LLC.	100.00%		(24,101)	23
24	V	39	Ancillary	18,360	Vent Lease, LLC.	100.00%		(18,360)	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			\$ 42,461			\$ 31,218	\$ * (11,243)	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	17 Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 124	\$ 124	15	
16	V	19 Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	543	543	16	
17	V	20 Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	47	47	17	
18	V	21 Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	418	418	18	
19	V	24 Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	104	104	19	
20	V	26 Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	131	131	20	
21	V	30 Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	77	77	21	
22	V	32 Interest		Therapy Works Rehabilitation Services, LLC	100.00%	586	586	22	
23	V	35 Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	170	170	23	
24	V	39 Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	4	4	24	
25	V	39 Ancillary (Direct)		Therapy Works Rehabilitation Services, LLC	100.00%			25	
26	V	17 Administrative Salaries		Therapy Works Rehabilitation Services, LLC	100.00%	1,046	1,046	26	
27	V	27 Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	138	138	27	
28	V	39 Ancillary Salaries	42,813	Therapy Works Rehabilitation Services, LLC	100.00%	35,088	(7,725)	28	
29	V	43 Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	4,641	4,641	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		\$ 42,813			\$ 43,117	\$ *	304	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 Westshire Nursing & Rehab Ctr # 0042325 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	Eric Rothner	Owner	Administrative	9.60%	See Attached	2.48	5.37%		\$	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	4.09	7.44%	Alloc. Salary	11,349	17-7	2
3	Adam Vales	Owner	Clerical	2.48%	See Attached	1.32	3.30%	Alloc. Salary	2,382	22-7	3
4	Kim Rudolph	Owner	Clerical	2.48%	See Attached	0.55	3.30%	Alloc. Salary	484	22-7	4
5	David Aronin	Owner	Administrative	0.82%	See Attached	2.98	5.23%	Alloc. Salary	6,493	17-7	5
6	Steve Miretzky	Owner	Admin. / Clerical	0.41%	See Attached	2.97	7.43%	Alloc. Salary	6,045	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,753		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning: 01/01/08

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 Westshire Nursing & Rehab Ctr

0042325

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	\$ 121,451	\$ 1,023	1
2	02	Food	Patient Days	1,635,146	31	13,971	121,451	1,039	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	121,451	1,015	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	121,451	6,166	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	121,451	7,788	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	121,451	4,902	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	121,451	36,485	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	121,451	13,561	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	121,451	59,186	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	121,451	3,461	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	121,451	2,948	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	121,451	2,142	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	121,451	27,993	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	121,451	76,613	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	121,451	9,526	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	121,451	7,237	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	121,451	2,414	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 263,499	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	121,451	15,036	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013		2,282	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		121,451	4,731	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015			295	4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	121,451	18,280	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	121,451	284,462	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		15,390	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		121,451	45,196	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			1,879	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		\$ 387,551	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	\$ 121,451	\$ 112	1	
2	05	Utilities	Patient Days	1,635,146	31	3,449	121,451	256	2	
3	06	Maintenance	Patient Days	1,635,146	31	431	121,451	32	3	
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	121,451	2,911	4	
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	121,451	18	5	
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	121,451	489	6	
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	121,451	396	7	
8	26	Insurance	Patient Days	1,635,146	31	465	121,451	35	8	
9	30	Depreciation	Patient Days	1,635,146	31	25,565	121,451	1,901	9	
10	32	Interest	Patient Days	1,635,146	31	191,164	121,451	14,194	10	
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	121,451	416	11	
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	121,451	7,514	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	121,451	973	13	
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	121,451	64,417	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	121,451	5,501	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	121,451	31,957	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	121,451	13,176	17	
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	121,451	93,351	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	121,451	31,220	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	121,451	16,103	20	
21	10	Nursing Salary	Direct Allocation			401,447	401,447		5,605	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016		2,169	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816			728	23
24										24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 293,474		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	31	111,096		47,994	1,379	1
2	03	Housekeeping	Gross Billable Income	31			47,994		2
3	05	Heat and Other Utilities	Gross Billable Income	31	12,529		47,994	156	3
4	06	Maintenance	Gross Billable Income	31	2,136		47,994	27	4
5	19	Professional Fees	Gross Billable Income	31	6,873		47,994	85	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	6,095		47,994	76	6
7	21	Clerical and General Office	Gross Billable Income	31	27,280		47,994	339	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	11,773		47,994	146	8
9	26	Insurance	Gross Billable Income	31	14,568		47,994	181	9
10	30	Depreciation	Gross Billable Income	31	13,298		47,994	165	10
11	32	Interest	Gross Billable Income	31	40,850		47,994	507	11
12	33	Real Estate Taxes	Gross Billable Income	31			47,994		12
13	34	Rent - Building	Gross Billable Income	31	43,000		47,994	534	13
14	35	Rent - Equipment	Gross Billable Income	31	4,135		47,994	51	14
15	01	Dietary	Direct Billable Income	31	102,965		8,647	3,189	15
16	02	Food	Direct Billable Income	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	31	1,321,550		597	220	21
22	17	Administrative	Gross Billable Income	31	179,474	179,474	47,994	2,227	22
23	21	Clerical and General Office	Gross Billable Income	31	185,549	185,549	47,994	2,303	23
24	27	Employee Benefits	Gross Billable Income	31	49,573		47,994	615	24
25	TOTALS				\$ 2,134,357	\$ 365,023		\$ 12,200	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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			\$	\$		\$	1
2	3	Housekeeping						56,308	2
3	4	Laundry						4,420	3
4	6	Repairs & Maintenance						2,119	4
5	10	Nursing						74,470	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions							8
9	21	Office And Clerical						972	9
10	22	Employee Benefits						2,718	10
11	24	Seminars & Education							11
12	39	Ancillary						70,137	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				\$	\$		\$ 211,143	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$	\$		\$ 173,057	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				\$	\$		\$ 173,057	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	\$ 18,360	\$ 2,180	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933	18,360	245	2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473	18,360	13	3
4	26	Insurance	Direct Billing	669,310	26	1,630	18,360	45	4
5	30	Depreciation	Direct Billing	669,310	26	264,263	18,360	7,249	5
6	32	Interest	Direct Billing	669,310	26	44,568	18,360	1,223	6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	121,451	16,441	7
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	121,451	3,822	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	\$	\$ 31,218	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 Therapy Works Rehabilitation Services, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 922-0702
 Fax Number (847) 905-4040

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Administration	Billable Income	(4,665,397)	14	\$ 13,500	\$ (42,813)	\$ 124	1	
2	19	Professional Fees	Billable Income	(4,665,397)	14	59,199	(42,813)	543	2	
3	20	Dues and Subscriptions	Billable Income	(4,665,397)	14	5,081	(42,813)	47	3	
4	21	Office & Clerical	Billable Income	(4,665,397)	14	45,575	(42,813)	418	4	
5	24	Travel and Seminar	Billable Income	(4,665,397)	14	11,318	(42,813)	104	5	
6	26	Insurance	Billable Income	(4,665,397)	14	14,252	(42,813)	131	6	
7	30	Depreciation	Billable Income	(4,665,397)	14	8,410	(42,813)	77	7	
8	32	Interest	Billable Income	(4,665,397)	14	63,875	(42,813)	586	8	
9	35	Rent - Equipment	Billable Income	(4,665,397)	14	18,528	(42,813)	170	9	
10	39	Ancillary	Billable Income	(4,665,397)	14	389	(42,813)	4	10	
11	39	Ancillary (Direct)	Direct			143,969			11	
12	17	Administrative Salaries	Billable Income	(4,665,397)	14	113,937	113,937	(42,813)	1,046	12
13	27	Emp. Ben. - Gen. Admin.	Billable Income	(4,665,397)	14	15,069	(42,813)	138	13	
14	39	Ancillary Salaries	Billable Income	(4,665,397)	14	3,823,568	3,823,568	(42,813)	35,088	14
15	43	Emp. Ben. - Other	Billable Income	(4,665,397)	14	505,700	(42,813)	4,641	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 4,842,370	\$ 3,937,504	\$ 43,117	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 Westshire Nursing & Rehab Ctr # 0042325 Report Period Beginning: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	HUD		X	Mortgage			\$	\$ 20,204,823			\$ 1,203,702	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
Working Capital																	
6	DIAWA Loan		X	Line of Credit				15,675			661	6					
7	Shareholder Loan	X						3,285,029			37,802	7					
8	See Supplemental Schedule											8					
9	TOTAL Facility Related						\$	\$ 23,505,527			\$ 1,242,165	9					
B. Non-Facility Related*																	
10	Interest Income		X								(7,203)	10					
11	Allocated from CCI/ECC		X								76,613	11					
12	Allocated from CC/EC Clinical		X								14,194	12					
13	See Supplemental Schedule										6,138	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 89,742	14					
15	TOTALS (line 9+line14)						\$	\$ 23,505,527			\$ 1,331,907	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 101,487 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15	Allocated from CC Health Sys.		X				\$	\$			\$	507	15
16	Allocated from Vent Lease		X									5,045	16
17	Allocated from Therapy Works		X									586	17
18													18
19													19
20	TOTAL Non-Facility Related											6,138	20

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

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

IMPORTANT NOTICE

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

FACILITY IDPH LICENSE NUMBER 0042325

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>16-29-202-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>105,584.53</u>	\$ <u>105,584.53</u>
2. <u>16-29-202-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>105,584.53</u>	\$ <u>105,584.53</u>
3. <u>16-29-202-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>211,169.38</u>	\$ <u>211,169.38</u>
4. <u>16-29-202-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>120,133.02</u>	\$ <u>120,133.02</u>
5. <u>16-29-202-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>211,064.83</u>	\$ <u>211,064.83</u>
6. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	\$ <u>122,122.75</u>	\$ <u>4,059.62</u>
7. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>43,667.89</u>	\$ <u>2,162.03</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>919,326.93</u>	\$ <u>759,757.94</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 Westshire Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042325

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1996</u>	<u>\$ 120,000</u>	1
2	<u>Allocate Care Centers, Inc.</u>			<u>30,370</u>	2
3	TOTALS			\$ 150,370	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	3,490		20	89	89	1,085	9
10	Various			1997	58,633		20	1,503	1,503	17,352	10
11	Various			1998	73,844		20	1,893	1,893	19,961	11
12	Various			1999	19,521		20	501	501	4,776	12
13	Various			2000	37,266		20	1,355	1,355	11,574	13
14	Various			2001	53,553		20	1,947	1,947	14,685	14
15	Various			2002	40,664		20	1,043	1,043	6,821	15
16	Various			2003	38,215		20	980	980	5,430	16
17											17
18											18
19											19
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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

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
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62								62
63								63
64								64
65								65
66								66
67		20,415,207	577,002		543,086	(33,916)	5,910,621	67
68		169,399	8,948		8,948		58,393	68
69			82,654			(82,654)		69
70		\$ 20,909,792	\$ 668,604		\$ 561,345	\$ (107,259)	\$ 6,050,698	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 20,909,792	\$ 668,604		\$ 561,345	\$ (107,259)	\$ 6,050,698	1
2	Blue Prints	2005	3,347		20	167	167	628	2
3	Paint Rooms	2005	10,000		20	500	500	1,708	3
4	Painting 5Th Floor	2005	6,000		20	300	300	950	4
5	Blinds 5Th Floor	2005	4,810		20	241	241	762	5
6	Handrails/Bumpers 5Th Floor	2005	7,433		20	372	372	1,177	6
7	Call System	2005	5,307		20	354	354	1,386	7
8	Ptac'S	2005	14,518		20	2,904	2,904	9,921	8
9	Alarm Repair	2005	3,652		20	730	730	2,373	9
10	Permits For Modernization	2005	2,517		20	503	503	1,594	10
11	A/C Condensor	2005	1,750		20	88	88	306	11
12	Concrete	2005	1,575		20	79	79	263	12
13	Replace Ball Valves	2005	2,836		20	142	142	508	13
14	Replace Compressor	2005	4,350		20	218	218	743	14
15	Circulating Pump	2005	2,464		20	123	123	421	15
16	Compressor Installation	2005	1,760		20	88	88	308	16
17	Glass Insulating Units	2005	2,112		20	106	106	370	17
18	Fire Alarm Repair	2005	1,600		20	80	80	253	18
19	Call System	2005	938		20	47	47	180	19
20	Hvac Repairs	2005	951		20	48	48	174	20
21	Overbed Light	2005	128		20	6	6	20	21
22	Locks	2005	1,112		20	56	56	171	22
23	Bath And Shower Room Remodeling	2006	15,000		20	1,001	1,001	2,501	23
24	Bright Electric	2006	5,518		20	368	368	920	24
25	Hvac For Elevator	2006	9,277		20	619	619	1,546	25
26	Bathroom Renovation	2006	27,377		20	1,826	1,826	4,564	26
27	Circuit Breaker	2006	3,500		20	233	233	583	27
28	S. Electronic	2006	1,564		20	104	104	261	28
29	Monitoring System	2006	1,170		20	78	78	195	29
30	Duct System	2007	33,500		20	1,675	1,675	2,931	30
31	Painting (Transfer Expense From Home Office)	2007	5,560		20	2,317	2,317	5,560	31
32	Dairy Cooling System	2007	10,125		20	506	506	717	32
33	New Water Main Pipes	2007	113,300		20	5,665	5,665	8,025	33
34	TOTAL (lines 1 thru 33)		\$ 21,214,843	\$ 668,604		\$ 582,889	\$ (85,715)	\$ 6,102,717	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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 12B, Carried Forward		\$ 21,214,843	\$ 668,604		\$ 582,889	\$ (85,715)	\$ 6,102,717	1
2	New Furnace	2007	130		20	11	11	15	2
3	Ac Unit	2007	12,022		20	1,002	1,002	1,336	3
4	Voice Evacuation System	2007	25,900		20	3,700	3,700	4,317	4
5	Install Cabling & Electrical	2007	2,682		20	134	134	212	5
6	Fix Heating Problem	2008	2,580		20	129	129	129	6
7	Adj #000114 (Voice Evacuation System)	2008	1,038		20	74	74	74	7
8	Replace Compressor	2008	11,398		20	190	190	190	8
9	Wiring For Matrix	2008	8,527		20	142	142	142	9
10									10
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12									12
13									13
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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 12C, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
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4									4
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 12D, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
2									2
3									3
4									4
5									5
6									6
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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 12E, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
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3									3
4									4
5									5
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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 12F, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
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4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
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3									3
4									4
5									5
6									6
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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 12H, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
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4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

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Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 12I, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
2									2
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4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

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Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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 12J, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
2									2
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4									4
5									5
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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 12K, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	1
2									2
3									3
4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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 12L, Carried Forward		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	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
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19									19
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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)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	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
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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)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	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
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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)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	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)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

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		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 21,279,120	\$ 668,604		\$ 588,271	\$ (80,333)	\$ 6,109,132	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	1	2	3	4	5	6	7	8	9		
	Bed* ^s	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	485		1996	1974	\$ 19,609,780	\$ 502,815	39	\$ 502,815	\$	\$ 5,740,470	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Hot Water Heaters			2004	22,404	1,120	20	1,120		5,321	9
10	Vertical Pumps			2004	5,860	293	20	293		1,380	10
11	New Conduit			2004	3,160	158	20	158		744	11
12	Plumbing			2004	15,337	767	20	767	(0)	3,611	12
13	Compressor			2004	11,023	551	20	551	0	2,503	13
14	Elevator Door			2004	38,820	1,941	20	1,941		8,330	14
15	Remodel Patient Room			2005	10,000	1,000	20	500	(500)	3,250	15
16	Overbed Lights			2005	7,157	716	20	358	(358)	2,266	16
17	Passenger Elevator 3			2005	21,900	1,095	20	1,095		3,741	17
18	Modernize 3 Elevators			2005	197,100	9,855	20	9,855		32,029	18
19	5th Floor Rehab (Nurses Station)			2006	15,480	1,548	20	774	(774)	4,515	19
20	5th Floor Rehab (Drawings)			2006	6,605	661	20	330	(331)	1,927	20
21	Remove & Replace Doors			2006	5,836	584	20	292	(292)	1,654	21
22	5th Floor Rehab (Remodel of Bathrooms)			2006	76,000	7,600	20	3,800	(3,800)	19,633	22
23	5th Floor Rehab (Drawings)			2006	16,763	1,676	20	838	(838)	4,330	23
24	Elevator Wiring, HVAC Wiring, Elevator Recall System			2006	56,300	5,630	20	2,815	(2,815)	16,890	24
25	5th Floor Rehab (Overbed Lights)			2006	6,940	1,388	20	347	(1,041)	4,048	25
26	Butterfly Valves for Chiller			2006	2,739	548	20	137	(411)	1,415	26
27	5th Floor Rehab (Cubicle Curtains)			2006	8,787	1,757	20	439	(1,318)	4,393	27
28	6th Floor Rehab (Cubicle Curtains)			2006	9,981	1,996	20	499	(1,497)	4,658	28
29	Fire Panel			2007	5,947	850	20	297	(553)	1,345	29
30	Tiling			2007	12,500	833	20	625	(208)	1,528	30
31	Fire Panel			2007	67,578	9,654	20	3,379	(6,275)	16,895	31
32	Repair Shower Room			2007	11,200	1,120	20	560	(560)	1,867	32
33	Compressor			2007	6,250	625	20	313	(313)	885	33
34	Accessories for AC Unit			2007	8,092	674	20	405	(269)	899	34
35	Patio Fence			2007	4,800	480	20	240	(240)	640	35
36	Replace Doors and Build Frames			2007	7,100	710	20	355	(355)	888	36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Doors	2007	\$ 3,442	\$ 172	20	\$ 172	\$ 0	\$ 201	37
38	New Furnace	2007	5,170	431	20	259	(173)	610	38
39	Fire Alarm System Install	2008	86,574	14,428	20	4,329	(10,099)	14,429	39
40	Electrical Wiring 8th Floor	2008	5,000	458	20	250	(208)	458	40
41	Electrical Wiring 3th Floor	2008	6,000	550	20	300	(250)	550	41
42	Replace Compressor - Walk in Freezer	2008	3,500	146	20	175	29	146	42
43	Replaced Condensor Fans	2008	2,996	100	20	150	50	100	43
44	HVAC Repairs	2008	31,086	2,072	20	1,554	(518)	2,072	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 20,415,207	\$ 577,002		\$ 543,086	\$ (33,916)	\$ 5,910,621	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocated from EC/CC Clinical, Inc.		2002	2002	\$ 3,732	\$ 96	39	\$ 96		\$ 602	4
5	Allocated from CCI/ECC - CCI Building			1996	55,960	1,435	39	1,435		17,278	5
6	Allocated from CCI/Extended Care Consulting, LLC		2002	2002	33,762	866	39	866		5,447	6
7											7
8											8
	Improvement Type**										
9	Allocated from CCI/Extended Care Consulting, LLC			2002	27,890	2,549	20	2,549		12,769	9
10	Allocated from CCI/Extended Care Consulting, LLC			2003	32,867	3,004	20	3,004		15,047	10
11	Allocated from CCI/Extended Care Consulting, LLC			2005	1,633	174	20	174		415	11
12	Allocated from CCI/Extended Care Consulting, LLC			2007	341	17	20	17		40	12
13											13
14	Allocated from CCI/ECC- CCI Building			1996	944	-	20	-		944	14
15	Allocated from CCI/ECC- CCI Building			1997	5,374	174	20	174		2,731	15
16											16
17	Allocated from CC/EC Clinical, Inc.			2002	3,083	282	20	282		1,411	17
18	Allocated from CC/EC Clinical, Inc.			2003	3,633	332	20	332		1,663	18
19	Allocated from CC/EC Clinical, Inc.			2005	180	19	20	19		46	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 Westshire Nursing & Rehab Ctr

0042325

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		
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56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	169,399	\$	8,948	\$	8,948	\$	58,393	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 376,290	\$ 47,563	\$ 44,022	\$ (3,541)	10	\$ 322,461	71
72	Current Year Purchases	15,000	355	7,504	7,149	10	7,277	72
73	Fully Depreciated Assets	2,466,636				10	1,011,636	73
74								74
75	TOTALS	\$ 2,857,926	\$ 47,918	\$ 51,526	\$ 3,608		\$ 1,341,374	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from CCC/EC Clinical	2008	\$ 5,345	\$ 1,069	\$ 1,069	\$	5	\$ 2,079	76
77		Allocated from CCI/ECC	2008	64,120	3,984	3,984		5	55,127	77
78		Allocated from CC Health Sys	2008	157	31	31		5	37	78
79										79
80	TOTALS			\$ 69,622	\$ 5,084	\$ 5,084	\$		\$ 57,243	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 24,357,038	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 721,606	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 644,881	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (76,725)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 7,507,749	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocate Care Centers, Inc.</u>				<u>7,237</u>			5
6	<u>Allocate Care Centers Health Sys.</u>				<u>534</u>			6
7	TOTAL				\$ <u>7,771</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u> </u> /2009	\$ <u> </u>
13.	<u> </u> /2010	\$ <u> </u>
14.	<u> </u> /2011	\$ <u> </u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,244

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			85			85	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			42,728			42,728	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				88,848		88,848	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					23,520	68,932		92,452	13
14	TOTAL			\$		\$ 66,333	\$ 157,780		\$ 224,113	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr# 0042325Report 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	\$ 2,922	\$ 98,817	1
2	Cash-Patient Deposits	87,506	87,506	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,391,504	1,391,504	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,076	31,076	6
7	Other Prepaid Expenses	900	255,209	7
8	Accounts Receivable (owners or related parties)	206,338	38,386	8
9	Other(specify): <u>See Attached Schedule</u>	15,154	1,677,476	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,735,400	\$ 3,579,974	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		120,000	13
14	Buildings, at Historical Cost		19,609,781	14
15	Leasehold Improvements, at Historical Cost	632,865	1,403,895	15
16	Equipment, at Historical Cost	1,169,306	1,245,922	16
17	Accumulated Depreciation (book methods)	(1,238,651)	(7,673,082)	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>		162,228	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 563,520	\$ 14,868,744	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,298,920	\$ 18,448,718	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,437,809	\$ 1,476,193	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	101,370	101,370	28
29	Short-Term Notes Payable	15,675	15,675	29
30	Accrued Salaries Payable	297,977	297,977	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,268	23,268	31
32	Accrued Real Estate Taxes(Sch.IX-B)		791,200	32
33	Accrued Interest Payable		99,846	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	17,225	17,225	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,893,324	\$ 2,822,754	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,285,029	3,285,029	39
40	Mortgage Payable		20,204,823	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,285,029	\$ 23,489,852	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,178,353	\$ 26,312,606	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,879,433)	\$ (7,863,888)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,298,920	\$ 18,448,718	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,824,677)	1
2	Restatements (describe):		2
3	Pension Expense	(1,090)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,825,767)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(53,666)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (53,666)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,879,433)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning: 01/01/08

Ending: 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	\$ 13,756,655	1
2	Discounts and Allowances for all Levels	(196,129)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,560,526	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	79,873	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 79,873	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	86,742	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,486	19
20	Radiology and X-Ray	1,850	20
21	Other Medical Services	1,701	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 118,779	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,321	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,321	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	19,707	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,707	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,782,206	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,849,637	31
32	Health Care	4,982,389	32
33	General Administration	2,860,724	33
B. Capital Expense			
34	Ownership	2,652,726	34
C. Ancillary Expense			
35	Special Cost Centers	224,131	35
36	Provider Participation Fee	266,265	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,835,872	40
41	Income before Income Taxes (line 30 minus line 40)**	(53,666)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (53,666)	43

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

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

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

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning: 01/01/08

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	1,954	2,085	\$ 94,188	\$ 45.17	1
2	Assistant Director of Nursing	3,836	4,722	140,098	29.67	2
3	Registered Nurses	19,427	20,842	574,476	27.56	3
4	Licensed Practical Nurses	57,470	61,494	1,560,216	25.37	4
5	CNAs & Orderlies	118,440	129,114	1,468,098	11.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,572	13,792	205,914	14.93	8
9	Activity Director	1,920	2,155	37,478	17.39	9
10	Activity Assistants	13,260	14,546	148,918	10.24	10
11	Social Service Workers	35,719	38,454	509,288	13.24	11
12	Dietician	3,475	3,792	60,782	16.03	12
13	Food Service Supervisor	3,384	3,843	94,966	24.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,026	5,550	73,212	13.19	15
16	Dishwashers	35,455	38,198	373,934	9.79	16
17	Maintenance Workers	31,574	33,806	390,731	11.56	17
18	Housekeepers	32,435	35,113	361,613	10.30	18
19	Laundry	9,608	10,736	127,520	11.88	19
20	Administrator	1,642	1,720	72,808	42.33	20
21	Assistant Administrator	1,866	2,280	77,427	33.96	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,015	12,732	209,998	16.49	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	1,913	2,440	37,157	15.23	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	402,991	437,414	\$ 6,618,822 *	\$ 15.13	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		\$ 75	01-03	35
36	Medical Director	Monthly	18,300	09-03	36
37	Medical Records Consultant	Monthly	4,680	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,153	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	271	11,378	12-03	45
46	Other(specify)				46
47	<u>See Attached</u>		2,169	12-03	47
48	<u>See Attached</u>		5,605	10-03	48
49	TOTAL (lines 35 - 48)	275	\$ 47,560		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 Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning: 01/01/08

Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Blake A Willey	Administrator	0	\$ 72,808	Workers' Compensation Insurance	\$ 105,494	IDPH License Fee	\$ 995	
Serena M. Carter	Asst. Admin.	0	77,427	Unemployment Compensation Insurance	118,839	Advertising: Employee Recruitment	18,678	
				FICA Taxes	500,576	Health Care Worker Background Check		
				Employee Health Insurance	232,434	(Indicate # of checks performed <u>304</u>)	6,223	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	3,617	
				Employee Physicals	140	Dues & Subscriptions	5,293	
				Pension Expense	46,809	Advertising & Promotions	16,352	
				Other Employee Welfare	13,663	Charitable Donations	1,750	
				Holiday Expense	5,185	See Supplemental Schedule	14,850	
						Less: Public Relations Expense	(648)	
						Non-allowable advertising	(18,852)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 150,235				\$ 1,023,140		\$ 48,258		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	6,069
							Allocate Care Centers, Inc.	3,461
							Allocate Care Centers Clinical, Inc.	396
							Allocate Therapy Works	104
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$ 10,030	
C. Professional Services								
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting		\$ 14,055					
ADP	Payroll Processing		12,034					
Paycor Services	Payroll Processing		1,050					
National Data Corp.	Data Processing		4,673					
eHealth Data Solutions	MDS Software		3,975					
Personnel Planners	Unemployment Consult.		4,457					
Care Centers, Inc.	Other Professional Fees		3,250					
Legat Architects	Architecture		1,100					
Property Valuation Services	Real Estate Appeal		3,750					
Allegiance, Inc.	Employee Compliance		262					
Pinnacle Consulting	Customer Satisfaction		1,874					
See Supplemental Schedule			636,364					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 686,844								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
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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? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IAHCF = \$4,440
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,955 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. \$ 266,265
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 100% Ln 14
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? No
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT